Safe Travels Study Abroad Plan
Summary of Coverage

Plan is underwritten by GBG Insurance Limited

Policy Number: SAS-11852 **Member ID #:** 999999999

Covered Person: John Q. Traveler **DOB:** 2/5/1958

Home Country: IN **Destination:** US

Policy Period: 8/26/2018 **through** 10/15/2018 **Premium Paid:** 1,500

If you have questions about your coverage or need to renew please contact your agent:

Crossborder Services, LLC 877-340-7910

$100,000 per Maximum per Accident/Sickness per Policy Year

$50 Deductible per Accident/Sickness per Policy Year

After the Deductible the plan pays 100% of Usual, Reasonable and Customary Charge (RC)

Description of Service	Basic Plan
Hospital Room & Board (including Intensive Care)	100% of RC
Hospital Miscellaneous	100% of RC
Inpatient Surgery	100% of RC
In Hospital Doctor's Visits	100% of RC
Outpatient Surgery	100% of RC
Inpatient/ Outpatient Surgeon's Fee	100% of RC
Anesthesia/Assistant Surgeon/Nurse / Anesthetist/CRNA	100% of RC
Doctor Office Visits	100% of RC
Laboratory, Diagnostic X-rays, Tests, Procedures and Injections	100% of RC
Chiropractic Care/ Physiotherapy	UP to $1,000 maximum per Policy Year
Speech Therapy	100% of RC
Emergency Room Services	100% of RC

Mental & Nervous	Inpatient $5,000 30 days Max per Policy Year Outpatient $1000 Max per Policy Year
Alcohol & Substance Abuse	$1,000 combined Inpatient/ Outpatient Max per Policy Year
Maternity	Covered to Policy max; conception must occur while the covered person is insured under the policy
Routine nursery care of a newborn child of a covered pregnancy	RC up to $500
DME (Durable Medical Equipment)	Rental to purchase price
Ambulance Expense	Covered to Policy Max per Policy Year
Accident Dental Injury (including Palliative Treatment)	$100 per tooth, max $500 per Policy Period
Prescription Drugs	50% of the actual charge
Emergency Medical Evacuation	$50,000 max per Policy Year
Repatriation of Remains	Maximum $25,000
Accidental Death and Dismemberment Principal Sum	$10,000 Maximum
Political and Natural Disaster Evacuation Benefit	Up to $15,000 per person; $1,000,000 Aggregate

ELIGIBILITY
Effective Date – The beginning date of the term for which premium has been paid.
Coverage Ends- Your coverage ends on the earliest of the following: 1. The date you cease to be eligible for coverage; or 2. The end of your term of coverage.
Maximum Benefit Period -1 year from the date of the Covered Accident or Sickness while outside your home country.

ACCIDENTAL DEATH AND DISMEMBERMENT - will apply only to Injury sustained by such Insured Person during the course of coverage. Such Insurance includes such Injury which: Coverage A) occurs during the course of time the Insured Person is covered under the Policy; Coverage B) is sustained during such trip while the Insured Person is riding as a passenger (but not as a pilot, operator or member of the crew) in or on, boarding or alighting from: 1. a Common Carrier provided that this Insurance will not apply while such Insured Person is riding in any civilian or military aircraft unless previously consented to in writing by the Company. The Company will pay an indemnity determined from the Table of Losses, if an Insured Person sustains a Loss stated therein resulting from Injury, provided that: 1. such Loss occurs within 30 days after the date of Accident causing such Loss; and 2. the indemnity payable for any such Loss will be the Principal Sum stated in Accidental Death and Dismemberment, Principal Sum, as applicable to such Insured Person and this Insurance; and 3. if more than one Loss stated in said Table is sustained as the result of one Accident, only one of the amounts so stated in said Table, the largest, will be payable and the Insured must still be covered under the Policy.

Exposure If by reason of an Accident covered by the Policy an Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a Loss for which the Principal Sum is otherwise payable hereunder such Loss will be covered under the terms of this Policy. Disappearance If the body of an Insured Person has not been found within one year of the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which such Insured Person was an occupant, then it will be deemed, subject to all other terms and provisions of the Policy, that such Insured Person will have suffered Loss of life within the meaning of the Policy. The beneficiary or beneficiaries of an Insured Person will be that person or those persons designated by the Insured Person and filed with the Company. Any Insured Person who has not made an irrevocable designation of beneficiary may designate a new beneficiary at any time, without the consent of the beneficiary, by filing with the Company a written request for such change but such change will become effective only upon receipt of such request at the office of the Company. When such request is received by the Company, whether the Insured Person be then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment theretofore made by it.

ACCIDENT MEDICAL EXPENSES The Company will pay Covered Expenses due to Accident as per the limits stated in Accident Medical. Coverage is limited to Covered Expenses incurred subject to Exclusions. All bodily Injuries sustained in any one Accident will be

considered one Disablement; all bodily disorders existing simultaneously which are due to the same or related causes will be considered one Disablement. If a Disablement is due to causes which are the same or related to the cause of a prior Disablement (including complications arising there from), the Disablement will be considered a continuation of the prior Disablement and not a separate Disablement.

Treatment of an Injury must occur within 30 days of the Accident.
Medical expenses incurred for treatment of injuries sustained as a result of a covered motor vehicle accident are payable up to the limit stated in Accident Medical, Motor Vehicle Limit.
Medical expenses incurred for treatment of sports related accidents are not payable.
When a covered Injury is incurred the Company will pay Reasonable and Customary medical expenses in excess of the Deductible and Coinsurance as stated in Accident Medical. In no event will the Company's maximum liability exceed the maximum stated as to Covered Expenses during any one period of individual coverage.
The Deductible and Coinsurance amount consists of Covered Expenses which would otherwise be payable under this Policy. These expenses must be borne by the Insured Person.

Covered Accident Medical Expenses

For the purpose of this section, only such expenses, incurred as the result of a Disablement, which are specifically enumerated in the following list of charges, and which are not excluded in Section V, Exclusions, will be considered as Covered Expenses:
1) Charges made by a Hospital for semi-private room and board, floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation.
2) Charges made for Intensive Care or Coronary Care charges and nursing services to a maximum per day.
3) Charges made for diagnosis, treatment and Surgery by a Physician, Asst. Physician at 100% of Paid surgical expense and Anesthetist paid at 100% of the paid surgical expenses.
4) Charges made for an operating room.
5) Charges made for Outpatient treatment, same as any other treatment covered on an Inpatient basis. This includes ambulatory surgical centers, Physicians' Outpatient visits/examinations, clinic care, and surgical opinion consultations.
6) Charges made for the cost and administration of anesthetics.
7) Charges for medication, x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, oxygen, blood, transfusions, iron lungs, and medical treatment. Outpatient x-ray services and laboratory tests are limited as follows: Inpatient Laboratory tests are limited to CPT codes 80000-89999 inclusive. Outpatient Laboratory tests are limited to CPT codes 70000-79999 inclusive.
8) Charges for physiotherapy.
9) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
10) Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items. Charges for athletic or special appliances will not be covered.
11) Local transportation to or from the nearest Hospital or to and from the nearest Hospital with facilities for required treatment. Such transportation will be by licensed ground ambulance only if the Insured Person is in a rural area, and then the Emergency repatriation benefit to the nearest metropolitan area will be considered a Covered Expense to the maximum.
Accident Medical Benefit Period - Only those expenses specifically described above which are incurred within the Benefit Period from the onset of an Injury and which are not excluded are considered Covered Expenses. Initial treatment of an Injury must occur within 30 days of the Accident. All covered expenses are subject to the Medical Maximum based on the Plan chosen.

