TRAVEL MEDICAL INSURANCE PLAN CERTIFICATE

STUDY ABROAD

GBG
Insurance Without Borders℠

DIANins OPTion

We are pleased that you have selected Global Benefits Group (GBG) to provide you with medical protection while you are abroad from your Home Country. This is a limited benefit travel medical Plan intended to provide you with basic medical benefits while you are travelling. Below are highlights of some of the important features of this Plan:

Plan Highlights

- ***Medical benefits are provided for treatment due to an acute, sudden, and unexpected Illness or Injury that arises while covered under this Plan.*** Benefits are *not* provided for the treatment and maintenance of chronic conditions, routine, or general care.

- If you have a ***Pre-Existing Condition***, this Plan will *not* provide coverage for routine care and maintenance of such a condition. However, if a Medical Emergency should arise resulting from a Pre-Existing Condition that the Insurer considers stable, this Plan will cover cost for the immediate relief of an acute symptom only, up to a specified limit.

- ***Hospital emergency room*** benefits are provided in the event of a Medical Emergency. A Medical Emergency situation is where your life or health is in jeopardy. *Use of the Hospital emergency room for non-emergency care is not covered.*

- ***Pre-Authorization is a process for obtaining approval for specified medical procedures or treatment***. Failure to Pre-Authorize may result in the reduction in payment by GBG. See the section titled, *"Assistance Services Including Pre-Authorization Requirements and Procedures"* for more details.

- **GBG Assist** is the dedicated 24 hours a day, 7 days a week customer service division, providing assistance on all medical services and emergency medical situations. In the Event of a Medical Emergency, you can count on highly trained and experience case managers, trained nurses, and a medical director to work as a team to manage all aspects of your case, from the initial contact to the safe arrival back in your Home Country.

  - Worldwide Collect +1.905.669.4920
  - Inside USA/Canada Toll Free +1.866.914.5333
  - Email: customerservice@gbg.com
  - Website: www.gbg.com

We look forward to providing you with this valuable insurance protection and outstanding service during your period of travel.

Sincerely,

Bob Dubrish
Chief Executive Officer
GBG Insurance Limited

SCHEDULE OF BENEFITS

This Schedule of Benefits and Face Page form part of the insurance Plan and are a summary outline of the benefits payable. All benefits described are subject to the definitions, limitations, exclusions, and provisions of the Plan. All dollar ($) amounts are shown in USD.

The following benefits are per Plan Participant per Period of Insurance and subject to the Plan Participants Deductible, Copayment, Coinsurance, and Maximum Benefit per Period of Insurance. After satisfaction of the Deductible, the Insurer will pay the eligible benefits set forth in this Schedule at the Allowable Charge, which is defined as Usual, Customary, and Reasonable (UCR).

General Plan Specifications	
Area of Coverage	Worldwide, excluding the Home Country
U.S. Network	Aetna Passport
Maximum Benefit per Period of Insurance	$1,000,000
Copayment • Urgent Care Facility, Walk-In Clinic, Physician Office Visit • Emergency Room	 $50/visit $350/visit
Pre-Existing Conditions	**Not Covered** In the event of a Medical Emergency resulting from a Pre-Existing Condition the Insurer considers stable, this Plan will cover costs for the immediate relief of an acute symptom only, up to the Maximum Benefit shown below.
PLAN BENEFITS This Plan is designed to protect you from an Acute Illness or Accident requiring Emergency Treatment. It also provides coverage in Non-Emergency situations where medical intervention would be the proper course of action, provided such condition first manifested during the Period of Insurance. This Plan does not cover care for wellness medical conditions, extended treatment, or Pre-Existing Conditions and is not a replacement for longer term medical, preventive, or maintenance needs. Non-Emergency care and treatment that should be rendered in the Plan Participant's Home Country, in the opinion of the Insurer, will not be covered.	
COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Copayment, Coinsurance, and Maximum Benefit per Period of Insurance.	**WHAT THE PLAN COVERS** The following coinsurance applies for In-Network Providers in the U. S. or for expenses incurred outside the U. S. Coinsurance reduces to 60% when Out-of-Network providers in the U.S. are used.
Emergency Treatment of a Pre-Existing Condition • Due to a Medical Emergency resulting from a Pre-Existing Condition • Pre-Existing Condition must be stable • Emergency Treatment benefits only provided	100% UCR Maximum Benefit per Period of Insurance: $25,000

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Copayment, Coinsurance, and Maximum Benefit per Period of Insurance.	WHAT THE PLAN COVERS The following coinsurance applies for In-Network Providers in the U. S. or for expenses incurred outside the U. S. Coinsurance reduces to 60% when Out-of-Network providers in the U.S. are used.
Hospitalization and Inpatient Benefits	
Hospitalization • Hospital Accommodations (semi-private) • Inpatient consultation by a physician or specialist, medical treatment, medicines, laboratory and diagnostic tests	100% UCR
Outpatient Benefits	
Physician Visit or consultation by a specialist, diagnostic testing including X-Ray, and laboratory	100% UCR
Emergency Benefits	
Emergency Room • $350 Copayment per visit • Non-emergency use of the emergency room is **Not Covered**	100% UCR
Ambulance Services (to the nearest Hospital) • Ground only	100% UCR
Emergency Dental Care • Due to an Accident • For immediate relief of pain	100% UCR 100% UCR Maximum Benefit per Period of Insurance: $500
Other Medical Benefits (Inpatient/Outpatient)	
Mental health treatment	100% UCR **Inpatient**: Maximum Benefit per Period of Insurance: 60 days or $150,000 **Outpatient:** Up to $50/visit Maximum Benefit per Period of Insurance: $500
Prescription drugs • For an Illness covered under this Policy	100% UCR
Surgery and anesthesiology services	100% UCR
Physical therapy	100% UCR Up to $50/ visit Maximum Benefit per Period of Insurance: $1,000
Maternity including Complications of Pregnancy	Not Covered

COVERED SERVICES AND BENEFIT LEVELS Subject to Deductible, Copayment, Coinsurance, and Maximum Benefit per Period of Insurance.	WHAT THE PLAN COVERS The following coinsurance applies for In-Network Providers in the U. S. or for expenses incurred outside the U. S. Coinsurance reduces to 60% when Out-of-Network providers in the U.S. are used.
Other Emergency Services	
Emergency Medical Evacuation/Repatriation	100% UCR Maximum Benefit per Period of Insurance: $100,000
Emergency Reunion	Up to $500/day Maximum Benefit per Period of Insurance: $15,000
Continuation (Return to Host Country)	Maximum Benefit per Period of Insurance: $2,500
Emergency Assistance Services via GBG Assist	Included
Other Benefits	
Accidental Death and Dismemberment (AD&D)	Maximum Benefit: $50,000
Repatriation of Mortal Remains	Maximum Benefit: $50,000
Personal Liability	Maximum Benefit Period of Insurance: $100,000
Damage to Property	Maximum Benefit per Period of Insurance: $25,000
Trip Curtailment/Study Interruption	Maximum Benefit per Period of Insurance: $2,500
Baggage Delay	$100/day Maximum Benefit per Period of Insurance: $500
Baggage Loss/Theft • Deductible: $50 per claim (excluding temporary loss) • Maximum Benefit for valuables/Electronics: $300 per item/pair	Maximum Benefit per Period of Insurance: $1,500
Loss of Passport	Maximum Benefit per Period of Insurance: $250
Travel Delay • Maximum Benefit per 24 hour period: $200	Maximum Benefit per Period of Insurance: $1,000
Missed Departure	Maximum Benefit per Period of Insurance: $1,000
Legal Expenses	Maximum Benefit per Period of Insurance: $10,000

1.0 GENERAL PROVISIONS

The **Policyholder** is the International Benefit Trust, hereinafter shall be referred to as the "Trust".

The **Insurer,** the Second party, GBG Insurance Limited, hereinafter shall be referred to, sometimes collectively, as the "Insurer", "We", "Us", or "Company".

The declarations of the Plan Participant and eligible Dependents in the application serve as the basis for participation in the Trust. If any information is incorrect or incomplete, or if any information has been omitted, the insurance coverage may be rescinded or terminated. Any references in this Certificate to the Plan Participant and his Dependents that are expressed in the masculine gender shall be interpreted as including the feminine gender whenever appropriate**.**

No change may be made to this Certificate unless it is approved by an Officer of the Insurer. A change will be valid only if made by a Rider signed by an Officer of the Insurer. No agent or other person may change this Certificate or waiver any of its provisions.

This GBG Insurance Limited Plan is an international insurance Policy issued to the Trust. As such, this Plan is subject to the laws of the Bailiwick of Guernsey, and the Plan Participant should be aware that laws governing the terms, conditions, benefits and limitations in health insurance policies issued and delivered in other countries including the United States are not applicable. If any dispute arises as to the interpretation of this document, the English version shall be deemed to be conclusive and taking precedence over any other language version of this document. GBG Insurance Limited is an insurance company incorporated in Guernsey with registration number 42729 and licensed by the Guernsey Financial Services Commission to conduct insurance business under the Insurance Business (Bailiwick of Guernsey) Law, 2002 as amended.

In the Event of any conflict between the Master Policy and the Schedule of Benefits, the Schedule of Benefits will govern.

2.0 ELIGIBILITY

2.1 Eligible Classes

Individuals enrolled in and attending a study abroad program within the United States, including: Optional Practical Training (OPT), language programs/schools, and students temporarily enrolled on this Plan prior to the start of the school session. Students must be residing outside of their Home Country. Study abroad students must actively attend classes. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend class.

The Insurer has the right to examine eligibility status and attendance records to verify eligibility requirements are met. If it is discovered the eligibility requirements are not met, the insurance coverage will be terminated.

2.2 Persons Eligible to be a Plan Participant

Plan Participants are those Plan Participant's described as an Eligible Class:

- Minimum age is 5 years and maximum is 50 years,
- Must be travelling outside their Home Country.

Note: Coverage for a dependent spouse or child is not available.

2.3 Period of Insurance

The Period of Insurance must be the entire duration the Plan Participant is enrolled in the study abroad program. Eligible individuals may enroll onto the plan no earlier than 30 days prior to the start of their study abroad program and terminate coverage no later than 30 days after their study abroad program has ended. The maximum duration of the Period of Insurance shall not exceed 365 days. Any request for coverage exceeding this limit will be written as a new Plan subject to the terms, conditions, and rates in effect at that time.

3.0 PREMIUM, CANCELLATION, AND PLAN PROVISIONS

3.1 Premium Payment

All premiums are payable before coverage is provided.

3.2 Cancellation

While the Insurer shall not cancel this Plan because of eligible claims made by a Plan Participant, it may at any time terminate a Plan Participant, or modify coverage to different terms, if the Plan Participant has at any time:

- Misled the Insurer by misstatement or concealment, or
- Knowingly claimed benefits for any purpose other than are provided for under this Plan, or
- Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the Insurer's detriment, and
- Failed to observe the terms and conditions of this Plan, or failed to act with utmost good faith.

If the Plan Participant cancels the insurance coverage after it has been issued, or reinstated, the Insurer will not refund the unearned portion of the Premium.

3.3 Duration of Coverage

Benefits are paid to the extent that a Plan Participant receives any of the treatments covered under the Schedule of Benefits following the Effective Date, including any additional waiting periods and up to the date such individual no longer meets the definition of Plan Participant, or their last date of coverage as listed on the Face Page.

3.4 Compliance with the Plan Terms

The Insurer's liability will be conditional upon each Plan Participant complying with its terms and conditions.

3.5 Fraudulent/Unfounded Claims

If any claim is in any respect fraudulent or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and, if appropriate, recoverable.

3.6 Privacy

The confidentiality of information is of paramount concern to GBG Insurance Limited, Global Benefits Group, Inc., and their affiliates ("GBG Family of Companies"). GBG Family of Companies complies with Data Protection Legislation, Medical Confidentiality Guidelines, and Privacy Shield. The Insurer does not share information unless it pertains to the administration of the benefits for Plan Participants. For more detailed information, Our privacy Plan can be viewed on Our website at: https://www.gbg.com/#/AboutGBG/PrivacyPlan.

3.7 Waiver

Waiver by the Insurer of any term or condition will not prevent us from relying on such term or condition thereafter.

3.8 Denial of Liability

The Insurer is not responsible for the quality of care received from any institution or individual. This insurance coverage does not give the Plan Participant any claim, right, or cause of action against the Insurer based on an act of omission or commission of a Hospital, Physician, or other provider of care or service.

Unless specified, this insurance does not cover anything caused directly or indirectly through bankruptcy/ liquidation of any tour operator, travel agent, and transportation company or accommodation supplier.

3.9 Jurisdiction

This Plan does not cover United States citizens residing in the United States. As such, the insurance is not subject to, and is not administered as a PPACA (Patient Protection and Affordable Care Act) insurance Plan and is not subject to guaranteed issuance or renewal.

4.0 GEOGRAPHIC AREAS OF COVERAGE

4.1 Area of Coverage

The Plan is written on a Worldwide basis, excluding the Home Country.

4.2 Preferred Provider Network

The Insurer maintains a Preferred Provider Network both within and outside the United States.

United States only:

- **Preferred Provider In-Network:** This consists of all Providers as well as other preferred Providers designated by the Insurer and listed on the website. In-Network Providers have agreed to accept a negotiated discount for services. The Medical Identification Card contains the logo for the network. Present the Medical ID card to the Physician or Hospital.
- **Out-of-Network Provider:** Utilizing Providers that are Out-of-Network is a more costly financial option for the Plan Participant. The Insurer reimburses such Providers up to an Allowable Charge as determined by the Insurer. The Provider may bill the Plan Participant the difference between the amounts reimbursed by the Insurer and the Provider's billed charge. Additionally, the Plan Participant will pay a Coinsurance amount that is higher than if an In-Network Provider were used.
- **Out-of-Network Area:** When there are no network providers located within a 30 mile radius of your local residence, charges from such providers will be treated the same as a U.S. Preferred Provider In-Network.

All other Countries: The Plan Participant may utilize any licensed Provider. However, we suggest the Plan Participant contact GBG Assist to locate a Provider with a direct billing arrangement with the Insurer.

The Insurer retains the right to limit or prohibit the use of Providers which significantly exceed Allowable Charges.

5.0 ASSISTANCE SERVICES INCLUDING PRE-AUTHORIZATION REQUIREMENTS AND PROCEDURES

GBG Assist is available 24 hours a day, 7 days a week, providing assistance on: locating a Physician or facility, arrange for medical services, Pre-Authorization, answer benefit questions, and update you on the status of claims.

GBG Assist services include:

- Pre-Authorization of medical services
- Emergency and assistance services
- Locating an In-Network Provider
- General customer services
- Medical Evacuation handling and coordination
- Repatriation for medical treatment
- Repatriation of Mortal Remains coordination
- Medical Case Management and review

5.1 Pre-Authorization of Medical Services

Pre-Authorization is a process by which a Plan Participant obtains approval for certain medical procedures or treatments prior to the commencement of the proposed medical treatment. This requires the submission of a completed Pre-Authorization request form to GBG Assist, a minimum of five business days prior to the scheduled procedure or treatment date.

Failure to obtain Pre-Authorization will result in a 50% reduction in payment of Covered Expenses. If treatment would not have been approved by the Pre-Authorization process, all related claims will be denied. The following services require Pre-Authorization:

- Specialist office visit,
- Any Hospitalization,
- Inpatient, Outpatient or Ambulatory Surgery,
- CAT scan, PET scan, MRI, and other high-tech scans,
- Prescription medications in excess of $500 per refill, and
- Any condition, which does not meet the above criteria, but are expected to accumulate over $1,500 of medical treatment.

Either you, your Physician, or your representative must call the number listed on the back of the Medical Identification Card to obtain Pre-Authorization and verification of network utilization. Prior to the performance of services a letter of authorization will be provided.

Medical Emergency Pre-Authorizations must be received within 24 hours of the admission or procedure. In instances of an emergency, the Plan Participant should go to the nearest Hospital or provider for assistance even if that Hospital or provider is not part of the Network.

Pre-Authorization approval does not guarantee payment of a claim in full, as additional Copayments and Out-of-Pocket expenses may apply. Benefits payable under the Plan are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Plan.

6.0 MEDICAL BENEFITS AND OTHER SERVICES

This Plan is designed to protect you from an Acute Illness or Accident requiring Emergency Treatment. It also provides coverage in Non-Emergency situations where medical intervention would be the proper course of action, provided such condition first manifested during the Period of Insurance. This Plan does not cover

care for wellness medical conditions, extended treatment, or Pre-Existing Conditions and is not a replacement for longer term medical, preventive, or maintenance needs. Non-Emergency care and treatment that should be rendered in the Plan Participant's Home Country, in the opinion of the Insurer, will not be covered.

THE FOLLOWING PROVIDES AN EXPLANATION OF THE BENEFITS OFFERED BY THE INSURER. ONLY THOSE SERVICES AND BENEFITS SHOWN ON THE SCHEDULE OF BENEFITS ARE OPERATIVE UNDER THIS POLICY. PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR THE SPECIFIC BENEFITS AND LIMITS.

7.0 EMERGENCY TREATMENT OF A PRE-EXISTING CONDITION

Benefits for routine care and maintenance of a Pre-Existing Condition are not covered. In the event of a Medical Emergency resulting from a Pre-Existing Condition the Insurer considers stable, this Plan will cover costs for the immediate relief of an acute symptom of a stable Pre-Existing Condition only, to the limit shown on the Schedule of Benefits, provided such Pre-Existing condition meets the Insurer's definition of stable.

There are no benefits for continued care or Hospitalization beyond the treatment of the acute symptom.

8.0 HOSPITALIZATION AND INPATIENT BENEFITS

8.1 Accommodations

Coverage is provided for room and board, special diets, and general nursing care. All charges in excess of the allowable semi-private room rate are the responsibility of the Plan Participant. Intensive Care Unit benefits will be provided based on the Allowable Charge for Medically Necessary Intensive Care services.

Inpatient Hospital confinements, where an overnight accommodation, ward, or bed fee is charged, will only be covered for as long as the patient meets the following criteria:

- Admission to the Hospital was Pre-Authorized, or was deemed to be an eligible Medical Emergency by GBG Assist; or
- The patient's medical status continues to require either acute or sub-acute levels of curative medical treatment, skilled nursing, physical therapy, or rehabilitation services. GBG Assist is responsible for the determination of the patient's medical status.