SICKNESS MEDICAL EXPENSES The Company will pay Covered Expenses, as per the limits stated. Coverage is limited to Covered Expenses incurred subject to Exclusions. All bodily disorders existing simultaneously which are due to the same of related causes will be considered one Disablement. If a Disablement is due to causes which are the same or related to the cause of a prior Disablement (including complications arising there from), the Disablement will be considered a continuation of the prior Disablement and not a separate Disablement. Treatment of an Illness must occur within 365 days of the onset of the Illness. Illness must manifest itself during the Period of Coverage. When a covered Illness is incurred the Company will pay Reasonable and Customary medical expenses excess of the Deductible and Coinsurance. In no event will the Company's maximum liability exceed the maximum stated, as to

Covered Expenses during any one period of individual coverage. The Deductible and Coinsurance amount consists of Covered Expenses which would otherwise be payable under this Policy. These expenses must be borne by the Insured Person.

Covered Sickness Medical Expenses
For the purpose of this section, only such expenses, incurred as the result of a Disablement, which are specifically enumerated in the following list of charges, and which are not excluded in Section V, Exclusions, will be considered as Covered Expenses:

1) Charges made by a Hospital for semi-private room and board, floor nursing while confined in a ward or semi-private room of a Hospital and other services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation.
2) Charges made for Intensive Care or Coronary Care charges and nursing services to a maximum.
3) Charges made for diagnosis, treatment and Surgery by a Physician, Asst. Surgeon, and Anesthetist.
4) Charges made for an operating room.
5) Charges made for Outpatient treatment, same as any other treatment covered on an Inpatient basis. This includes ambulatory surgical centers, Physicians' Outpatient visits/examinations, clinic care, and surgical opinion consultations.
6) Charges made for the cost and administration of anesthetics.
7) Charges for medication, x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, oxygen, blood, transfusions, iron lungs, and medical treatment. Outpatient x-ray services and laboratory tests are limited as specified.
8) Charges for physiotherapy, if recommended by a Physician for the treatment of a specific Disablement and administered by a licensed physiotherapist.
9) Physician visits are limited to one per day.
10) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
11) Charges made for artificial limbs, eyes, larynx, and orthotic appliances and other DME, but not for replacement of such items. Rental price may not exceed Purchase price.
12) Local transportation to or from the nearest Hospital or to and from the nearest Hospital with facilities for required treatment. Such transportation will be by licensed ground ambulance only. (If the Insured Person is in a rural area, then qualified emergency air repatriation transportation will be used and must be pre-authorized to the nearest hospital in a metropolitan area.
13) Chest X-ray required as the result of a positive PPD screening as the result of tuberculosis (TB) will be covered up to $50 up to the Reasonable and Customary limit.
14) Mental and Nervous
15) Alcohol and Substance Abuse

Sickness Medical Benefit Period - Only those expenses specifically described above which are incurred within the Benefit Period and from the onset of the Illness and which are not excluded are considered Covered Expenses. Initial treatment of an Illness must occur within 30 days of the onset of the Illness and only during the Period of Coverage. Illness must manifest itself during the Period of Coverage.

MATERNITY
When a covered Maternity is incurred the Company will pay Reasonable and Customary medical expenses excess of the Deductible and Coinsurance as stated Maternity. In no event will the Company's maximum liability exceed the maximum Maternity, as to Covered Expenses during any one period of individual coverage. Benefits will be payable for Covered Expenses an Insured Person incurs before, during, and after delivery of a Child, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Insured Person and her newborn Child in a Hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Perinatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Insured Person's attending Physician determines further Inpatient postpartum care in not necessary for the Insured Person or her newborn Child provided the following are met:
In the opinion of the Insured Person's attending Physician, the newborn Child meets the criteria for medical stability in the guidelines for Perinatal Care prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of: The antepartum, intrapartum, postpartum course of the mother and infant; The gestational stage, birth weight, and clinical condition of the infant; The demonstrated ability of the mother to care for the infant after discharge; and The availability of post discharge follow up to verify the condition of the infant after discharge; and One (1)

at-home post delivery care visit is provided to the Insured Person at her residence by a Physician or nurse performed no later than forty-eight (48) hours following discharge of the Insured Person and her newborn Child from the Hospital. Coverage for this visit includes, but is not limited to: Parent education; Assistance in training in breast or bottle feeding; and Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Insured Person or newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At the Insured Person's discretion, this visit may occur at the Physician's office.)

MENTAL AND NERVOUS – ALCOHOL AND DRUG ABUSE

When covered Mental or Nervous or Alcohol or Drug Abuse expenses are incurred the Company will pay Reasonable and Customary expenses in excess of the Deductible and Coinsurance, Mental and Nervous – Alcohol and Drug Abuse. In no event will the Company's maximum liability exceed the maximum stated in Mental and Nervous – Alcohol and Drug Abuse, as to Covered Expenses during any one period of individual coverage.

Mental or Nervous

For the purpose of this section, only such expenses, incurred as the result of Mental or Nervous treatment or medication, which are specifically enumerated in the following list of charges, and which are not excluded in Section V, Exclusions, will be considered as Covered Expenses:

1. Inpatient Care:

a. Charges made by a Hospital or mental institution for room and board, floor nursing and other services inclusive of charges for professional service and with the exception of personal services of a non-medical nature, provided, however, that expenses do not exceed the Hospital's or mental institution's average charge for semiprivate room and board accommodation.

b. Charges made for diagnosis and treatment by a Physician.

c. Charges made for the cost and administration of anesthetics.

d. Charges for medication, x-ray services, laboratory tests and services, oxygen, and medical treatment.

e. Drugs and medicines that can only be obtained upon a written prescription of a Physician.

2. Outpatient care:

a. Charges made for diagnosis and treatment by a Physician.

b. Charges made for the cost and administration of anesthetics.

c. Charges for medication, x-ray services, laboratory tests and services, oxygen, and medical treatment.

d. Drugs and medicines that can only be obtained upon a written prescription of a Physician.

Only those expenses specifically described above which are incurred within the Limits stated in Mental and Nervous – Alcohol and Drug Abuse, from the onset of the Mental Illness and which are not excluded, are considered Covered Expenses. Mental Illness must first manifest itself during the Period of Coverage.