Inpatient Hospital confinements primarily for purposes of receiving non-acute, long term custodial care, respite care, chronic maintenance care, or assistance with Activities of Daily Living (ADL), are not eligible expenses.

8.2 Medical Treatment, medicines, laboratory, diagnostic tests, and ancillary services

If Medically Necessary for the Diagnosis and treatment of the Illness or Injury for which a Plan Participant is Hospitalized, the following services are also covered:

- Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services, or
- Laboratory testing, or
- Durable medical equipment, or
- Diagnostic X-ray examinations, and
- Respiratory therapy.

Physical and Occupational therapy must be rendered by a Physician, registered physical/occupational therapist, and relate specifically to the physician's written treatment Plan. Therapy must:

- Produce significant improvement in the Plan Participant's condition in a reasonable and predictable period of time, and
- Provide a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist, and
- Support the establishment of an effective maintenance program.

8.3 Inpatient Consultation by a Physician or Specialist

The Insurer will reimburse one Physician visit per day while the Plan Participant is a patient in a Hospital. Visits that are part of normal preoperative and postoperative care are covered under the surgical fee and Insurer will not pay separate charges for such care. If Medically Necessary, the Insurer may elect to pay more than one visit of different physicians on the same day if the physicians are of different specialties. The Insurer will require submission of records and other documentation of the Medical Necessity for the intensive services.

9.0 OUTPATIENT BENEFITS

When a Plan Participant is treated as an outpatient of a Hospital or other approved facility, benefits will be paid for facility charges and ancillary services for the following:

- Treatment of Accidental Injury within 48 hours of the Accident;
- Minor surgical procedures;
- Medically Necessary covered emergency services, as defined herein.

9.1 Physician Visits

The Insurer provides benefits for medical visits to a Physician, in the Physician's office, if Medically Necessary. Benefits are limited to one visit per day per Plan Participant. The Insurer may elect to pay more than one visit to different physicians on the same day if the physicians are of different specialties.

9.2 Diagnostic Testing

The Insurer provides benefits for diagnostic testing including echocardiography, ultrasound, MRI, and other specialized testing, to diagnose an Illness or Injury.

10.0 SURGICAL BENEFITS

10.1 Surgical Services

The Insurer will provide benefits for covered surgical services received in a Hospital, a Physician's office or other approved facility. Surgical services include: use of operation room and recovery room, operative and cutting-procedures, treatment of fractures and dislocations, surgical dressings, and other Medically Necessary services.

10.2 Anesthesia Services

Benefits are provided for the service of an anesthesiologist, other than the operating surgeon or assistant, who administers anesthesia for a covered surgical or obstetrical procedure.

11.0 EMERGENCY BENEFITS

11.1 Emergency Room

Benefits are provided for services due to a Medical Emergency when incurred in a Hospital's emergency room. Admission to the Hospital is not required for benefit consideration. Within the United States, use of the emergency room for non-emergency services is a costly alternative and all services provided will not be eligible for benefit payment.

11.2 Emergency Ground Ambulance Services

Benefits are provided for Medically Necessary emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care. The use of ambulance services for the convenience of the Plan Participant will not be considered a covered service.

11.3 Emergency Dental

Benefits are provided for the Emergency Dental treatment and restoration of sound natural teeth required as a result of an Accident. All treatment must be completed within 120 days of the Accident or before the expiration date of the Plan.

Benefits are also provided for the treatment of the immediate relief of pain to teeth or gums, to the limit shown on the Schedule of Benefits.

Routine dental treatment including diagnostic examinations, basic restoration, and other preventive, basic, or major dental services are not covered under this benefit.

12.0 OTHER MEDICAL BENEFITS (INPATIENT/OUTPATIENT)

12.1 Mental Health Benefits

Benefits are provided for psychotherapeutic treatment, psychiatric counseling, and treatment for an approved psychiatric Diagnosis. Benefits are for both inpatient mental health treatment in a Hospital or approved facility and for outpatient mental health treatment. A Physician or a licensed clinical psychologist must provide all mental health care services.

12.2 Prescription Drugs

Prescription Drugs are medications which are prescribed by a Physician and which would not be available without such Prescription. Certain treatments and medications, such as vitamins, herbs, aspirin, cold remedies, medicines, experimental and/or investigational drugs, or supplies, even when recommended by a Physician, do not qualify as Prescription Drugs. Any drug that is not scientifically or medically recognized for a specific Diagnosis or that is considered as off label use, experimental, or not generally accepted for use, will not be covered, even if a Physician prescribes it.

12.3 Therapeutic Services

The Insurer will provide benefits for Medically Necessary therapeutic services rendered to a Plan Participant as an outpatient of a Hospital, provider's office, or approved independent facility. Services must be pursuant to a physician's written treatment plan, which contains short and long term treatment goals and is provided to the Insurer for review.

The following services must either:

- Produce significant improvement in the Plan Participant's condition in a reasonable and predictable period of time; or
- Be of such a level of complexity and sophistication, and the condition of the patient must be such that the required therapy can safely and effectively be performed.

12.4 Sports and other Activities

The Plan covers **leisure sports and activities** meaning such activities that are for relaxation or fun, do not require any special training, and do not heighten the risk of Injury or death to a Plan Participant. The following sports and activities are covered under the Plan:

Covered Leisure Sports & Activities
• Aerobics, Jazzercise, Dancing, Yoga
• Baseball, Basketball
• Bicycle Riding
• Calisthenics
• Cycling
• Diving up to depths of 15 meters/50 feet
• Frisbee
• Hiking/trekking below 3,500 meter elevation
• Horseback Riding (trail only – no jumping, competition, dressage or racing)
• Jogging/Running
• Roller Skating, Roller Blading
• Sailing, Sea Kayaking/Canoeing

• Snow Skiing/Snow Boarding (on marked groomed trails only-No coverage for Jumps, stunts, aerials, half-pipes, moguls, racing or skiing outside of any designated boundaries see additional exclusions below)
• Soccer
• Squash
• Surfing/Swimming
• Tennis
• Volleyball
• Whitewater Rafting / Canoeing up to and including Class 3 Level

This Plan does not cover **intercollegiate, interscholastic, professional sports, or hazardous or extreme sports and activities**, meaning such activities that require a higher degree of knowledge or training and has an increased risk of Injury or death. The following are examples of such sports including but not limited to:

Non-Covered Hazardous & Extreme Sports
• Bungee Jumping, Base Jumping (with or without a parachute), Parkour
• Driving a Golf Cart
• Driving a Motor Driven Vehicle
• Diving to depths deeper than 15 meters, Flying Within 24 Hours of Diving Activity
• Extreme skiing/snowboarding (no jumps, stunts, aerials, half-pipes, moguls, racing, or skiing outside of any designated boundaries)
• Flying either as a Pilot in Command, Student Pilot, or Sport Flying (can only fly as passenger in a fully-licensed passenger carrying aircraft)
• Hiking / trekking above 3,500 meter elevation
• Hunting, Archery, Use of Any Type of Firearm (any device that discharges a projectile of any type)
• Martial Arts, Boxing
• Mountaineering that requires specialized climbing equipment or above 3,500 altitude, Rappelling
• Mountain biking
• Motorcycles, Snowmobiles, Mopeds, Scooters, ATV's or any two or three wheeled motorized vehicle, wave runners, jet skis or other sport watercraft or powered devices whether the vehicle is in motion or not, Motorsport, Motorsport Race or Contest
• Paragliding, Parachuting, Hang Gliding, Parasailing
• Whitewater Rafting/canoeing (above Class 3 Level)

13.0 OTHER EMERGENCY SERVICES

13.1 Emergency Medical Evacuation/Medical Repatriation

In the event a Plan Participant requires emergency medical evacuation or medical repatriation, GBG Assist must approve and arrange such medical air transportation. The following conditions will apply:

- Approved medical evacuation/medical repatriation will be to the Home Country or nearest medical facility capable of providing the necessary medical treatment. Transportation is provided by the most economic means in economy class unless medically authorized for premium cabins based on the medical condition.
- GBG Assist, on behalf of the Insurer, retains the right to decide if the Plan Participant shall be transported to the Home Country or the nearest medical facility capable of providing the necessary medical treatment, to the limit as shown on the Schedule of Benefits.
- If the Plan Participant chooses not to be repatriated to the Home Country or treated at the facility and location arranged by GBG Assist, then all medical and transportation expenses shall be the responsibility of the Plan Participant. The Insurer will not be liable for any expenses related to continued treatment of such medical condition, recurrence or complications resulting from such condition during the Period of Insurance.
- Failure to arrange transportation through GBG Assist will result in non-payment of transportation costs.

13.2 Sea and Offshore Evacuation

If a Plan Participant is injured or becomes ill at sea (i.e cruises, yachting, etc.), the Insurer will not consider any benefit until the Plan Participant is on land. This means any costs involved from an evacuation from sea to land will not be considered under this Plan. Once on land, this Plan will cover medical costs and further evacuation, according to the Plan coverage and terms. If a Plan Participant is at sea, the Insurer would request the Plan Participant be evacuated by sea rescue to a country within their purchased Area of Coverage, where circumstances allow.

13.3 Accompaniment/Emergency Reunion

The Plan allows for the travel and accommodation expenses of one person (i.e., a parent, guardian or close relative, who is a resident of the Plan Participant's Home Country), whom upon medical advice is advised to join (5 days minimum Hospital stay), accompany or remain with the Plan Participant. Transportation costs will be by commercial carrier and in economy class only.

13.4 Continuation (Return to Host Country)

Coverage includes transportation by economy travel for the Plan Participant, if medically able, to return to the point of initial destination to continue with the Trip.

14.0 OTHER BENEFITS

14.1 Accidental Death and Dismemberment (AD&D)

If a Plan Participant has suffered any of the losses as shown in the benefit schedule as a direct consequence of an Accident within 365 days from the date of Accident and provided that such loss is not the direct or indirect result of a risk excluded under this Plan, a capital sum becomes payable in accordance with the provisions and limitations as set forth.

The Maximum Benefit payable is as defined in the schedule. If a dismemberment benefit has been paid to the Plan Participant who dies later, while still being covered under the Accidental Death & Dismemberment coverage, any dismemberment benefit already paid will be subtracted from the Accidental Death benefit.

Loss Description	Percentage Of Principle Sum
1. Loss of Life	100%
2. Loss of Speech and Loss of Hearing	100%
3. Loss of Speech and one of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100%

4.	Loss of Hearing and one of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100%
5.	Loss of Hands (Both), Loss of Feet (Both), Loss of Sight or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of One Eye	100%
6.	Quadriplegia	100%
7.	Paraplegia	75%
8.	Hemiplegia	50%
9.	Loss of Hand, Loss of Foot or Loss of Sight of One Eye (any one of each)	50%
10.	Uniplegia	25%
11.	Loss of Thumb and Index Finger of the same hand	25%

PAYMENT OF 100% OF THE AD&D BENEFIT SHALL EXHAUST THE AD&D BENEFITS FOR THE PLAN PARTICIPANT

Exclusions and Limitations: The Insurer shall not be liable for:

a. **Armed Forces:** Any loss resulting from engagement as an active participant.
b. **Criminal Act:** Any loss sustained while committing a criminal act.
c. **Exceptional Danger:** Any loss directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily Injury, except in an endeavor to save human life.
d. **Extortion, Kidnap:** Any loss caused directly or indirectly from extortion, kidnap or wrongful detention of the Plan Participant or hijacking of any aircraft, motor vehicle, train or waterborne vessel on which the Plan Participant is travelling.
e. **Flying:** Any loss resulting from engagement in flying of any kind other than as a fare paying passenger in a scheduled aircraft.
f. **Medical/Surgical Treatment:** Any loss arising from medical or surgical treatment (unless rendered necessary by Accidental bodily Injury).
g. **Motorcycling:** Any loss resulting from motorcycling as either a driver or passenger.
h. **Professional Sports and Hazardous Activities:** Injury sustained while participating in a hazardous activity or training for any professional sport or activity.
i. **Self-Inflicted Illness or Injuries:** Any loss as a result of self-inflicted injuries, suicide or attempted suicide, while sane or insane.
j. **Substance Abuse:** Any loss resulting from alcohol, illegal drug abuse, other addiction, or any drugs or medicines that are not take in the dosage or for the purposed prescribed.

14.2 Repatriation of Mortal Remains

A benefit for either repatriation of mortal remains or local burial is included in this Plan. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar person burial preferences. The necessary clearances for the return of a Plan Participant's mortal remains by air transport to the Home Country will be coordinated by GBG Assist.

14.3 Personal Liability & Damage to Property

Coverage is provided for third party legal liability including legal cost arising from an Accident resulting in bodily Injury to persons other than the Plan Participant and his family. This coverage also includes damage to property excluding that owned by or in the custody or control of the Plan Participant during the Period of Insurance.

Benefits for Property Damage to a third party home or property under this Plan are secondary to any other insurance plan and are limited to the maximum stated in the Schedule of Benefits and/or the maximum Deductible applied by the primary carrier.

In the absence of insurable interest by the aggrieved party this Plan will revert as primary subject to legal assignment by a court order or binding arbitration assigning liability to the Plan Participant and in the Event of a partial judgment the maximum payable benefit will be reduced by the percentage assigned.

Conditions:

a. The Plan Participant cannot have a binding effect if they admit liability for any loss damage or Injury caused by their actions unless represented via court or legal action;
b. The coverage under this section is limited to one claim per year.

The losses shown below or expenses resulting from or in connection with any of the following are excluded from coverage under this Plan.

Exclusions: The Insurer shall not be liable for:

a. Employers' liability, contractual liability or liability to a member of a family or a travelling companion;
b. Animals belonging to or in the care, custody or control of a Plan Participant;
c. Any willful, malicious, or unlawful act;
d. Pursuit of trade, business or profession;
e. Ownership or occupation of land or buildings;
f. Ownership, possession or use of vehicles, aircraft, or motor-powered watercraft;
g. The influence of intoxicating liquor, or the use of firearms;
h. Damage caused by lack of conditioning, care or age;
i. Legal costs resulting from any criminal proceedings;

14.4 Trip Curtailment / Study Interruption

Coverage is provided for the return of the Plan Participant to their Home Country for an unexpected occurrence. Return travel is by the lowest cost travel option available and in economy class due to any cause listed below commencing and occurring during the Period of Insurance provided such expenses are not recoverable from any other source. If multiple return Trips occur during the Period of Insurance, the amount shown in the Schedule of Benefits includes all Trips.

Conditions:

a. **Illness or Injury of the Plan Participant, or Illness/Injury/death of a Family Member traveling with the Plan Participant:** The Illness/Injury must be so disabling as to reasonably cause a Trip to be cancelled or interrupted, or which results in medically imposed restrictions as certified by a Physician at the time of Loss preventing your continued participation in the Trip.

b. **Illness or Injury or death of a Family Member not traveling with the Plan Participant, provided such**

person is resident in the Home Country of the Plan Participant: The Illness/Injury must be a condition that is life-threatening, as certified by a Physician or because they directly require the Plan Participant's care.

Exclusions and Limitations: The Insurer shall not be liable for:

a. The Plan Participant is aware of any medical condition or set of circumstances, which could reasonably be expected to give rise to a claim;
b. The Plan Participant is suffering or has suffered from any previously diagnosed psychiatric disorder, anxiety or depression;
c. The Plan Participant is receiving, is on a waiting list for or has the knowledge of the need for inpatient treatment at a Hospital or nursing home;
d. The Plan Participant is expected to give birth before or within eight weeks of the date of arrival home;
e. The Plan Participant is travelling against the advice of a Medical Practitioner or for the purpose of obtaining medical treatment abroad;
f. The Plan Participant is terminally ill.

14.5 Baggage Delay

This Plan provides reimbursement for the replacement of necessities in the event of baggage being temporarily lost in transit during the outward journey for longer than 12 hours.

Conditions:

a. Proof of a Missing Bag Report must be filed with the common carrier.

Exclusions and Limitations: The Insurer shall not be liable for:

a. Any items purchased after the return of the baggage will not be covered.
b. Benefit does not apply to the return or homeward journey.

14.6 Baggage Loss/Theft

The Plan provides coverage for the Accidental loss or theft to luggage, clothing and personal effects owned by (not hired, loaned, or entrusted to) the Plan Participant. Coverage is secondary to the common carrier settlement and no claims will be accepted until *after* the Plan Participant has filed and received settlement from the common carrier.

Conditions:

a. If the common carrier used weight as a maximum compensation, then this Plan of Insurance will reimburse up to 2 times that of the common carrier reimbursement, subject to the limits shown on the Schedule of Benefits.
b. Benefits will be calculated using the Insurer's estimate of the market value of the item less deduction for age, wear, tear and depreciation, or the cost of repair, whichever is less.
c. Any amount paid by a common carrier in settlement toward the loss will be deducted from the reimbursement made by the Insurer.
d. The Plan Participant must observe ordinary proper care in the supervision of the insured property and in all cases of loss.
e. In the event of a claim in respect to a pair or set of items, the Insurer shall only be liable in respect of the value of that part of the pair or set which is lost, stolen, or damaged.
f. Claims will not be considered unless proof of ownership and evidence of value is provided.
g. Any amount paid for temporary loss of baggage will be deducted from the final claim settlement if baggage proves to be permanently lost.

Exclusions: The Insurer shall not be liable for:

a. Damage to baggage of any kind and or its contents;
b. Any loss or theft, or suspected theft not reported to the Police within 24 hours of discovery and a written report obtained;
c. Any damage or loss or theft of property in transit (or in possession of the Plan Participant), which has not been reported to the carrier and written report obtained;
d. Loss of theft of any property left unattended in a public place;
e. Any theft from an unattended motor vehicle unless the property is in a locked/covered luggage area, and there is evidence of forced entry which has been verified by a Police Report;
f. Any loss from motor vehicles left unattended at any time between the hours of 10:00 p.m. and 8:00 a.m.;
g. Loss, damage or theft of valuables and money packed in suitcases or other receptacles while travelling.
h. Loss or damage caused by decay, wear and tear, moth, vermin, or atmospheric conditions'
i. Deterioration or mechanical derangement of any kind;
j. Loss due to confiscation or detention by Customs or other authority;
k. Damage to sports equipment while in use or loss of jewelry while swimming (other than wedding rings);
l. Breakage of or damage to fragile articles and any consequence thereof.
m. Property not covered by this Plan includes but is not limited to; unset precious stones, contact or corneal lenses, spectacles or accessories; stamps, documents, deeds, manuscripts or securities of any kind; items of a perishable nature; business goods, samples, tools of trade or motor accessories; household goods and home contents.