Alcohol and Drug Abuse

For the purpose of this section, only such expenses, incurred as the result of Alcohol and Drug Abuse treatment or medication, which are specifically enumerated in the following list of charges, and which are not excluded will be considered as Covered Expenses:

1. The process whereby a person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum, will be considered a covered benefit.
2. Additional treatment as a covered benefit will be provided by a hospital, a non-hospital residential facility, an outpatient treatment facility, a physician, a psychologist, or a social worker, and will include inpatient services, outpatient services, or any combination of these, certified as medically or psychologically necessary by a physician, psychologist, or social worker.

The Company will not be liable for more than one such Inpatient or Outpatient occurrence per Lifetime under this Policy, with respect to one Insured Person.

DENTAL

When covered Dental expenses are incurred the Company will pay Reasonable and Customary expenses in excess of the Deductible and Coinsurance as stated. In no event will the Company's maximum liability exceed the maximum stated for Dental, as to Covered Expenses during any one period of individual coverage. For the purpose of this section, only such expenses, incurred as the result of an eligible Dental condition, in which services or Medications are prescribed, performed, or ordered by a Dentist and enumerated below, and which are not excluded will be considered as Covered Expenses.

1. With respect to Accidental Dental, an eligible Dental condition will mean emergency dental repair or replacement to sound, natural teeth damaged as a result of a covered Accident.

2. With respect to Palliative Dental, an eligible Dental condition will mean emergency pain relief treatment to natural teeth.

SPINAL MANIPULATION
When covered Spinal Manipulation expenses are incurred the Company will pay Reasonable and Customary expenses in excess of the Deductible. In no event will the Company's maximum liability exceed the maximum for Spinal Manipulation, as to Covered Expenses during any one period of individual coverage. For the purpose of this section, only such expenses incurred which are prescribed, performed, or ordered by a licensed chiropractor for the relief of pain, and which are not excluded, will be considered as Covered Expenses.

EMERGENCY MEDICAL EVACUATION/REPATRIATION The Company will pay benefits for Covered Expenses incurred up to the maximum for Emergency Medical Evacuation/Repatriation, if any Injury or covered Illness commencing during the Period of Coverage results in the Medically Necessary Emergency Medical Evacuation or Repatriation of the Insured Person. The decision for an Emergency Medical Evacuation or Repatriation must be ordered by the Company's appointed Assistance Company in consultation with the Insured Person's local attending Physician.
Emergency Medical Evacuation or Repatriation means: a) the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is located (due to inadequate medical facilities) to the nearest adequate medical facility where medical treatment can be obtained; or b) after being treated at a local medical facility as a result of a Medical Evacuation, the Insured Person's medical condition warrants transportation with a qualified medical attendant to his/her Home Country to obtain further medical treatment or to recover; or c)both a) and b) above.

Covered Expenses are expenses, up to the maximum stated for Emergency Medical Evacuation/Repatriation, for transportation, medical services and medical supplies necessarily incurred in connection with Emergency Medical Evacuation or Repatriation of the Insured Person. All transportation arrangements must be by the most direct and economical route.
Expenses for Special transportation and medical supplies and services must be: a) pre-approved and ordered by the Company's appointed assistance company representative and b) required by the standard regulations of the conveyance transportation the Insured Person. Transportation means any land, water or air conveyance required to transport the Insured Person. Special transportation includes, but is not limited to, licensed ground and air ambulances, commercial airlines, and private motor vehicles.
All transportation in connection with an Emergency Medical Evacuation or Repatriation must be pre-approved and arranged by an assistance company representative appointed by the Company.

RETURN OF MORTAL REMAINS OR CREMATION
The Company will pay the reasonable Covered Expenses incurred up to the maximum as stated for Return of Mortal Remains or Cremation, to return the Insured Person's remains to his/her then current Home Country, if he or she dies. Covered Expenses include, but are not limited to, expenses for embalming, or Cremation, a minimally necessary container appropriate for transportation, shipping costs, and the necessary government authorizations. All Covered Expenses in connection with a Return of Mortal Remains or Cremation must be pre-approved and arranged by an assistance company representative appointed by the Company.

POLITCAL AND NATURAL DISASTER EVACUATION BENEFIT
The Company will pay for the evacuation of a covered person due to political or natural disaster. In order to be considered, this benefit must be coordinated through the UM Assistance Company – GBG Assist.

DEFINITIONS

"Accident" or **"Accidental"** means an event, independent of Illness or self-inflicted means, which is the direct cause of bodily Injury to an Insured Person.
"Alcohol or Drug Abuse" means any pattern of pathological use of alcohol or drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.
"Amateur or Interscholastic Athletics" means a sponsored and/or organized league.
"Certificate" means a document created from the Master Policy, the Insured Person's Application and any endorsements, riders or amendments that will attach during the Insured Person's Period of Coverage.

"Child" means the Primary Insured Person's step-child or a Child under the Insured Person's legal guardianship, but only if such Child depends on the Primary Insured Person's support and maintenance and lives with the Primary Insured Person in a Parent-Child relationship. The term Child does not include a foster Child who is eligible for benefits provided by a governmental program or law, unless required by the law of the State.

"Class" means a group of people defined by a common characteristic, including but not limited to demographic group and geographic region.

"Coinsurance" means the percentage amount of eligible Covered Expenses, after the Deductible, which are the responsibilities of the Insured Person and must be paid by the Insured Person. The Coinsurance amount is stated, under each stated benefit.

"Common Carrier" means any motorized land, sea, and/or air conveyance operating under a valid license for the transportation of passenger for hire.

"Company" will be the company shown on the declarations page.

"Complications of Pregnancy" means any or all of the following conditions which are made worse by, occur during, or are caused by pregnancy: acute nephritis, nephrosis, cardiac decompensation, missed abortion, hyperemesis gravid arum, ectopic pregnancy that is ended, non-elective cesarean section, pre-eclampsia, gestational diabetes, spontaneous end of pregnancy which occurs when a viable birth is not possible, and other medical problems of similar severity.

"Cosmetic Surgery" means the surgical alteration of tissue primarily for the improvement of appearance rather than to improve or restore bodily functions.

"Covered Expenses" means expenses which are for Medically Necessary services, supplies, care, or treatment; due to Illness or Injury; prescribed, performed of ordered by a Physician; Reasonable and Customary charges; incurred while insured under this Policy; and are not listed under Section 6, Limitations and Exclusions, and which do not exceed the maximum limits shown.

"Deductible" means the amount of eligible Covered Expenses which are the responsibility of each Insured Person and must be paid by each Insured Person before benefits under the Policy are payable by the Company.

"Dentist" means a legally licensed doctor of dental surgery; dental medicine or dental science. A dental hygienist who works within the scope of his/her license, under the supervision of a Dentist, is a covered practitioner.