14.7 Loss of Passport

Coverage is provided for the reasonable additional travel and accommodation expenses necessarily incurred abroad in obtaining the replacement of the Plan Participant's lost or stolen passport during the Period of Insurance.

14.8 Travel Delay

Coverage is provided if the departure of the coach, aircraft or sea vessel in which the Plan Participant had arranged to travel on the *first* outward or *first* return leg of the journey is delayed for at least 12 hours from the time specified in the travel itinerary due to strike, industrial action, bankruptcy, or mechanical breakdown of the coach, aircraft or sea vessel. The Plan provides for all necessary and reasonable expenses including accommodations, food and local transportation minus any compensation paid by the common carrier.

Exclusions and Limitations: The Insurer shall not be liable for:

a. Strike or Industrial Action existing or publicly declared at the time of effecting this Insurance;
b. Technical reasons such as aircraft commitment or availability;
c. Where the Plan Participant has not checked in according to the itinerary supplied and has failed to obtain written confirmation from the carrier (or their handling agents) of the period of or reason for the delay;
d. Directly or indirectly from withdrawal from service (temporary or otherwise) of a coach, an aircraft or sea vessel on the recommendation of a Port Authority or the Civil Aviation Authority or of any similar body.

14.9 Missed Departure (Flight, Bus, Train, Sea Vessel)

Coverage is provided in the event a Plan Participant misses their outward journey flight to the final overseas destination. This includes reasonable room only accommodation and travel expenses necessary to reach the overseas destination.

Conditions:

a. Missed departure as a result of the following is covered under the Plan.

Exclusions: The Insurer shall not be liable for:

a. As a consequence of strike, riot, or mechanical breakdown,
b. Due to inclement weather causing interruption of scheduled public transport services,
c. Accidental or mechanical failure involving the car in which the Plan Participant is travelling.

14.10 Legal Expenses

Coverage is provided for legal costs and expenses incurred by the Plan Participant in pursuit of compensation and/or damages against a third party arising from or out of the death or personal Injury of the Plan Participant occurring during the Period of Insurance.

Conditions:

a. The Insurer shall have complete control over the legal proceedings and the appointment and control of a lawyer.
b. The Plan Participant must follow the legal representative's advice and provide any and all information and assistance as required. Failure to do so will entitle the Insurer to withdraw cover.
c. The Plan Participant must have access to any and all of the legal representatives' file of papers.
d. Failure by the Plan Participant to comply with all or any of these conditions will entitle the Insurer to render the legal expenses aspect of this Certificate void and thereby withdraw cover.

Exclusions: The Insurer shall not be liable for:

a. Costs incurred in pursuance of any claim against a travel agent, tour operator, carrier, accommodation provider, the Insurer or Insurers Agent or any other person covered under the same Certificate.
b. Legal expenses incurred prior to the granting of support by the Insurer.
c. Any claims reported more than 90 days after the commencement of the incident, giving rise to such claim.
d. Any claim where the law, practices, and/or financial regulations of the country in which the proposed action will take place indicate that the costs of such action are likely to be unreasonably greater than the anticipated value of the compensation award.
e. Costs incurred in pursuance of a claim against any person with whom the Plan Participant had arranged to travel.
f. Any claim wherein the Insurer's opinion there is insufficient prospect of success in obtaining a reasonable benefit.
g. The Insurer shall not be liable for any claim where legal costs and expenses are based directly or indirectly on the amount of an award.
h. The insurance will not extend to covering the Plan Participant in the pursuit of any appeal except at the Insurers sole discretion.
i. Where there is a possibility of a claim being brought in more than one country the Insurers shall not be liable for the cost if an action is brought in more than one country.

15.0 HOW TO FILE A CLAIM

15.1 Excess Insurance Provision

The coverage provided under both Medical and Evacuation benefits shall:

a. Be in excess of all other valid and collectable insurance or indemnity, and
b. Apply only when such other benefits are exhausted.

In the event no other insurance coverage exists, this Plan becomes primary.

15.2 Subrogation

When the Plan pays for expenses that were either the result of the alleged negligence, or which arise out of any claim or cause of action which may accrue against any third party responsible for Injury or death to the Plan Participant by reason of their eligibility for benefits under the Plan, the Insurer has a right to equitable restitution. The Insurer will subrogate with any coverage whether known or unknown to the Plan Participant.

15.3 Claims Filing

Claims must be filed within **90 days** of treatment/loss to be eligible for reimbursement of Covered Expenses. Claim forms should be submitted only when the medical service provider does not bill the Insurer directly, and when you have Out-of-Pocket expenses to submit for reimbursement. All claims worldwide are subject to Usual, Customary, and Reasonable charges as determined by the Insurer and are processed in the order in which they are received.

In order for claims to be considered under this Plan claims must be:

1. In a form acceptable to the Insurer, and
2. Contain complete supporting documentation. If the Insurer requests additional information from either the Plan Participant, Physician, or other party to evaluate the claim and such information is not submitted, the claim will be denied.

15.4 Medical and Prescription Claims

To file your claim, submit it online at *www.gbg.com*. Log into the *Member Area* and select *Submit Claim*, and then follow the instructions to complete the online claim form. If you are unable to submit your claim electronically, you can mail or fax your completed claim form and copies of supporting documentation. After submitting the claim, you will receive a claim reference number and an electronic receipt for the claim will be sent to you by email.

Claims may be submitted to the Insurer directly by the Provider or Facility. The Insurer will process the claim according to the Schedule of Benefits and Plan terms, and remit payment to the health care provider. Ineligible charges or those in excess of the Allowable Charges will be the responsibility of the Plan Participant.

If the Plan Participant has paid the health care provider, the Plan Participant will submit the claim form along with the original paid receipts directly to the Insurer. Photocopies will not be accepted unless the claim is submitted electronically. The Insurer will reimburse the Plan Participant directly according to the Schedule of Benefits and Plan terms.

15.5 Accidental Death and Dismemberment Claims

To substantiate a claim for benefits covered by the terms of this Plan, the following initial documents must be submitted:

a. An official certificate of death, indicating date of birth of the Plan Participant;
b. A detailed medical report at the onset and course of the disease, bodily Injury or Accident that resulted in the death or dismemberment. In the Event of no medical treatment, a medical or official certificate stating the cause and circumstances of death;
c. The Insurer will pay the benefit as soon as the validity of the claim for benefits has been reasonably satisfied. Expenses incurred in relation to the substantiation of a claim will not be the responsibility of the Insurer.

15.6 All Other Claims (Personal Liability, Baggage Loss/Theft, Loss of Passport, Etc.)

Please visit the Insurer's website at: *www.gbg.com*, to access the *Travel Claim Form*. Required documentation for all claims:

1. A signed and fully completed claim form must be submitted with each claim,

2. All claims must be submitted with proof of travel including flight records,
3. Medical Records: Physicians' notes reports, bills, receipts including names and addresses,
4. Proof of loss and detailed description of loss,
5. Police Reports (if applicable),
6. Baggage Loss/Theft (if applicable) – airline records must include confirmation of claim including phone numbers and any applicable reports from the common carrier,
7. Any additional documentation requested by the Insurer to support your claim.

Submit claims or claims appeal by:

Web:	**Mail:**	**Fax:**	**Email:**
www.gbg.com	GBG Administrative Services 27422 Portola Parkway Suite 110 Foothill Ranch, CA 92610 USA	+1 949 271 2330	eclaims@gbg.com

15.7 Reimbursement Options

Claims reimbursements will be made by:

- Electronic Direct Deposit for Plan Participant where the receiving bank is located in the U.S.,
- Wire Transfer for members and overseas providers where the receiving bank is located outside of the U.S., or
- Check sent to member or provider where electronic payment is not possible.

15.8 Settlement of Claims

When claims are presented to the Insurer, the Allowable Charges will be applied towards the Deductible. Once the Deductible has been satisfied, all Allowable Charges will be paid at the percentage listed on the Schedule of Benefits, up to the listed benefit maximum. Note the amount of Allowable Charges applied towards the Deductible also reduces the applicable benefit maximum by the same amount.

If the Plan has an Out-of-Pocket maximum, once it is met the Plan will begin paying 100% of Allowable Charges for the remainder of insurance coverage, subject to the benefit maximums. The Out-of-Pocket maximum does not apply to any expenses covered under the Prescription Benefit.

15.9 Status of Claims

Plan Participant's wishing to request the status of a claim or have a question about a reimbursement received, please submit the status request form via our website at *www.gbg.com* or e-mail customer service at *customerservice@gbg.com*. Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.

15.10 Releasing Necessary Information

It may be necessary for the Insurer to request a complete medical file on a Plan Participant for purpose of claims review or administration of the Plan. It may also be necessary to share such information with a medical or utilization review board, or a reinsurer. The release of such confidential medial information will only be with written consent of the Plan Participant.