"Dependent" means the spouse who is legally married to the Primary Insured Person; the Primary Insured Person's unmarried Child from birth until his/her 19th birthday; or the Primary Insured Person's unmarried Child who is over 18 years old but not older than 26 years old and is enrolled as a full-time student at an accredited school or college outside of the United States and its territories and is not employed on a full-time basis and is dependent on the Primary Insured Person for his/her support and maintenance. The age limits that apply to Dependent Child (ren) will not apply to any insured Child of the Primary Insured Person who remains dependent on the Primary Insured Person for support and maintenance because he a she becomes incapable of working due to a physical handicap or retardation which occurs: before reaching the age limit; and while insured under this Policy or any prior plan, provided such Child was insured on the date of termination of the prior plan.

"Disablement" as used with respect to medical expenses means an Illness or an Accidental Bodily Injury necessitating medical treatment by a Physician as defined in this Policy.

"Effective Date" means the date the Insured's Persons coverage under this Policy begins. The Effective Date of this Policy is the later of the following: 1. The Date the Company approves the Application and has received the correct premium; 2. The date requested by the Participating Organization for the term beginning.

"Elective Surgery" means surgery or medical treatment which is not necessitated by a pathological or traumatic change in the function or structure in any part of the body first occurring after the Insured's effective date of coverage. Elective Surgery includes, but is not limited to, circumcision, tubal ligation, vasectomy, breast reduction, sexual reassignment surgery, and sub mucous resection and/or other surgical correction for deviated nasal septum, other than for necessary treatment of covered acute purulent sinusitis. Elective Surgery does not apply to cosmetic surgery required to correct a covered Accident.

"Elective Treatment" means surgery or medical treatment which is not necessitated by a pathological or traumatic change in the function or structure in any part of the body first occurring after the Insured's effective date of coverage. Elective Treatment includes, but is not limited to, treatment for acne, nonmalignant warts and moles, weight reduction, infertility, learning disabilities.

"Eligible Benefits" means benefits payable by the Company to reimburse expenses which are for Medically Necessary services, supplies, care, or treatment; due to Illness or Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary charges; incurred while insured under this Policy; and are not listed under Section 6, Limitations and Exclusions, and which do not exceed the maximum limits shown.

"Emergency" means a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within 24 hours.

"Experimental/Investigational" means all services or supplies associated with: 1) treatment or diagnostic evaluation which is not generally and widely accepted in the practice of medicine in the United States of America or which does not have evidence of effectiveness documented in peer reviewed articles in medical journals published in the United States. For the treatment or diagnostic

evaluation to be considered effective such articles should indicate that it is more effective than others available: or if less effective than other available treatments or diagnostic evaluations, is safer or less costly; 2) A drug which does not have FDA marketing approval; 3) A medical devise which does not have FDA marketing approval; or has FDA approval under 21 CFR 807.81, but does not have evidence of effectiveness for the proposed use documented in peer reviewed articles in medical journals published in the United States. For the devise to be considered effective, such articles should indicate that it is more effective than other available devices for the proposed use; or if less effective than other available devises, or is safer or less costly. The company will make the final determination as to whether a service or supply is Experimental/Investigational.

"Family Member" means a spouse, parent, sibling or Child of the Insured Person.

"Home Country" means the country where an Insured Person has his or her true, fixed and permanent home and principal establishment holds a current and valid passport

"Hospital" as used in this Policy means except as may otherwise be provided, a Hospital (other than an institution for the aged, chronically ill or convalescent, resting or nursing homes) operated pursuant to law for the care and treatment of sick or Injured persons with organized facilities for diagnosis and Surgery and having 24-hour nursing service and medical supervision means a place that 1.) is legally operated for the purpose of providing medical care and treatment to sick or injured persons for which a charge is made that the Insured is legally obligated to pay in the absence of insurance 2.) provides such care and treatment in medical, diagnostic, or surgical facilities on its premises, or those prearranged for its use; 3.) provides 24-hour nursing service under the supervision of a Registered Nurse at all times; and 4.) operates under the supervision of a staff of one or more Doctors. Hospital also means a place that is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, American Osteopathic Association, or the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Hospital does not mean: a convalescent, nursing, or rest home or facility, or a home for the aged; a place mainly providing custodial, educational, or rehabilitative care; or a facility mainly used for the treatment of drug addicts or alcoholics.

"Host Country" means any country other than the country where an Insured Person has his or her true, fixed and permanent home and principal establishment holds a current and valid passport except the United States and its territories.

"Illness" wherever used in this Policy means sickness or disease of any kind contracted and commencing after the Effective Date of this Policy and Disablement covered by this Policy.

"Incident" or **"Occurrence"** means all Illnesses that exist simultaneously and which are due to the same or related causes are considered to be one Incident. Further, if an Illness is due to causes which are the same as or related to the causes of a prior Illness, the Illness will be deemed to be a continuation of the prior Illness and not a separate Incident. All Injuries due to the same Accident will be deemed to be one Incident.

"**Injury**" wherever used in this Policy means bodily Injury caused solely and directly by violent, Accidental, external, and visible means occurring while this Policy is in force. The Injury must be the direct cause of the Loss, independent of disease or bodily infirmity. Any Loss due to Injury must begin after the Effective Date of this Policy.

"Inpatient" means an Insured Person who is confined in an institution and is charged for room and board.

"Insurance" means the coverage that is provided under this Policy.

"Insured Person(s)" means a person eligible for coverage under the Policy as defined in Section I, Declarations #3 "Eligible Persons" who has applied for coverage and is named on the application and for whom the company has accepted premium. This may be the Primary Insured Person or Dependent(s).

"Intensive Care Unit" means a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

"Loss" with regard to hands and feet, actual severance through and above the wrist or ankle joints, and with regard to eyes, entire irrecoverable Loss in reference to other coverages means injury or damage sustained by the Insured in consequence of happening of one or more of the accidents against which the Company has undertaken to indemnify the Insured

"Maximum Benefit" means the largest total amount of Covered Expenses that the Company will pay for the Insured as found on the ID card.

"Medically Necessary" or **"Medical Necessity"** means services and supplies received while insured that are determined by the Company to be: 1) appropriate and necessary for the symptoms, diagnosis, or direct care and treatment of the Insured Person's medical conditions; 2) within the standards the organized medical community deems good medical practice for the Insured Person's condition; 3) not provided solely for educational purposes or primarily for the convenience of the Insured Person, the Insured Person's Physician or another Service Provider or person; 4) not Experimental/Investigational or unproven, as recognized by the organized medical community, or which are used for any type of research program or protocol; and 5) not excessive in scope, duration, or intensity to provide safe and adequate, and appropriate treatment. For Hospital stays, this means that acute care as an Inpatient is necessary due to the kinds of services the Insured Person is receiving or the severity of the Insured Person's condition, in that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The fact that any particular

Physician may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary or make the charge of a Covered Expense under this Policy.

"Medicine" or **"Medications"** means the drugs prescribed or dispensed to the Insured Person, by a licensed Physician, as a result of a Covered Expense. Medicine or Medication means the generic equivalent of a drug, or if the generic equivalent is not available, the brand name drug.