16.0 CLAIMS APPEAL

16.1 Level One Appeal

If you are not satisfied with an administrative, eligibility, rescission of coverage, denial or reduction of benefit or if a health care determination for pre-service or current care coverage has been denied; the Plan Participant or your appointed representative has the right to file an appeal within 90 days.

Your appeal will be reviewed and the decision made by a member of the claims staff who was not included in the original decision. Appeals involving Medical Necessity, clinical appropriateness, or experimental and investigational treatments will be considered by a health care professional.

For Level One Appeals regarding required pre-service or concurrent care coverage decision, GBG will respond with a decision within 15 calendar days. We will respond within 30 calendar days for appeals regarding a post service coverage decision. If more time or information is needed to make the decision, GBG will notify you to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

16.2 Level Two Appeal

If you are dissatisfied with the Level One appeal decision, you may request a Level Two Appeal. To start, follow the same process required for a Level One appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decisions may not vote on the committee. For appeals involving Medical Necessity, clinical appropriateness, or being experimental or investigational, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by our medical review agent.

For Level Two appeals we will notify you that we have received your request and schedule a Committee Review. For required pre-service and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post-service claims, the Committee Review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional time needed by the committee to complete the review. You will be notified in writing of the decision within five working days of the meeting, and within the Committee Review time frames.

16.3 Independent Review Procedure

If you are not satisfied with the final decision of the Level Two appeal review, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by us, our administrator, or any of our affiliates. A decision to use this external level of appeal will not affect the claimant's rights to any other benefits under the Plan.

There is no charge for you to initiate this Independent Review process. The Insurer will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination or because it is considered to be experimental or investigational by our medical review agent. Administrative, eligibility, or benefit coverage

reductions or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of the Insurer's final adverse benefit determination. The Insurer will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 30 days of request.

16.4 Expedited Appeals

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health, ability to regain maximum function or, in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient stay. GBG Medical Review Agent in consultation with the treating Physician will decide if an expedited review is necessary. When an appeal is expedited, GBG will respond within 72 hours, followed up in writing or electronically within five days.

16.5 Complaints Procedure

If you are not satisfied with the outcome of the Appeals process as described above, you may file a formal complaint. The complaints procedures are listed at GBG's website:
https://www.gbg.com/#/AboutGBG/ComplaintsProcedures.

17.0 EXCLUSIONS AND LIMITIATIONS

Unless specified in the Schedule of Benefits, in any written endorsement, or agreed by the Insurer in writing, no claim can be made for compensation or payment for damage or expenses caused by or as a result of the following:

1. **Abortion:** Any voluntarily induced termination of pregnancy and complications thereof, except if the mother's life is in danger.
2. **AIDS/HIV, Sexually Transmitted Diseases:** Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARC), HIV positive, all secondary diseases, and all sexually transmitted diseases.
3. **Alcohol and Drug Abuse:**
   a. Treatment related to the detoxification, rehabilitation, and all support service;
   b. Treatment of any Illness or Injury arising directly or indirectly from alcohol or illegal drug abuse or other addiction, or any drugs or medicines that are not taken in the dosage or for the purposed prescribed.
4. **Alternative Care:** Treatment including but not limited to acupuncture, acupressure, homeopathy, and Chinese herbs.
5. **Breast reduction:** All services and treatments.
6. **Cardiac Treatment:** Expenses related to coronary artery angioplasty, cardiac surgery, or implantable cardioverter defibrillator (ICD) including any associated diagnostic tests or charges, unless necessary in a Medical Emergency and pre-authorized by the Insurer.
7. **Certificate:** The document provided to the Plan Participant that includes the Schedule of Benefits and the terms of the Master Policy issued to the Trust.
8. **Charges in Excess of Usual, Customary, and Reasonable:** Any portion of any charge in excess of UCR for the particular service or treatment for the specific geographical area.
9. **Charges Incurred before the Effective Date and After the Expiration Date:** Claims and costs for medical treatment occurring before the effective date of coverage (including waiting periods) or after the expiration

date of the policy are not covered. This includes any portion of a covered prescription to be used after the expiration of the current Policy year.

10. **Charges Reimbursable by Another Entity:** Services, supplies, or treatment that are provided by or payment is available from:
    a. Workers' Compensation law, Occupational Disease law or similar law concerning job related conditions of any country;
    b. Another insurance company or government;
    c. A government entity due to an epidemic or public emergency.
11. **Circumcision:** Unless due to underlying medical reasons.
12. **Congenital and Hereditary Conditions:** Treatment to correct inherited disorders or Illnesses that existed prior to childbirth regardless of cause, whether or not they have manifested or been diagnosed during childbirth or years thereafter.
13. **Consultations:** Telephone, E-mail, and internet consultations, and telemedicine, missed appointments, and after hours expenses, and charges made by a provider who is a member of your family or your dependent's family.
14. **Cosmetic and Elective Surgery for Non-Medical Reasons:** Treatments, procedures or drugs which are primarily for enhancement, improvement, or altering one's appearance, unless required due to a non-occupational Injury occurring while Plan Participant under this Policy. Medical complications arising from such treatments or procedures are also not covered.
15. **Counselling and Testing Services:** Non-medical counselling services including but not limited to marriage and family counselling, educational counseling, aptitude testing, educational testing and services.
16. **Dental Care:**
    a. General diagnostic examinations, cleaning, basic restoration, periodontal treatments, oral surgery, crowns, bridges, endodontic, extraction of wisdom teeth, orthodontic and all other preventive, basic, or major dental services; Dental Services at a Hospital, including general anesthesia are not covered under the medical plan.
    b. Inlays, dentures, or false teeth and replacement of lost or stolen crowns, bridges, or dentures
    c. Implants and all related services
    d. Temporomandibular Joint Disorders (TMJ) or Malocclusion Temporomandibular Joint Disorders and Mouth guards for teeth grinding.
17. **Dehydration:** A harmful reduction in the amount of water in the body due to alcohol/substance abuse or exposure to the elements.
18. **Dialysis:** Treatment related to kidney disease and the failure of the kidneys to remove waste from the body.

19. **Durable Medical Equipment:** Includes but are not limited to the following:
    a. Comfort items such as telephone arms and over bed tables;
    b. Items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers;
    c. Miscellaneous items such as exercise equipment, heat lamps, heating pads, toilet seats, bathtub seats,
    d. The customizing of any vehicle, bathroom facility, or residential facility.
20. **Emergency Room:** Expenses related to non-emergency use.
21. **Epidemic:** Treatment and services related to infectious diseases declared to be an outbreak, epidemic, or public emergency by the World Health Organization (WHO), Center for Disease Control and Prevention (CDC), or any other Government or Government Agency or ruling body of the country where the outbreak or epidemic has occurred in. Additionally, such coverage is also excluded if there has been an official warning issued against travel to the area, by the State Department, Embassy, Airline or other Governmental Agency, prior to travel to the affected country. This exclusion will not apply if exposure occurs accidentally or unknowingly while travelling to or from areas not declared to be at risk, or if exposure occurs as a result of residing or working in the area prior to the outbreak.

22. **Exceptional Risks:** Treatment related to:
    a. Injury sustained while participating in a intercollegiate, interscholastic, hazardous or extreme sports and activity or training for any professional sport or activity,
    b. Injury sustained while participating in, or training for, or as a consequence of: war (declared or not), acts of terrorism, invasion, civil war, riot, rebellion, or overthrow of government;
    c. Chemical contamination;
    d. The malicious use of Nuclear, Chemical, or Biological Weapons or warfare;
    e. Contamination by radioactivity from any nuclear material or from the combustion of nuclear fuel;
    f. Expeditions, and mountaineering and or trekking above 3,500M or 11,500 ft. is considered extreme sport and not covered, included and not limited to expeditions to Mt Everest, K2, Kilimanjaro, Antarctica, The Arctic, North Pole and Greenland;
    g. Travel to Cuba, North Korea or any location that is known to be in armed military conflict.
23. **Experimental or Off-Label Services:** Services, supplies or treatments, including drugs, which are deemed to be experimental or investigational or that is not medically recognized for a specific Diagnosis.
24. **Extended Care:** All expenses related to Extended Care from an Extended Care Facility.
25. **Fertility/Infertility Treatments and Birth Control:** Any services, procedure, or treatment including drugs used to:
    a. Diagnose or treat infertility including in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and any variations of these procedures, and any costs associated with the preparation or storage of sperm for artificial insemination. All expenses related to the use of a surrogate mother are also excluded.
    b. Vasectomies and sterilization, and any expenses for male or female reversal of sterilization.
    c. Contraceptive devices including the insertion or removal of such devices. Oral Contraceptives are covered under this Policy.
26. **Genetic Screening:** Counseling, screening, testing, or treatment in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
27. **Growth Hormones:** Excluded unless used as an integral treatment plan for an Illness covered under this Policy.
28. **Hair Treatment:** Treatment for alopecia or hair loss including but not limited to Hairplasty, hair transplants or any other procedure to stimulate hair growth; the temporary removal of hair by laser; electrolysis; waxing; or any other means.
29. **Hearing Care:** Routine examination, hearing aids or devices, and the surgical implantation of, or removal of bone anchored hearing devices.

30. **Home Health Care:** Home nursing services, assistance with the Activities of Daily Living, and other home health care related services.
31. **Hospice Care:** Palliative and supportive services to terminally ill Plan Participant's and their families.
32. **Illegal Activities:** Illnesses and Injuries resulting or arising from or occurring during the commission or perpetration of a violation of law.
33. **Immunizations and Preventive Care:** Well woman and well man examinations and tests, well child, routine exams and screenings, immunizations, and family health screenings.
34. **Maternity:**
    a. All expenses related to pregnancy including but not limited to prenatal care, childbirth, miscarriage, premature birth, and all complications related to the mother or child,
    b. Maternity or delivery preparation classes,
    c. Elective Caesarean section,
    d. Care or treatment for an individual acting as a surrogate.
35. **Medical Examinations or Certificates:** Any examination, immunization, or tests necessary for the issuance of

medical certificates or determining employment, or suitability for school, sport related activities, or travel or determining insurability.

36. **Mental Health:** All services including treatment for Bulimia, Anorexia, and Bereavement, Attention Deficit Disorder (ADD), and Attention-Deficit Hyperactivity Disorder (ADHD). Services for conditions not determined by Insurer as to be emotional or personality Illnesses; psychiatric services extending beyond the period necessary for evaluation and Diagnosis of mental deficiency or retardation; and services for mental disorders or Illness which are not amenable to favorable modification.
37. **Motor Vehicle:** Any expenses for Accidents related to the use of a motor vehicle caused by the Plan Participant unless they are carrying a legally issued driver's license and insurance from the country in which they are participating in Study or Work Abroad.
38. **Non-Covered Treatments:** Treatment of any Illness or Injury, or charges relating to such that is:
    a. Not ordered or recommended by a Physician; or
    b. Not Medically Necessary; or
    c. Not rendered under the scope of the Physician's licensing; or
    d. Not professionally recognized or is determined by Insurer to be unnecessary for proper treatment.
39. **Non-Emergency Care:** Medical treatment that is not considered a Medical Emergency by the Insurer, including but not limited to; routine or general physical examinations, medical check-ups, regular care of chronic conditions, elective surgery, and continued services following emergency medical treatment once the Medical Emergency is deemed over by GBG Assist.
40. **Non-Medical Care:** Services related to custodial care, respite care, home-like care, assistance with Activities of Daily Living (ADL), or Milieu Therapy. Any admission to a nursing home, home for the aged, long term care facility, sanitarium, spa, hydro clinic, or similar facilities. Any admission, arranged wholly or partly for domestic reasons, where the Hospital effectively becomes or could be treated as the Plan Participant's home or permanent abode.
41. **Non-Urgent Care:** Treatment or surgery, in the opinion of GBG Assist and the Physician in attendance that can be delayed until return to your Home Country.
42. **Oncology:** Diagnosis, prevention and treatment, including any prescribed medications, of tumors, growths, cancer, and other malignant neoplasms.
43. **Organ Transplant:** All expenses related to the recipient or the donor for human organ, bone marrow, and stem cell transplants.

44. **Over-the-Counter and Non-Prescription Drugs:** Over the counter drugs or non-prescribed drugs or medical devices, even if recommended by a Physician, including but not limited to the following:
    a. Tobacco dependency
    b. Weight reduction or appetite suppressant,
    c. Cosmetic drugs, even if ordered for non-cosmetic purposes
    d. Acne and rosacea drugs (including hormones and Retin-A), except for cystic and pustular acne, Vitamins, supplements, or herbs.
45. **Personal Comfort and Convenience Items:** Expense for items that are provided solely for personal comfort or convenience such as television, private rooms, housekeeping services, guest meals and accommodations, special diets, telephone charges, and take home supplies.
46. **Podiatric Care:** Routine foot care, including the paring and removing of corns, calluses, or other lesions, or trimming of nails or other such services not resulting from an Illness or Injury. Orthopedic shoes or other supportive devices such as; arch supports, orthotic devices, or any other preventative services or supplies to

treat the Diagnosis of weak, strained, or flat feet or fallen arches.

47. **Power Vehicles:** Expenses for Accidents and Injuries as a result of Motorcycles, Mopeds, Scooters, ATV's any two or three wheeled motorized vehicle and or sport watercraft such as wave runners, jet skis or other powered devices whether the vehicle is in motion or not.
48. **Pre-Existing Conditions:** All treatment and expenses for routine care and maintenance related to Pre-Existing medical conditions.
49. **Prosthetics:** All expenses related to prosthetics limbs and devices intended to replace the functionality of a body part. This includes but not limited to arms, hands, legs, and feet. This includes any therapy related to the usage of the new limb.
50. **Sanctions:** Notwithstanding any other terms under this Policy, we shall not provide coverage nor will we make any payments or provide any service or benefit to any Plan Participant, beneficiary, or third party who may have any rights under this Policy to the extent that such cover, payment, service, benefit, or any business or activity of the Plan Participant would violate any applicable trade or economic sanctions law or regulation.
51. **Skin Conditions:**
    a. Acne, rosacea, skin tags, and any treatment to enhance the appearance of the skin, except for cystic or pustular acne.
    b. Treatment as a result of sun burn/damage to the skin including use of artificial tanning devices in which the Plan Participant did not take prudent measures to protect the skin from damage.
52. **Search and Rescue:** Any expenses relating to search and rescue operations to find a Plan Participant in mountains, at sea, in the desert, in the jungle and similar remote locations including air/sea rescue charges for evacuation to shore from a vessel or from the sea.
53. **Self-Inflicted Illnesses or Injuries:** Treatment for any conditions as a result of self-inflicted Illnesses or injuries, suicide or attempted suicide, while sane or insane. Treatment for any loss or expense of nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily Injury, except in an endeavor to save human life.
54. **Sexual Dysfunction:** Any procedures, supplies, or drugs used to treat male or female sexual enhancement or sexual dysfunction such as erectile dysfunction, premature ejaculation, and other similar conditions.
55. **Sleep Studies:** Sleep studies and other treatments relating to sleep apnea.
56. **Smoking Cessation:** Treatments whether or not recommended by a Physician.
57. **Transsexual Surgery:** Medical or psychological counseling, hormonal therapy in preparation for, or subsequent to, any such surgery, surgical procedures, and any other expenses related to sexual reassignment including the complications arising from such procedures.
58. **Trips** specifically made for the purpose of obtaining medical treatment.
59. **Undiagnosed Medical Conditions:** Diagnostic testing and other related expenses for an unknown medical condition that does not result in a Diagnosis.
60. **Urinary Tract Infection:** Any infection of the urinary tract (including, without limitation, infection of the kidney, ureter, bladder, prostate or urethra) and any complication, medical condition or other Illness directly or indirectly related, that occurs within 180 days of the Effective Date and that requires treatment in a Hospital as an inpatient.
61. **Vision Care:** Services and supplies related to;
    a. Visual therapy, or eye surgery to correct refractive error or deficiencies, including myopia or presbyopia,
    b. Eye examinations, frames, lenses, or contact lenses,
    c. Optional lens coating for anti-glare, anti-scratch, or UV sun protection and sunglasses and related accessories.
    d. Other devices to assist with impaired vision.
62. **Weight Related Treatment:** Any expense, service, or treatment for obesity, weight control, any form of food supplement, weight reduction programs, dietary counseling, or surgical procedures related to morbid or non-morbid obesity. Charges relating to complications arising from such treatments or surgical procedures are also

excluded.

18.0 DEFINITIONS

Please note certain words used in this document have specific meanings.

Accident: A sudden, unexpected and unintended Event where the Plan Participant has sustained bodily Injury caused by Accidental, external, violent and visible means which shall solely and independently of any other cause.

Acute Illness: A sudden, unexpected, and unforeseen Illness occurring after you have started your Trip abroad.

Allowable Charge: The fee or price Insurer determines to be the Reasonable and Customary Charge for health care services provided to Plan Participant's that are covered under the Policy. The Plan Participant is responsible for the payment of any balance over the Allowable Charge (except in the U.S. when a Preferred Provider has delivered the service, then there is no balance due). All services must be Medically Necessary. Once an Allowable Charge is established then the Deductible, coinsurance, Copayments and any excess charges must be paid by the Plan Participant.

Automobile: A self-propelled, private passenger motor vehicle with four or more wheels that is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

Coinsurance: The percentage amount of the Allowable Charges that the Plan Participant and the Insurer will share after the Deductible is met. Coinsurance does not include Deductible, Copayments or any excess fees.

Copayment: A fixed dollar amount that may be applied per office visit each time medical services are received. Ancillary services such as Laboratory and Radiology service (i.e. blood tests, x-rays) that may be in conjunction with an office visit do not require a separate Copayment. Copayments do not apply to the Deductible or to the Out-Of-Pocket Maximum.

Covered Accident: An Accident that occurs while coverage is in force for a Plan Participant and results in a loss or Injury covered by the Plan for which benefits are payable.

Covered Expenses: Expenses actually incurred by or on behalf of a Plan Participant for treatment, services and supplies covered by the Plan. Coverage under the Plan must remain continuously in force from the date of the Illness or Accident until the date of treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

Covered Loss or Covered Losses: An Accidental death, dismemberment or other Injury covered under the Plan.