"Member" means hand, foot or eye.

"Mental Illness" means any condition or disease listed in the most recent edition of the International Classification of Diseases as a mental disorder, which clinically significant behavioral or psychological disorder marked by a pronounced deviation from a normal healthy state and associated with a present painful symptom or impairment in one or more important areas of functioning. This disease must not be merely an expectable response to a particular stimulus. Mental Illness does not mean learning disabilities, attitudinal disorders or disciplinary problems.

"Mountaineering" means the sport, hobby, or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above.

"Nurse" means a person who has been registered or licensed to practice by the State Board of Nurse Examiners or other state authority in the state where he or she works, and who is practicing within the scope and limitation of that license. The term Nurse will not include the Insured Person or his/her spouse, children, brothers, sisters, or parents, or any person residing in his/her household.

"Outpatient" means an Insured Person who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for an Illness or Injury, but who is confined and is not charged for room and board.

"Parachuting" means an activity involving the breaking of a free fall from an airplane using a parachute.

"Participating Organization" means any organization that has been approved by the Company to sponsor coverage under this Policy.

"Participating Provider Network" means the Hospitals, Physicians, or other Service Providers who have entered into a contractual agreement with the Company to provide Hospital and medical services to Insured Persons at negotiated fee.

"Policy Period" or **"Period of Coverage"** means the period of coverage issued by the Company to the Insured Person, typically beginning with the Effective Date and ending with the Termination Date or the date coverage is renewed by the Company.

"Permanent Residence" means the country where an Insured Person has his or her true, fixed and permanent home and principal establishment, and to which he or she holds a current and valid passport.

"Physical Medicine" means Treatment prescribed by a Physician including diathermy, ultrasonic, whirlpool or heat Treatment, adjustments, manipulation, massage or any form of physical therapy and/or office visits connected with such Treatment.

"Physician" as used in this Policy means a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform Surgery in accordance with the laws of the jurisdiction where such professional services are performed, however, such definition will exclude chiropractors and physiotherapists.

"Policy" means this document, the Application of the Policyholder and the Participating Organization and any endorsements, riders or amendments that will attach during the Period of Coverage.

"Policyholder" means the Policyholder shown on the face page of this Policy.

"Pre-Certification" and **"Pre-Certify"** means the Company, following advance notification for all Hospital admissions worldwide, or for any Outpatient Surgery or Covered Expenses as listed in the Pre-Certification list worldwide, will provide the Insured Person with the names and addresses of local Hospitals that are member of the Participating Provider Network, to which the Insured Person may have access, and confirm that such confinement is Medically Necessary.

"Pregnancy" means the physical condition of being pregnant, including Complication of Pregnancy.

"Primary Insured Person" means the person on the Application, who is listed as the Primary Insured, and whom may have Dependents who are Insured Persons.

"Reasonable and Customary" means the maximum amount that the Company determines is Reasonable and Customary for Covered Expenses the Insured Person receives, up to but not to exceed charges actually billed. The Company's determination considers: 1) amounts charged by other Service Providers for the same or similar service in the locality were received, considering the nature and severity of the bodily Injury or Illness in connection with which such services and supplies are received; 2) any usual medical circumstances requiring additional time, skill or experience; and 3) other factors the Company determines are relevant, including but not limited to, a resource based relative value scale. For a Service Provider who has a reimbursement agreement, the Reasonable and Customary charge is equal to the amount that constitutes payment in full under any reimbursement agreement with the Company. If a Service Provider accepts as full payment an amount less than the negotiated rate under a reimbursement agreement, the lesser amount will be the maximum Reasonable and Customary charge. The Reasonable and Customary charge is reduced by any penalties for which a Service Provider is responsible as a result of its agreement with the Company.

"Registered Nurse" means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other jurisdictional authority, and who is legally entitled to place the letters "R.N." after his or her name.

"Relative" means spouse, parent, sibling, Child, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent, son, daughter, brother and sister), aunt, uncle, niece, nephew, legal guardian, ward, or cousin of the Insured Person.
"Return of Mortal Remains" means the transport of bodily remains or ashes of an Insured person to their Home Country.
"Service Provider" means a Hospital, convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, Physician, Dentist, chiropractor, licensed medical practitioner, nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.
"Sickness" means illness or disease contracted and causing loss commencing while the policy is in force as to the Insured Person whose Sickness is the basis of claim. Any complication or any condition arising out of a Sickness for which the Covered Person is being treated or has received Treatment will be considered as part of the original Sickness.
"Spinal Manipulation" means outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference as a result of or related to distortion, misalignment or subluxation of or in the vertebral column.
"Substance Abuse" means alcohol, drug or chemical abuse, overuse or dependency.
"Surgery or Surgical Procedure" means an invasive diagnostic procedure; or the treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.
"Termination Date" means the date the Insured Person's Coverage terminates under this Policy. The Termination Date of coverage for an Insured Person is the earlier of the following: 1. The end of the Policy Period for which premium has been paid, or 2. The date the Insured Person fails to be considered an Eligible Person.
"Traveling Companion" means spouse, parent, sibling, Child, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent son, daughter, brother, or sister), aunt, uncle, niece, nephew, legal guardian, ward, or business partner of the Insured Person.
"Treatment" means a specific in-office or Hospital physical examination of, care rendered to, the Insured Person, including a consultation or diagnostic procedures and services, Surgery, medical services and supplies including medication prescribed or provided by a Service Provider.
"We, Us or Our" means the GBG Insurance Limited.
"You" or "Your" means the Insured Person.
"Pre-Existing Conditions" for the purposes of this Policy means Any Injury or Illness which meets the following criteria unless covered under the Unexpected Recurrence benefit: 1) An illness, disease or other condition that would have caused a person to seek medical advice, diagnosis, care or treatment during the 12 months prior to the Effective Date of coverage under this Policy; 2) A condition that first manifested itself, worsened, became acute or exhibited symptoms for which medical advice, diagnosis, care or treatment was recommended, received or noticed during the 12, months prior to the Effective Date of coverage under this Policy; a) expenses for a Pregnancy existing within 10 months of the Effective Date of coverage under this Policy; b) a condition that required taking drugs or medicines, unless the condition for which the prescribed drugs or medicines is controlled without any change; c) was treated by a doctor or treatment was recommended. 3) The Pre-Existing waiting period is 12 months. If you receive services or treatment for a pre-existing condition; a) No benefits will be paid for such condition until the day after a consecutive month period has passed from your effective date; and b) The plan will pay only for Covered Expenses incurred after such 12 consecutive month period. 4) If the Injured Person is covered under this Policy for 12 consecutive months, the Pre-Existing Condition exclusion will no longer apply and any eligible expenses incurred thereafter will be considered for reimbursement; or this includes renewals of this Policy. If you have had prior comprehensive coverage without a break of more than 63 days, then the 12 month waiting period will be reduced by the number of months you were covered.

EXCLUSIONS

For expenses listed for **Accidental Death and Dismemberment**, this Insurance does not cover:

1. Illness disease or Sickness of any kind.
2. Bacterial infections except pyogenic infection which will occur through an accidental cut or wound;
3. Hernia of any kind;
4. Injury sustained while the Insured Person is riding as a pilot, student pilot, operator or crew member, in or on, boarding or alighting from, any type of aircraft;
5.. Injury sustained while the Insured Person is riding as a passenger in any aircraft (a) not having a current and valid Airworthy Certificate and (b) not piloted by a person who holds a valid and current certificate of competency for piloting such aircraft;
6. Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with: a) War, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war. b) Mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or usurped power. c) Any act of any person acting on behalf of or in connection with any organization with activities directed towards the

overthrow by force of the Government de jure or de facto or to the influencing of it by terrorism or violence. d) Martial law or state of siege or any events or causes which determine the proclamation or maintenance of marital law or state of siege (hereinafter for the purposes of this Exclusion called the "Occurrences"). Any consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether directly or indirectly, proximately or remotely occasioned by, or contributed to by, traceable to, or arising in connection with, any of the said Occurrences will be deemed to be consequences for which the Company will not be liable under this Policy except to the extent that the Insured Person will prove that such consequence happened independently of the existence of such abnormal conditions.

7. Service in the military, naval or air service of any country;
8. Flying in any aircraft being used for or in connection with acrobatic or stunt flying, racing or endurance tests;
9. Being under the influence of alcohol or having taken drugs or narcotics unless prescribed by a legally qualified Physician or surgeon;
10. Injury occasioned or occurring while the Insured Person is committing or attempting to commit a felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation;
11. While riding or driving in any kind of competition.

For benefits listed in Accident, Injury or Sickness Medical, Maternity and Pre-Natal Care, Mental and Nervous – Alcohol and Drug Abuse, Dental, Spinal Manipulation, Emergency Medical Evacuation/Repatriation, Return of Mortal Remains or Cremation, Emergency Medical Reunion, this Insurance does not cover:

1. Pre-Existing Conditions, as defined in the Definitions section;
2. Charges for treatment which is not Medically Necessary;
3. Charges provided at no cost to the Insured Person;
4. Charges for treatments which exceed Reasonable and Customary charges;
5. Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;
6. Services, supplies or treatment, including any period of Hospital confinement, which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician;
7. Suicide or any attempt thereof, while sane or self-destruction or any attempt thereof, while sane; (*This exclusion does not apply to Return of Mortal Remains);*
8. Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with: a) War, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war. b) Mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or usurped power. c) Any act of any person acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the Government de jure or de facto or to the influencing of it by terrorism or violence. d) Martial law or state of siege or any events or causes which determine the proclamation or maintenance of marital law or state of siege (hereinafter for the purposes of this Exclusion called the "Occurrences"). Any consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether directly or indirectly, proximately or remotely occasioned by, or contributed to by, traceable to, arising in connection with, any of the said Occurrences will be deemed to be consequences for which the Company will not be liable under this Policy except to the extent that the Insured Person will prove that such consequence happened independently of the existence of such abnormal conditions.
9. Injury sustained while participating in professional athletics;
10. Injury sustained while participating in Amateur or Interscholastic Athletics;
11. Routine physicals, immunizations or other examinations where there are no objective indications or impairment in normal health, and laboratory diagnostic or x-ray examinations, except in the course of a Disablement established by a prior call or attendance of a Physician unless otherwise covered under this Policy;
12. Treatment of the Temporomandibular joint;
13. Services or supplies performed or provided by a Relative of the Insured Person, or anyone who lives with the Insured Person;
14. Medical reports and records or history of treatment provided free-of-charge, by a Relative, or a friend of the Insured Person will not be considered reliable and will cause an otherwise valid claim to be denied;
15. Cosmetic or plastic Surgery, except as the result of a covered Accident; for the purposes of this Policy, treatment of a deviated nasal septum will be considered a cosmetic condition;
16. Elective Surgery which can be postponed until the Insured Person returns to his/her Home County, where the objective of the trip is to seek medical advice, treatment or Surgery;
17. Treatment and the provision of false teeth or dentures, normal ear tests and the provision of hearing aids;
18. Eye refractions or eye examinations for the purpose of prescribing corrective lenses for eye glasses or for the fitting thereof, unless caused by Accidental bodily Injury incurred while insured hereunder;

19. Treatment in connection with alcoholism and drug addiction, or use of any drug or narcotic agent unless otherwise covered under this Policy;
20. Injury sustained while under the influence of or Disablement due to wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with treatment prescribed and directed by a Physician for a condition which is covered hereunder but not for the treatment of drug addiction;
21. Any Mental and Nervous disorders or rest cures, unless otherwise covered under this Policy;
22. Home Country coverage is limited to $1,000 and not more than 30 days;
22. Treatment while confined primarily to receive custodial care, educational or rehabilitative care, or nursing services;
23. Congenital abnormalities and conditions arising out of or resulting therefrom, unless otherwise covered under this Policy;
24. Expenses which are non-medical in nature;
25. Expenses as a result or in connection with intentionally self-inflicted Injury or Illness;
26. Expenses as a result or in connection with the commission of a felony offense;
27. Injury sustained while taking part in mountaineering; hang gliding, Parachuting, bungee jumping, racing by horse, motor vehicle or motorcycle, snowmobiling, motorcycle/motor scooter riding, scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified, scuba diving, involving underwater breathing apparatus, snorkeling, spelunking, parasailing and snowboarding;
28. Treatment paid for or furnished under any other individual or group policy or other service or medical pre-payment plan arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for treatment without cost to any individual;
29. Injuries for which benefits are payable under any no-fault automobile Insurance Policy;
30. Dental care, except as the result of Injury to natural teeth caused by Accident, unless otherwise covered under this Policy;
31. For Pregnancy or Illness resulting from Pregnancy incurred prior to the effective date of this Policy, childbirth, or miscarriage including those incurred by Type III Insured Person;
32. Expenses incurred within the Insured Person's Home Country or country of residence;
33. Expenses incurred during a Hospital emergency visit which is not of an emergency nature;
34. Injury sustained as the result of the Injured Person operating a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place;
35. Covered Expenses incurred for which the Trip to the Host Country was undertaken to seek medical treatment for a condition;
36. Covered Expenses incurred during a Trip after the Insured Person's Physician has limited or restricted travel;
37. Diagnosis and treatment of acne;
38. Outpatient treatment for specified therapies, spinal manipulation, physiotherapy and acupuncture unless otherwise covered under this Policy.

CLAIMS STATUS, ELIGIBILITY VERIFICATION & COVERAGE QUESTIONS

GBG ADMINISTRATIVE SERVICES

GBG Administrative Services, Inc.
26741 Portola Parkway, St, 1E #527
Foothill Ranch, CA 92610
Toll Free: 877-916-7920 Fax 949- 919-7943

Find a provider who accepts this insurance at http://www.trawickinternational.com/resources/find-a-healthcare-provider and follow the instructions.
Provide the hospital or doctor with a copy of your ID card so they can bill us for the services provided to you. This shows your member ID and is how to find you in our system to verify benefits. Failure to give the correct information to the provider could result in bills getting sent to you, instead of the insurance company.
In most cases, you are only required to pay your deductible and the cost for any services which may not be covered under your policy. However, if you are required to pay for services in full, then you will need to provide the necessary documentation for reimbursement: a. Signed medical statement which includes medical coding for service performed by the Service Provider; b. Proof of payment (receipts) and c. Copy of your ID card. If you get a bill from a provider call them to make sure they have your insurance information. Failure to contact them with your information will delay the processing of your claim and could result in you

being solely responsible for the charges. All claims, regardless of submission date, must be received in our office within 180 days of treatment or an explanation will be requested. Initial treatment must occur within 90 days of the Accident or Sickness.
Once a claim has been reviewed, additional documentation may be required for processing. This request is made in writing or electronically to the address/e-mail on file. Please make sure your address/e-mail is current in our database.
After a claim has been processed your ***copy of the EOB information will be*** **available electronically** and the provider will also receive an explanation of benefits (EOB). This explanation has a claim number, date of service, paid date, amount paid, amount applied to your deductible and an explanation as to why/how the claim was processed. The EOB will also state if you owe the provider anything for the service. If there is a reimbursement to you, a check will be attached, and you may review your EOB electronically using the Trawick Assist Iphone app. If you get a bill from a provider, you should check the website for an electronic copy of the EOB. If it is not available within 60 days please contact us at the number above for claim status.
If a claim is denied you will receive a written explanation on the EOB. If you feel the decision is wrong, you have the right to appeal the decision which must be done in writing within 4 months of receiving the EOB electronically. You can get an appeal form by calling the claim office at 877-916-7920.
Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant will be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the policy for filing Proofs of Loss written proof covering the occurrence, the character and the extent of the Disablement for which claim is made.
Proof of Loss: Written Proof of Loss must be furnished to the Company at its said office in case of claim for loss for which this Policy Provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. In any case, the proof required must be given no later than one year from the time specified except in the absence of legal capacity.
Time of Payment of Claims: Indemnities payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written Proof of Loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid at the expiration or each four weeks during the continuance of the period for which the Company is liable, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. Claims will be processed within 30 days following receipt by the Company of due Proof of Loss. Failure to pay within such period will entitle the claimant to interest at the rate of 9 percent per annum from the 30th day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. A claimant or a claimant's assignee will be notified by the Company of any known failure to provide sufficient documentation for a due Proof of Loss within 30 days after receipt of the claim. Any required interest payments will be made within 30 days after the payment.
Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity will be payable to the estate of the Insured Person. Any other accrued indemnities unpaid at the Insured Person's death may, at the option of the Company, be paid either to such estate. All other indemnities will be payable to the Insured Person. If any indemnity of the Policy will be payable to the Insured Person or to an Insured Person who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding $1000, to any Relative by blood or connection by marriage of the Insured Person who is deemed by the Company to be equitably thereto. Any payment made by the Company in good faith pursuant to this provision will fully discharge the Company to the extent of such payment. Subject to any written direction of the Insured Person all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or Surgical service may, at the Company's option and unless the Insured Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the Hospital or person rendering such services, but is not required the service be rendered by a particular Hospital or person.

Physical Examination and Autopsy: The Company at its own expenses will have the right to examine the person of any individual whose Injury or Illness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law during the period of contestability.
Legal Actions: No actions at law or in equity will be brought to recover on the Policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with requirements of this Policy. No such action will be brought after expiration of three years six years after that time written Proof of Loss is required to be furnished.

Effective Date of Individual Insurance: Individual coverage will become effective upon the latest of the following: 1. The Date the Company receives a completed Application and correct premium for the Policy Period. or 2. The Date the Company approves the Application.

Termination Date of Individual Insurance: Individual coverage will terminate upon the earlier of the following: 1. the end of the Policy Period for which premium has been paid; or 2. The Date the Insured Person fails to be considered an Eligible Person.

Insured Persons will furnish all information requested on the Application and any additional information requested by the Company. All newborn Children of the Primary Insured Person, who are not initially covered under this Insurance, will be underwritten, no earlier than the age of thirty (30) days old. Failure on the part of the Primary Insured to furnish an Application for a newborn Child to the Company for underwriting, will not constitute valid Insurance under this contract for the newborn Child. A dependent Child cannot be added to this Insurance without a completed Application and approval of the Company.

Assignment: The Insurance provided hereunder is not assignable, but benefits may be assigned in accordance Payment of Claims.

Renewal of Individual Insurance: The initial Period of Coverage cannot exceed twelve (12) months. The Insured Person, however, may apply for renewal of coverage. The renewal Period of Coverage may not total more than twelve (12) months. Renewal(s) will be contingent upon the Insured Person submitting the application renewal premiums.

Not in Lieu of Worker's Compensation: The Policy is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.

Aggregate Limit of Indemnity: The Aggregate Limit of Indemnity stated for #1 Accidental Death and Dismemberment, will be the total limit of the Company's liability for all independents payable under Accidental Death and Dismemberment Indemnity with respect to all classes of Insured Persons arising out of Injury sustained by two or more Insured Persons as the result of any one Accident.

Excess Benefits: All coverages, except Accidental Death and Dismemberment, will be in excess of all other valid and collectible Insurance Indemnity and will apply only when such benefits are exhausted will be payable as primary coverage and will be paid according to the Coordination of Benefits provision of this Policy.

Other valid and collectable Insurance Indemnity for which benefits may be payable are Insurance programs provided by:

(a) Individual, group or blanket Insurance or coverage;
(b) Other prepayment coverage provided on a group or individual basis;
(c) Any coverage under labor management trusteed plans, union welfare plans, employer organizational plans, employee benefit organization plans, or other arrangement of benefits for individuals of a group;
(d) Any coverage required or provided by any statue, socialized Insurance program;
(e) Any no-fault automobile Insurance;
(f) Any third party liability Insurance.

Monetary Limits: The monetary limits stated in this Policy and the premium will be in U.S. dollars. For service outside of the territorial limits of the United States, the exchange rate date used to determine the amount of U.S. dollars to be paid is the exchange rate effective for the date the claims expense was incurred.

Subrogation: To the extent the Company pays for a loss suffered by an Insured, the Company will take over the rights and remedies the Insured had relating to the loss. This is known as subrogation. The Insured must help the Company to preserve its rights against those responsible for the loss. This may involve signing any papers and taking any other steps the Company may reasonable require. If the Company takes over an Insured's rights, the Insured must sign an appropriate subrogation form supplied by the Company.

UTILIZATION MANAGEMENT (U.M.) PROGRAM - An Insured Person must follow the Utilization Management Program (hereinafter called U.M. Program) in order to receive full benefits under the Policy. If the Insured Person does not properly follow the U.M. Program, their benefits under the Policy will be reduced, as described below. Pre-authorizations are subject to certification by the Assistance Company. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. Certain medical procedures or treatments will require a request form to be received by the Company or the Company's authorized representative. This must be received a minimum of 5 business days prior to the scheduled procedure date if the procedure is elective, or within 48 hours after the initial admission, if the admission is due to an emergency. Approval from the Company must be given prior to the commencement of the proposed medical treatment. *Failure to comply with prior authorization procedures will result in a 20% reduced benefit penalty, provided that the care is determined to be a procedure that would have been approved by the Plan Administrator.* If upon review of medical records, it is determined to be a medical procedure which would not have been approved, the entire claim and all related charges will be denied. Pre-authorization is based on information provided to the Company at the time of request, and does not guarantee payment of benefits nor verify eligibility. Payment for services is subject to all terms, conditions, limitations and exclusions related to the member's eligibility and subsequent medical review. Regardless of pre-authorization status, medical decisions concerning a course of treatment are solely between the doctor and you.

SERVICES REQUIRING PRE-AUTHORIZATION

Any hospitalization including Maternity Delivery;

Outpatient or Ambulatory Surgery;
RSV Immunization and other medications priced in excess of $3,000 per refill;
All cancer treatments/therapies;
Substance Abuse treatments/therapies;
Any condition, including chronic conditions that do not meet the above criteria, but are expected to accumulate $10,000 or more in Covered Expenses per Policy Period.
Subject to all provisions of the Policy, when the requirements of the U.M. Program are properly followed and the Hospital admission for Worldwide treatment is Pre-Certified, benefits for Covered Expenses will be payable as described in the Policy and in any amendments of endorsements to the Policy. If an Insured Person does not properly follow the U.M. Program and if the required Pre-Certification is not obtained, the benefit percentage payable for Covered Expenses incurred for all treatment, services, and supplies related to the Disablement will be reduced to and payable at 20% (whether or not the Coinsurance has been met), after any Deductible amount which may apply. The additional amounts an Insured Person is required to pay as a result of the lower percentage payable due to not following this U.M. Program will not be used to satisfy any Deductible amount or the Coinsurance in the Policy. PRE-CERTIFICATION DOES NOT GUARANTEE BENEFITS – the benefits payable under the Policy are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Policy. Pre-Certification does not guarantee or confirm benefits under the Policy.

COORDINATION OF BENEFITS

Applicability - The Coordination of Benefits ("COB") provision applies to This Plan when an Insured has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan: (a) Will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but (b) May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

Definitions

"Plan" is a form of coverage written on an expense incurred basis which provides benefits or services for, or because of, medical or dental care or treatment. "Plan" includes:
(a) Group insurance and group remittance subscriber contracts;
(b) Uninsured arrangements of group coverage;
(c) Group coverage through HMO's and other prepayment, group practice and individual practice Plans; and
(d) Blanket contracts, except blanket school accident coverages or a similar group when the Policy holder pays the premium.
"Plan" does not include individual or family: (a) insurance contracts; (b) direct payment subscriber contracts; (c) coverage through HMO's; or (d) coverage under other prepayment, group practice and individual practice Plans.
"This Plan" is the parts of this blanket contract that provide benefits for health care expenses on an expense incurred basis.
"Primary Plan" is one whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either:(a) The Plan either has no order of benefit determination rules, or it has rules which differ from those in the contract; or (b)All Plans which cover the person use the same order of benefits determination rules as in this contract, and under those rules the Plan determines its benefits first.
"Secondary Plan" is one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this contract decides the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this contract, has its benefits determined before those of that Secondary Plan.
"Allowable Expense" is the necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part under any of the Plans involved.
The difference between the cost of a private hospital room and a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.
When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an Allowable Expense and a benefit paid.
"Claim" is a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of: (a) services (including supplies); (b) payment for all or a portion of the expenses incurred; or (c) a combination of (a) and (b).

"Claim Determination Period" is the period of time, which must not be less than 12 consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine: (a) whether over insurance exists; and (b) how much each Plan will pay or provide.
For the purposes of this contract, Claim Determination Period is the period of time beginning with the effective date of coverage and ending 12 consecutive months following the date of loss or longer as may be determined by the proof of loss provision.

Order of Benefit Determination Rules

This Plan is always secondary to any other plan as it is considered to be excess benefits. Is benefits are determined after those of any other Plan only when, under these rules, it is secondary to that other Plan.
When there is a basis for a Claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:(a) The other Plan has rules coordinating its benefits with those of This Plan; and (b) Both those rules and This Plan's rules, as described below, require that This Plan's benefits be determined before those of the other Plan.

Effect on the Benefits of This Plan When it is Secondary

The benefits of This Plan will be reduced when it is a Secondary Plan so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than the total Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the Claim is made. As each Claim is submitted, This Plan determines its obligation to pay for Allowable Expenses based on all Claims which were submitted up to that point in time during the Claim Determination Period.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts are needed. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the Claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable monetary value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of: (a) the persons we have paid or for whom we have paid; (b) insurance companies; or (c) other organizations.

Noncomplying Plans

This Plan may coordinate its benefits with a Plan which is excess or always secondary or which uses order of benefit determination rules which are inconsistent with those of This Plan (noncomplying Plan) on the following basis:
If This Plan is the Secondary Plan, This Plan will pay its benefits first, but the amount of the benefits payable will be determined as if This Plan were the Secondary Plan. In this situation, our payment will be the limit of This Plan's liability; and (b)If the noncomplying Plan does not provide the information needed by This Plan to determine its benefits within 30 days after it is requested to do so, we will assume that the benefits of the noncomplying Plan are identical to This Plan and will pay benefits accordingly. However, we will adjust any payments made based on this assumption whenever information becomes available as to the actual benefits of the non-complying.

The Insured Person must remain continuously insured under the Policy for the duration of the treatment. The charges enumerated herein will in no event include any amount of such charges which are in excess of Reasonable and Customary charges. If the charge incurred is in excess of such average charge such excess amount will not be recognized as a Covered Expense. All charges will be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, are rendered or obtained.

POLICY PROVISIONS

Entire Contract; Changes: The Policy, including the endorsements and attachments, if any, and the applications of the Insured Persons, Policyholder and the Participating Organization constitute the entire contract of Insurance. All statements made by an Insured Person, the Policyholder or the Participating Organization will, in absence of fraud, are deemed representations and not warranties. No such statements will be used in defense to a claim under the policy, unless it is contained in a written application. No change in the Policy will be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon. No agent has authority to change this Policy or to waive any of its provisions;

Notice of Claim: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any Disablement covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Administrative Offices of the Company, or to any authorized agent of the Company, with information sufficient to the identify the Insured Person will be deemed notice to the Company.

Plan Administrator

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