Covered Trip: A period of round-Trip travel away from the Plan Participant's Home Country; the Trip has defined departure and return dates specified when the Plan Participant enrolls.

Deductible: The dollar amount of Covered Expenses that must be incurred as an out of-pocket expense by each Plan Participant on a per plan term basis before Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under the Plan.

Diagnosis: The result of examination or test by a medical Physician or licensed physician providing a specific international CPT or ICD9 code.

Effective Date: The date upon which the Plan Participant's coverage will commence under this Plan.

Emergency Treatment: Medical care for a Medical Emergency that is required for the immediate relief of an acute symptom or upon advice from a licensed physician cannot be delayed until your return to your Home Country.

Extended Care Facility: A nursing and/or rehabilitation center approved by the Insurer that provides skilled and rehabilitation services to patients who are discharged from a Hospital or who are admitted in lieu of a Hospital stay. The term Extended Care Facility does not include nursing homes, rest home, health resorts, homes for the aged, infirmaries or establishments for domiciliary care, custodial care, care of drug addicts or alcoholics, or similar institutions.

Family Member: Means a spouse, parent, parent-in-law, child, brother or sister of the Plan Participant.

Home Country: A country from which the Plan Participant holds a passport. If the Plan Participant holds passports from more than one country, his Home Country will be that country which the Plan Participant has declared on the application.

Hospital: An institution that: 1. operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2. provides 24-hour nursing service by Registered Nurses on duty or call; 3. has a staff of one or more licensed Physicians available at all times; 4. provides organized facilities for Diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5. Is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6. Is not a place solely for drug addicts, alcoholics, or the aged or any separate ward of the Hospital.

Hospital Stay/Confined: An overnight stay as a registered resident bed-patient in a Hospital.

Host Country: The country or countries other than the Home Country that the Plan Participant is traveling to/in.

Illness: A physical sickness, disease, pregnancy and complications of pregnancy. This does not include mental Illness.
Injury: Accidental bodily harm sustained by a Plan Participant that results directly and independently from all other causes from a Covered Accident. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these Injuries are considered a single Injury/event.

Insurer: GBG Insurance Limited.

Maximum Benefit: The payment specified in the Schedule of Benefits, for specific services, which is the maximum amount payable by the Insurer for the Plan Participant, per Period of Insurance regardless of the actual or Allowable Charge. This is after the Plan Participant has met his obligations of Deductible, Coinsurance, Copayments and any other applicable costs.

Medical Emergency: A sudden, unexpected, and unforeseen event caused by an Illness or Injury that manifests itself by symptoms of sufficient severity that a prudent layperson would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

Medically Necessary: A treatment, service or supply that is: 1. required to treat an Illness or Injury; prescribed or ordered by a Physician or furnished by a Hospital; 2. performed in the least costly setting required by the Plan Participant's condition (usual, reasonable and customary); and 3. Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

Missing Bag Report: A formal report of loss as filed with the common carrier commonly known as a PIR (Passenger Irregularity Report) or PAWOB (Passenger arriving without baggage). This must include the 6 digit "CLAIM NUMBER" or the "World Tracer Record Number" as provided by the carrier.

Missing Person: A Plan Participant who disappeared for an unknown reason and whose disappearance was reported to the Appropriate Authorities.

Natural Disaster: Storm (wind, rain, snow, sleet, hail, lightning, dust or sand) earthquake, flood, volcanic eruption, wildfire or other similar Event that: 1. is due to natural causes; and 2. results in such severe and widespread damage that the area of damage is officially declared a disaster area by the government in which the Plan Participant's Trip occurs and the area is deemed to be uninhabitable or dangerous.

Necessities: Personal hygiene items and clothing.

Non-Emergency/Non-Emergent Care: A condition in which a prudent person recognizes that a change in their health has taken place via on-set of Illness or Accident but is not considered a life threatening Medical Emergency but feels a medical intervention would be the proper course of action.

Period of Insurance: The start and end date for which insurance coverage is in effect as shown on the Face Page.

Physician: A licensed health care provider acting within the scope of his license and rendering care or treatment to a Plan Participant that is appropriate for the conditions and locality. It will not include a Plan Participant or a member of the Plan Participant's immediate family or household.

Plan: The agreement between the Insurer and the Policyholder. The Plan includes the Master Policy, the Certificate, the Schedule of Benefits, and the application.

Plan Participant: A person eligible for coverage as identified in the application form, a Non-United States Citizen traveling outside their Home Country and has his true, fixed and permanent home and principal establishment outside of the United States and holds a current and valid passport, and for whom proper Premium payment has been made when due, and who is therefore a Plan Participant under the Plan.

Pre-Departure Period of Insurance: The time period from the day after purchase until the scheduled departure date.

Pre-Existing Condition: Any Illness or Injury, physical or mental condition, for which a Plan Participant received any

diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident prior to the Effective Date. A Pre-Existing Condition is considered stable, which in the six months before the Effective Date, there have not been:

- New/change in treatment; medical management; medication including a change in dosage, and
- New/more frequent/more severe symptoms or findings, and
- New test results or test results showing a deterioration, and
- Investigations initiated or recommended for your symptoms, and
- Hospitalization or referral to a specialist.

Related Costs: Food, lodging and, if necessary, physical protection for the Plan Participant during the Transport to the Nearest Place of Safety.

Strike or Industrial Action: Any form of industrial action taken by employees, which is carried on with the intention of preventing, restricting or otherwise interfering with the production of goods.

Traveling Companion: A person or persons with whom you have coordinated travel arrangements, shares the same accommodations as you and intend to travel with during the Trip.

Trip: Travel by air, land, or sea from the Plan Participant's Home Country.

Usual, Customary and Reasonable: The lower of: 1) the provider's usual charge for furnishing the treatment, service or supply; or 2) the charge determined by the Insurer to be the general rate charged by the others who render or furnish such treatments, services or supplies to persons: 1) who reside in the same geographical area; and 2) whose Illness or Injury is comparable in nature and severity.

The Usual, Customary, and Reasonable charge for a treatment, service or supply that is unusual, or not often provided in the area, or that is provided by only a small number of providers in the area, will be determined by the Insurer. The Insurer will consider such factors as: 1) complexity; 2) degree of skill needed; 3) type of specialist required; 4) range of services or supplies provided by a facility; and 5) the prevailing charge in other areas.

Valuables/Electronics: Cellular phones, satellite phones, photographic equipment, tablet PC's, computers, iPods, CD players and personal music and stereo equipment, CD's, computers, computer games and associated equipment, hearing aids, telescopes and binoculars, antiques, jewelry, watches, furs, and articles made of or containing gold, silver or other precious metals or animal skins or hides. Any item of value to be evaluated on a case by case basis.

19.0 SUBSCRIPTION AGREEMENT

I hereby apply to be a Plan Participant of the International Benefit Trust established in the Cayman Islands (the "trust") and to participate in the insurance coverage extended by GBG Insurance Limited (the "Insurers") to Plan Participants under the trust (the "coverage"). I understand that the coverage is not a general health insurance product, but is intended for use in the Event of a sudden and unexpected Event while traveling outside my Home Country. I understand that the coverage extended to me will terminate upon my return to my Home Country unless I qualify for a benefit period or Home Country coverage. I understand that I may obtain full details of the coverage by requesting a copy of the master Plan from the Plan manager. I understand that the liability of the Insurers as underwriters of the coverage is as provided in the master Plan.

By acceptance of coverage and/or submission of any claim for benefits, the Plan Participant ratifies the authority of the signer to so act and bind the Plan Participant.

The Plan Participant undertakes to make all premium payments as they fall due in respect of the coverage extended to them. The trustee shall not be responsible for the administration of such payments.

If the Plan Participant fails to make any premium payment due in respect of the coverage extended to them, subject to the discretion of the insurance company, such coverage will lapse.

The Plan Participant hereby confirms the accuracy of all information validity of all representations and warranties provided to the trustee in connection with its participation in the Plan and/or the subscription for the insurance coverage, howsoever provided, including the terms of this subscription agreement,(together "representations & warranties"). The Plan Participant acknowledges that certain of such information will be relied upon by the Insurers as providers of the coverage and that any inaccuracy therein may result in the invalidity of such coverage as it relates to the Plan Participant, the loss of coverage and all monies paid in relation thereto. The Plan Participant hereby undertakes to inform the trustee of any change to any of matter that forms the subject of any of the representation & warranties. The Plan Participant hereby undertakes to indemnify and hold harmless the trustee against any loss or damage (including attorney's fees) occasioned by any inaccuracy in any representation & warranty or failure to advise the trustee of any change in any matter that forms the subject of any of the representation & warranties. The Plan Participant agrees that the trustee shall be entitled to rely on and to act in accordance with any written instruction purported to be provided by the Plan Participant and the Plan Participant hereby undertakes to indemnify and hold harmless the trustee against any loss or damage (including attorney's fees} occasioned by the trustee acting in accordance with any such instruction.

Payments under the terms of the coverage shall be paid by the Insurers to the Plan Participant or directly to a provider if assignment of benefits has been authorized. The trustee shall not be responsible for the administration of such payments.

I confirm that I have satisfied myself that the coverage is appropriate for me and that I meet the eligibility criteria.

Insured By:

GBG Insurance Limited

Administered By:
Global Benefits Group
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA