

Portland Christian Schools

2020 - 2021



LewerMark
International
Student
Health Insurance

Plan Brochure



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Program Managed and Administered by:

The Lewer Agency, Inc. *(the “Program Manager”)*

9900 W. 109th St., Suite 200 | Overland Park, KS 66210 | 1(800) 821-7710

Underwritten by:

GBG Insurance Limited *(the “Company”)*

27422 Portola Parkway | Suite 110 | Foothill Ranch, CA 92640

Policy Number: LHS-0005

IMPORTANT CONTACT INFORMATION



LEWERMARK CUSTOMER SERVICE

For questions regarding benefits or claims status, contact:

- Toll Free: **1 (800) 821-7710** (Monday–Friday, 8:00 a.m. to 6:00 p.m. Central Time)
- Chat us at: www.lewermark.com
- Email us at: lewermarksupport@lewer.com
- Your school webpage: www.lewermark.com/pcs
- The Lewer Agency, Inc. | Student Insurance | 9900 W 109th St. Ste 200 | Overland Park, KS 66210



LEWERMARK 24/7 NURSE LINE

The LewerMark 24/7 Nurse Line provides you with free access to speak with a nurse regarding your health questions or concerns anytime day or night.

- Toll Free: **1 (866) 549-5076**
- Available 24/7



SCHOLASTIC EMERGENCY SERVICES

Students, staff or parents should contact Scholastic Emergency Services if there is a life-threatening emergency or illness.

- Toll Free: **1 (877) 488-9833** (Toll free inside the USA)
- Phone: **1 (609) 452-8570** (If calling outside of the USA)
- Email: medservices@assistamerica.com
- Web: www.assistamerica.com/students.aspx
- Reference Number: **01-AA-LEW-05034**
- Available 24/7



PPO NETWORK

To locate doctors and facilities within the Aetna network, visit:

- Web: https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=passport

LEWERMARK 24/7 NURSE LINE

Medical Help Line for International Students

The LewerMark 24/7 Nurse Line features friendly, experienced, Registered Nurses who can help you decide what your best choices are and are available day or night. They can assist you with any health issues or questions and can provide general health and wellness information.



Both the call and the service are free and available 24 hours, 365 days a year. In addition, translator services are available in 200 languages.

CONTACT LEWERMARK 24/7 NURSE LINE

1(866) 549-5076

Call toll-free 24 hours, 365 days a year
In case of emergency, call 911

When should I think about going...

TO THE STUDENT HEALTH CENTER OR URGENT CARE

- Colds, Coughs, and Sore Throats
- Earaches
- Minor Cuts
- Potential Muscle / Ligament Strain
- Sunburn / Minor Cooking Burn
- Itchy Skin/ Rashes
- Fever / Flu
- Sexually Transmitted Diseases
- Pregnancy Testing

TO THE EMERGENCY ROOM

- Loss of Consciousness
- Intolerable / Uncontrollable Pain
- Shortness of Breath
- Chest Pain / Pressure
- Poisoning
- Major Injuries
- Severe / Worsening Insect Bite or Allergic Reaction
- Unable to Move
- Severe Bleeding
- Deep Cuts requiring stitches

Note: LewerMark does not offer medical advice. This information is presented to help international students better understand the U.S. health care provider and delivery system. In all situations, you should rely on your own best judgement in choosing when and where to receive health care services.

SCHOLASTIC EMERGENCY SERVICES (SES)

Service Arrangement for Emergency Situations

Students, staff and/or parents should contact Scholastic Emergency Services if there is a life-threatening emergency or illness. Scholastic Emergency Services is a service-arranger, not insurance, so please contact them first as they cannot reimburse for any services you pay for or use. SES will not pay for services on a reimbursement basis, so you must contact them immediately.



If you call 911 for a medical emergency, your next phone call should be to Scholastic Emergency Services. They will make all arrangements for you to provide for the following:

- Assistance Finding a Provider
- Translation Assistance
- Medical Evacuation or Transportation
- Critical Care Monitoring
- Compassionate Family Visit
- Medical Trauma Counseling
- Prescription Assistance
- Emergency Message Transmission
- Repatriation or Return of Mortal Remains

IMPORTANT: You must call SES prior to using any of the above services

CONTACT SES 24/7

1 (877) 488-9833 (Toll free inside the USA)

1 (609) 452-8570 (If calling outside the USA)

Reference Number: **01-AA-LEW-05034**

HOW TO PRINT AN ID CARD

To print an ID card, go to www.lewermark.com and at the top of the page, under **My Account**, click **Student**.

Using the drop-down menus, select your state and school.




Once you are at the login screen, your user name is your student ID number, and the default password is your date of birth (mmddyyyy). For example: July 8, 1998 would be 07081998.

Click the menu icon in the upper left-hand corner and select **Online ID Card**.

Download to print or save your card electronically.

Note: If you are a returning student who has logged into your online account before, you may have changed your password from your date of birth. Use that password instead.

If you are unable to retrieve your insurance card, please call LewerMark at **1 (800) 821-7710, Option 2**.

  	
Submit Medical Claims to Aetna: Electronic Payer ID: 60054 P.O. Box 30259 Tampa, FL 33630-3259 Claims Questions? Please call 800-414-0596 ID: 123456789 INSURED: STUDENT GROUP: LEWERMARK UNIVERSITY Aetna Group #: 123	
Office Visit Copay: \$20 Hospital Copay: \$50 ER Copay: \$100	Scrip World (PBM) Rx Bin 004336 RxPCN ADV Rx Grp RX2741
LewerMark Student Health Insurance	
For information concerning eligibility & benefits call LewerMark at 800-821-7710 or lewermarksupport@lewer.com	
Scrip World Pharmacy Help: Pharmacy: 800-364-6331 Member: 866-475-7589	
Scholastic Emergency Services (Reference # 01-AA-LEW-05034): 877-488-9833 inside the USA or 609-452-8570 outside of the USA Morneau Shepell's International Student Support Program (Help Line): 866-743-7732 or visit us.myissp.com 24 Hour Nurse Line: 866-549-5076	
To find an Aetna provider visit: www.aetna.com/docfind/custom/passport Benefits are not insured by Aetna or affiliates. Possession of this card does not guarantee coverage. Underwriter: GBG Insurance Limited	

HOW TO FIND A DOCTOR

Go to www.lewermark.com and select **Resources**. Select **Find a Doctor or Pharmacy**, then click on the **Aetna** option, and finally, click on **Find an Aetna Provider**. Enter your **Postal Code** and the mile range. Select **Primary PPO Network**. Then choose the type of provider you're looking for – **Physician, Hospital, Urgent care center, Lab and Radiology** or **All providers**. You can then sort the results alphabetically or by distance.



Start Search Here

Please enter your **home** location (zip, city, county or state) to access providers specific to your plan benefits.

Traveling? You can change your location after you select your plan

Look within

25 Miles

0 Miles 100 Miles

Search

Select a Plan

Enter plan name to narrow list below, e.g. **Managed Choice**

Medical Plans -

- Passport to Healthcare® Primary PPO Network
- Passport to Healthcare® Secondary PPO Network

Continue

WHAT IS A CLAIMS QUESTIONNAIRE?

You may receive a questionnaire in the mail after you visit the doctor or go the hospital. This is called a Claims Questionnaire. When we receive your claim for a medical condition or an accident, we use it to find out more information in order to process your claim. A sample questionnaire is shown below:

CLAIMS QUESTIONNAIRE

Administered by: The Lewer Agency, Inc.

Please submit completed form to:

lewermarksupport@lewer.com

The Lewer Agency
PO Box 32247
Kansas City, MO 64171



Important: An incomplete questionnaire could result in the delay of processing your claim.

Your Name: _____ Date of Birth (mm/dd/yyyy): _____

Name of Your School: _____ Your Insurance I.D. Number: _____

Your Present mailing address: _____ Gender: Male Female _____

Your E-mail address: _____ Visa Type: _____ Home Country: _____

If you are not the student, please fill out the following:

Name: _____ Date of Birth (mm/dd/yyyy): _____

Relationship to student: Spouse Child Gender: Male Female

If your claim was the result of an injury or an accident, please complete the following:

Date of injury or date your symptoms were first noticed: _____

If your claim was the result of an injury or accident, please provide as many details as possible. If this was due to a car accident or crime, please attach copy of police report and your driver's license: _____

Was injury the result of participation in Intercollegiate College Sports? Yes No If yes, which sport? _____

If no, was injury the result of participation in Intramural/Club Sports? Yes No If yes, which sport? _____

If your claim was the result of sickness, please complete the following:

Provide the name and address of doctor who is treating you for this condition: _____

Have you ever been treated for this condition before? Yes No

If yes, provide the date when you were first seen or treated by a doctor for this condition (include treatment in your home country) in the last 12 months: _____

List all medications that you are currently taking: _____

Do you have any other insurance (school insurance, travel insurance, auto insurance, spouse's insurance)? Yes No

If yes, have you filed a claim? Yes No

List the insurance company's name, address, phone number and policy number(s): _____

**To fill out a full Claims Questionnaire, please go to:
www.lewermark.com/claim-forms and submit.**

HOW TO FILE A CLAIM

Claims must be filed within **180 days** of treatment 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 Program Manager and are processed in the order in which they are received. In order for claims payment to be made, claims must be submitted in a form acceptable to Insurer.

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:

- An official certificate of death, indicating date of birth of the Plan Participant;
- 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;
- 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.

ATMSafe Claims

This benefit will be payable provided the robbery is reported to the police within 48 hours of its occurrence, and the following documentation is produced upon submission of a claim:

- A copy of the police report;
- A fully completed dated and signed (by the Plan Participant) claim form;
- A copy of the ATM transaction receipt, showing the amount withdrawn, time, date and location of the ATM; and;
- Confirmation from the financial institution records that the transaction occurred at the time, date and said location. The Robbery Benefit is limited to two benefits, per Period of Insurance.

All claims must be submitted to the Insurer within 10 days from the date of the Robbery.

Submit Claims or Appeals to:

Web:	Mail:	Fax:	Email:
www.lewemark.com	The Lewer Agency, Inc. 9900 W. 109th St., Suite 200 Overland Park, KS 66210 USA	+1 816-960-7064	lewemarksupport@lewer.com

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.

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.

Status of Claims

Plan Participants 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.lewemark.com or e-mail customer service at lewemarksupport@lewer.com. Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.

HOW TO FILE A CLAIM (CONTINUED...)

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.

Coordination of Benefits

It is the duty of the Plan Participant to inform Insurer of all other coverage. In no event will more than 100% of the Allowable Charge and/or maximum benefit for the covered services be paid or reimbursed.

If a Plan Participant has coverage under another insurance contract, including but not limited to health insurance, worker's compensation insurance, automobile insurance (whether direct or third party), occupational disease coverage, and a service received is covered by such contracts, benefits will be reduced under this plan to avoid duplication of benefits available under the other contract. This includes benefits that would have been payable had the Plan Participant claimed for them. The following guidelines will be used to determine the primary plan:

- The Plan is Primary if it covers the claimant as an active Insured.
- If two Plans cover the claimant as an Insured, the Plan that has covered him for the longer period of time is the Primary plan.
- If a Plan Participant is covered as an active Insured under the Plan and as a retired or laid off Insured under another Plan, the Plan that covers him as an active Insured is the Primary Plan. The Plan that covers him as a retired or laid off Insured is the Secondary Plan.

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 plan has a right to equitable restitution.

CLAIMS APPEAL

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; you or your appointed representative has the right to file an appeal within 180 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, the Program Manager 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, the Program Manager will notify you to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

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 serve 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.

HOW TO FILE A CLAIM (CONTINUED...)

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.

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. The Medical Review Agent in consultation with the treating Physician will decide if an expedited review is necessary. When an appeal is expedited, the Program Manager will respond within 72 hours, followed up in writing or electronically within five days.

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>.

SCHEDULE OF BENEFITS

GENERAL FEATURES & PLAN SPECIFICATIONS

Policy Year Maximum Benefit Per Student	\$500,000
Lifetime Maximum Benefit per Covered Injury or Covered Sickness	Unlimited
Inpatient Individual Deductible (per Admission)	\$100
Out-of-Pocket Maximum	None
Pre-Existing Conditions (Within the first six months of continuous coverage)	\$1,000

COPAYMENTS

	In-Network	Out-of-Network
Approved Walk-In Pharmacy Clinic	\$0	-
Office Visit (per visit)	\$20	\$20
Outpatient Surgery or Ambulatory Surgery (per Occurrence)	\$100	\$100
Hospital Emergency Room (waived if admitted)	\$100	\$100

COINSURANCE

In-Network Provider	100% of Preferred Allowance
Out-of-Network Providers	80% of Usual, Reasonable & Customary (URC) Charges

PRESCRIPTION DRUGS

Subject to Deductible, Coinsurance, Copayments and Maximum Benefit Per Period of Insurance.

	In-Network	Out-of-Network
Prescription Drugs <ul style="list-style-type: none"> Up to 31-day supply per prescription Includes contraceptives CVS/Caremark network pharmacy must be used Maximum Benefit per Period of Insurance: \$5,000 	100% of the Preferred Allowance	Not Covered

SCHEDULE OF BENEFITS (CONTINUED...)

COVERED BENEFITS Subject to Deductible, Coinsurance, Copayments and Maximum Benefit Per Period of Insurance.	In-Network	Out-of-Network
Accommodations including semi-private room (Subject to the Deductible)	100% of the Preferred Allowance	80% of URC
Intensive Care/Cardiac Care	100% of the Preferred Allowance	80% of URC
Inpatient Consultation by a Physician or Specialist	100% of the Preferred Allowance	80% of URC
Hospital Miscellaneous Expenses	100% of the Preferred Allowance	80% of URC
Pre-Admission Testing	100% of the Preferred Allowance	80% of URC
Inpatient, Outpatient or Ambulatory Surgery Includes: <ul style="list-style-type: none"> • Surgeon's Fees • Assistant Surgeon and Anesthesiologist • Facility fees • Laboratory tests • Medications and dressings • Other medical services and supplies 	100% of the Preferred Allowance	80% of URC
Emergency Room and Medical Services <ul style="list-style-type: none"> • \$100 Copayment, waived if admitted 	100% of the Preferred Allowance	80% of URC
Ambulance Services <ul style="list-style-type: none"> • Emergency Local Ground or Air Ambulance 	100% of the Preferred Allowance	100% of URC
Diagnostic Testing <ul style="list-style-type: none"> • X-Ray and Laboratory • MRI, PET, and CT Scans 	100% of the Preferred Allowance	80% of URC
Extended Care/Inpatient Rehabilitation <ul style="list-style-type: none"> • Maximum Benefit per Period of Insurance: 45 days • Must be confined to facility immediately following a hospital stay 	100% of the Preferred Allowance	80% of URC
Chiropractic & Acupuncture <ul style="list-style-type: none"> • Maximum Benefit per Period of Insurance: \$50/visit, up to 12 visits 	100% of the Preferred Allowance	80% of URC
Physician Visit/Consultation by Specialist (Outpatient) <ul style="list-style-type: none"> • General Practitioner or Specialist • Urgent Care Center • \$20 Copayment per visit 	100% of the Preferred Allowance	80% of URC
Diagnostic Testing (Outpatient) <ul style="list-style-type: none"> • X-Ray and Laboratory • MRI, PET, and CT Scans 	100% of the Preferred Allowance	80% of URC

SCHEDULE OF BENEFITS (CONTINUED...)

COVERED BENEFITS Subject to Deductible, Coinsurance, Copayments and Maximum Benefit Per Period of Insurance.	In-Network	Out-of-Network
Therapeutic Services (Outpatient) - Physical Therapy, Occupational Therapy, Vocational Therapy, and Speech Therapy <ul style="list-style-type: none"> Maximum Benefit per Period of Insurance: 20 visits; subject to copay 	100% of the Preferred Allowance	80% of URC
Self-Inflicted Injury Benefit Maximum Benefit per Period of Insurance: \$10,000	100% of the Preferred Allowance	80% of URC
Inpatient Mental Health <ul style="list-style-type: none"> To treat a covered diagnosis Maximum Benefit per Period of Insurance: \$25,000 	100% of the Preferred Allowance	80% of URC
Outpatient Mental Health <ul style="list-style-type: none"> Maximum Benefit per Period of Insurance, up to 10 visits 	100% of the Preferred Allowance	80% of URC
Preventive Care and Annual Exams <ul style="list-style-type: none"> Annual Exam, Immunizations Maximum Benefit per Period of Insurance: \$250 	100% of the Preferred Allowance	Not Covered
Palliative Dental Care <ul style="list-style-type: none"> Sudden onset of pain Maximum Benefit per Period of Insurance: \$600 	100% of the Preferred Allowance	80% of URC
Emergency Dental <ul style="list-style-type: none"> Limited to accidental injury of sound natural teeth sustained while covered Maximum Benefit per Period of Insurance: \$2,000 	100% of the Preferred Allowance	80% of URC
Durable Medical Equipment <ul style="list-style-type: none"> Reimbursement of rental up to purchase price Maximum Benefit per Period of Insurance: \$5,000 	100% of the Preferred Allowance	100% of URC
Sports Activities <ul style="list-style-type: none"> Injuries arising from interscholastic, intramural, and club sports Including non-competitive cheerleading Maximum Benefit per Period of Insurance: \$10,000 	100% of the Preferred Allowance	80% of URC
Medical Evacuation/Repatriation <ul style="list-style-type: none"> Must be Pre-Authorized with Scholastic Emergency Services 	\$50,000 Maximum per Period of Insurance for Evacuation \$25,000 Maximum per Period of Insurance for Repatriation	
Return of Mortal Remains	\$20,000 Maximum Benefit	
Passport Recovery	Up to \$100 Maximum Benefit per Period of Insurance	
Lost Baggage <ul style="list-style-type: none"> Expense reimbursement due to flight delays \$100 Deductible applies 	\$250 per Period of Insurance	
ATM Safe <ul style="list-style-type: none"> Provides lost cash replacement for losses occurring during a robbery at an ATM 	\$500 per Occurrence	

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

Applies only to Class 3 Plan Participants; terminates at age 65. Does not apply to spouses or dependents.

Principal Sum: \$10,000

Loss must occur within 90 days of the Covered Accident

INSURED STUDENT'S COVERED LOSS	AD&D BENEFIT
Accidental Death	100% of the Principal Sum
Loss of Both Hands or Feet, or Loss of Entire Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand and One Foot	100% of the Principal Sum
Loss of One Hand or Foot and Entire Sight of One Eye	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight of One Eye	50% of the Principal Sum

If, within 90 days from the date of an Accident or Injury covered by the Policy, the Plan Participant suffers from a Covered Loss, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Plan Participant sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Plan Participant. The Principal Sum is the Maximum Benefit Amount shown in Schedule of Benefit.

Benefits are payable if such Injury occurs during the course of time the Plan Participant is covered under the Policy.

COVERED MEDICAL EXPENSES

HOSPITALIZATION AND INPATIENT BENEFITS

Accommodations

Coverage is provided for room and board, special diets, and general nursing care. All charges in excess of the allowable semi-private 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. The Program Manager 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.

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,
- Laboratory testing,
- Durable medical equipment,
- Diagnostic X-ray examinations,
- Radiation therapy,
- 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, or
- Support the establishment of an effective maintenance program.

Inpatient Consultation by a Physician or Specialist

Insurer will reimburse one Physician visit per day while the Plan Participant is a patient in a Hospital or approved Extended Care Facility. 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, Insurer may elect to pay more than one visit of different physicians on the same day if the physicians are of different specialties. Insurer will require submission of records and other documentation of the medical necessity for the intensive services.

COVERED MEDICAL EXPENSES (CONTINUED...)

Extended Care Facility Services, Skilled Nursing and Inpatient Rehabilitation

Benefits are available for an Inpatient confinement and services provided in an approved extended care facility following, or in lieu of, an admission to a Hospital as a result of a covered illness, disability or injury. Care provided must be at a skilled level and is payable in accordance with the current Schedule of Benefits. Intermediate, custodial, rest and homelike care services will not be considered skilled and are not covered. Coverage for confinement is subject to Insurer approval. Covered services include the following:

- Skilled nursing and related services on an inpatient basis for patients who require medical or nursing care for a covered illness. A confinement includes all approved extended care facility admissions not separated by at least 180 days.
- Rehabilitation for patients who require such care because of a covered illness, disability or injury.

OUTPATIENT SERVICES

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.

Physician Visits

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. Insurer may elect to pay more than one visit to different physicians on the same day if the physicians are of different specialties.

Outpatient Diagnostic Testing

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

Therapeutic Services

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-term and long-term treatment goals and is provided to 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; and
- 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; or
- Be necessary to the establishment of an effective maintenance program.

SURGICAL BENEFITS

Surgical Services

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.

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.

Reconstructive Surgery

Reconstructive surgery as a result of an Accident or Illness will be covered as long as it is determined that it is Medically Necessary.

COVERED MEDICAL EXPENSES (CONTINUED...)

EMERGENCIES

Emergency Room

Hospital emergency room benefits are provided in the event of a Medical Emergency when your life or health is in jeopardy. 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 may not be eligible for benefit payment.

Emergency Ambulance Services

Benefits are provided for Medically Necessary emergency 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.

Emergency Dental

This includes 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. Routine dental treatment is not covered under this benefit.

OTHER MEDICAL BENEFITS

Mental Health Benefits

Benefits are provided for psychotherapeutic treatment and 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.

Services include treatment for Bulimia; Anorexia; Bereavement; non-medical causes of insomnia; Attention Deficit Disorder (ADD); and Attention-Deficit Hyperactivity Disorder (ADHD). The following services do not meet the criteria established by the Insurer for consideration under this benefit:

1. Services for conditions not determined by Insurer as to be emotional or personality illnesses;
2. Psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation;
3. Services for mental disorders or illness which are not amenable to favorable modification.

Preventive Care

This includes routine physical examinations, immunizations for infectious diseases as recommended by the Center for Disease Control, and preventive medical attention.

Palliative Dental Care

An eligible Palliative Dental condition will mean emergency pain relief treatment to natural teeth or gums and benefits are payable in accordance with the Schedule of Benefits.

Alternative Medicine

Insurer will provide benefits limited to the following:

- Acupuncture where such is provided as treatment for an illness covered under this plan;
- Treatment is covered only by certified acupuncture specialists.

Durable Medical Equipment

Insurer provides benefits for prosthetic devices (artificial devices replacing body parts), orthopedic braces and equipment including wheelchairs and hospital beds. Such Durable Medical Equipment (DME) must be:

- Prescribed by a Physician, and
- Customarily and generally useful to a person only during an illness or injury, and
- Determined by Insurer to be Medically Necessary and appropriate.

COVERED MEDICAL EXPENSES (CONTINUED...)

Allowable rental fee of the Durable Medical Equipment must not exceed the Purchase price. Charges for repairs or replacement of artificial devices or other Durable Medical Equipment originally obtained under this plan will be paid at 50% of the allowable reasonable and customary amount.

Some items not covered under Durable Medical Equipment include but are not limited to the following:

- Comfort items such as telephone arms and over bed tables;
- Items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers;
- Miscellaneous items such as exercise equipment, heat lamps, heating pads, toilet seats, bathtub seats,
- The customizing of any vehicle, bathroom facility, or residential facility.

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, 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 covered, even if a Physician prescribes it.

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 an individual. Examples of such covered activities include but are not limited to; kayaking, snorkeling, paddle boarding, sailing, white water rafting levels 1-3, and scuba diving up to 30 meters.

This plan does not cover **hazardous or extreme sports and activities, or professional sports and activities**. Please see Section 15.0 Appendix of Sports and Other Activities for more information.

Interscholastic, intramural, and club sports, are covered as shown in the Schedule of Benefits.

ADDITIONAL BENEFITS

Passport Recovery

The Insurer will pay up to a maximum as defined in the Schedule of Benefits in respect of reasonable expenses necessarily incurred abroad in obtaining the replacement of a Plan Participant's lost or stolen passport. Additional expenses for missing flight and extending accommodations are not covered by this benefit.

Lost Baggage

Benefits are provided for Accidental loss or theft to baggage, clothing, and personal effects owned by the Plan Participant, subject to depreciation tables selected by the Insurer, up to the maximum benefit indicated in the Schedule of Benefits. This plan provides benefits secondary to the reimbursement of the Common Carrier. Claims must be filed with the Common Carrier first. See Definitions, Conditions, and Exclusions for more information.

Conditions:

1. The Plan Participant must observe ordinary proper care in the supervision of the insured property and in all cases of loss;
2. Claims will be evaluated on an "indemnity basis" only – not "new for old". This means the market value of the article less deduction for age, wear, tear and depreciation, or the cost of repair; whichever is the lesser.
3. Claims will not be considered unless proof of ownership and evidence of value is provided;
4. Any amount paid for temporary loss of baggage will be deducted from the final claim settlement if baggage proves to be permanently lost;
5. Proof of a Missing Bag Report must be filed with the Common Carrier;
6. Any amount paid by a Common Carrier in settlement toward the loss will be deducted from the final claim;

COVERED MEDICAL EXPENSES (CONTINUED...)

7. The Insurer may request any information from the Plan Participant it deems necessary in the settlement of a claim. Failure to provide additional information will result in a denial of the claim;
8. In the event of a claim in respect of a pair or set of articles 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.

The Insurer shall not be liable for:

1. Damage to baggage of any kind and or its contents;
2. Any loss or theft, or suspected theft not reported to the police within 24 hours of discovery and a written report obtained;
3. Any damage or loss or theft of property in transit, which has not been reported to the Common Carrier and written report obtained. In the case of an airline a property irregularity report will be required;
4. Loss or theft of any property left unattended in a public place;
5. Any theft from an unattended motor vehicle unless the property is in a locked/covered baggage area and there is evidence of forced entry which has been verified by a police report;
6. Loss, damage or theft of Valuables/Electronic Items and money packed in checked baggage or other receptacles while travelling;
7. Loss or damage caused by decay, wear and tear, moth, vermin or atmospheric conditions;
8. Deterioration or mechanical derangement of any kind;
9. Loss due to confiscation or detention by customs or other authority;
10. Damage to sports equipment while in use;
11. Losses of jewelry while swimming;
12. Breakage of or damage to fragile articles and any consequence thereof;
13. Any loss or theft of phones, smart phones, computer equipment including tablet personal computers;
14. Unset precious stones, contact or corneal lenses, spectacles or accessories;
15. Stamps, documents, deeds, manuscripts or securities of any kind;
16. Items of a perishable nature;
17. Business goods, samples, tools of trade or motor accessories;
18. Household goods and home contents.

ATMSafe

This is an exclusive program that provides the Plan Participant with protection against theft when withdrawing cash from an ATM/Bank Machine anywhere in the world. In the event of loss, the Plan Participant will be reimbursed up to the daily withdrawal limit specified in the Schedule of Benefits. All claims require a police report to be filed.

Medical Evacuation/Repatriation

Medical Evacuation Benefit: Subject to prior approval from the Program Manager or its authorized representative, the plan will pay benefits for reasonable expenses related to the air evacuation of an injured or sick Plan Participant (and a Health Care Provider or Escort if such is directed by the attending Physician) to the Plan Participant's home country or country of regular domicile, provided the air evacuation:

1. is upon the attending Physician's written certification;
2. results from a covered Injury or Sickness; and
3. does not occur prior to the benefit approval.

Repatriation Benefit: Subject to prior approval from the Program Manager or its authorized representative, for reasonable expenses incurred in connection with the preparation and transportation of the body of a deceased Plan Participant to his place of residence in his home country. This benefit does not include transportation expenses of any person accompanying the body.

COVERED MEDICAL EXPENSES (CONTINUED...)

Accidental Death and Dismemberment Benefits

The Plan Participant must receive initial medical treatment within 30 days of the date of Accident. The insurance does not cover injuries received while making a parachute jump (unless to save a life). The maximum amount payable for this benefit is the Principal Sum indicated on the Schedule of Benefits. If the Plan Participant incurs a covered loss, the Insurer will pay the percentage of the Principal Sum shown in the table. If the Plan Participant sustains more than one such loss as the result of one Accident, the Insurer will only pay one amount, the largest to what the Plan Participant is entitled. The loss must result within 90 days of the Accident. Your coverage under the plan must be in force.

- Loss of a Hand or Foot means complete severance through or above the wrist or ankle joint.
- Loss of Sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.
- Severance means the complete separation and dismemberment of the part from the body.

War and Terrorism

This plan covers bodily injury directly or indirectly caused by, or resulting from certain acts of War and Terrorism, provided the Plan Participant is not an active participant, or in training for in such activities. This benefit considers the following activities, excluding the use of nuclear, chemical, or biological weapons of mass destruction.

1. War, hostilities or warlike operations (whether war be declared or not),
2. Invasion,
3. Act of an enemy foreign to the nationality of the Plan Participant or the country in, or over, which the act occurs,
4. Civil war, Riot, Rebellion, Overthrow of the legally constituted government,
5. Military or usurped power,
6. Explosions of war weapons,
7. Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Plan Participant whether war be declared with that state or not,
8. Terrorist activity.

EXCLUSIONS AND LIMITATIONS

For further clarity, please note that the coverage does not provide benefits, nor is any premium charged, for:

1. **Abortion** - Any voluntarily induced termination of pregnancy and complications thereof, except if the mother's life is in danger.
2. **Air Travel** - Flying except as a fare-paying passenger in a scheduled aircraft or in an employer owned or hired jet or helicopter for transportation of employees.
3. **Breast reduction** - All services and treatments.
4. **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.
5. **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 plan are not covered. This includes any portion of a covered prescription to be used after the expiration of the current plan year.
6. **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; or;
 - b. Another insurance company or government; or
 - c. A government entity due to an epidemic or public emergency.
7. **Circumcision** - Unless due to underlying medical reasons.
8. **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.
9. **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 insured under this plan. Medical complications arising from such treatments or procedures are also not covered.
10. **Counselling and Testing Services (Non-Medical)** - Non-medical counselling services including but not limited to marriage and family counselling, educational counseling, aptitude testing, educational testing and services.
11. **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.
 - b. Dental Services at a hospital, including general anesthesia are not covered under the medical plan.
 - c. Inlays, dentures, or false teeth and replacement of lost or stolen crowns, bridges, or dentures
 - d. Implants and all related services
 - e. Temporomandibular Joint Disorders (TMJ) or Malocclusion Temporomandibular Joint Disorders and Mouth guards for teeth grinding.
12. **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.

EXCLUSIONS AND LIMITATIONS (CONTINUED...)

13. Exceptional Risks - Treatment related to:

- a. Injury sustained while participating in a hazardous or extreme sport or activity, or training for any professional sport or activity.
- b. Injury sustained while participating in, or training for, (declared or not) or acts of terrorism.
- 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.

14. 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.

15. Fertility/Infertility Treatments and Birth Control - Any services, procedure or treatment including drugs used to:

- a. 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 plan.

16. Genetic Screening - Counseling, screening, testing, or treatment in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

17. Growth Hormones - Excluded unless used as an integral treatment plan for an illness covered under this plan.

18. 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.

19. Hearing Care - Routine examination, hearing aids or devices, and the surgical implantation of, or removal of bone anchored hearing devices.

20. Hernia - Treatment of a hernia, including sports hernia whether or not caused by a covered Accident.

21. Illegal Activities - Injuries and illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law.

22. Maternity - All expenses related to pregnancy including but not limited to prenatal care, childbirth, miscarriage, premature birth and all complications related to the mother of child.

23. 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.

24. 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.
- e. Enrolling solely for the purpose of obtaining medical treatment, while on a waitlist for a specific treatment, or while traveling against the advice of a physician.

EXCLUSIONS AND LIMITATIONS (CONTINUED...)

25. **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.
26. **Organ Transplant** - Organ transplant and related procedures and expenses.
27. **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:
- Tobacco dependency
 - Weight reduction or appetite suppressant,
 - Cosmetic drugs, even if ordered for non-cosmetic purposes
 - Acne and rosacea drugs and treatment (including hormones and Retin-A), except for cystic and pustular acne,
 - Vitamins, supplements, or herbs.
28. **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.
29. **Pre-Existing Conditions** - Expenses incurred for a Pre-Existing Condition or complication thereof. Expenses for Pre-Existing Conditions may be payable under the plan after the Plan Participant's coverage has been in force for six consecutive months.
30. **Podiatric Care** - Routine foot care, including the paring and removing of corns, calluses, or other lesions, or trimming of nails or other such services. 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.
31. **Prosthetics** - High performance prosthetic devices for sports or improvement of athletic performance, and power enhancement or power-controlled devices, nerve stimulators, and other such enhancements to prosthetic devices. Limbs and other devices intended to replace the functionality of the body part being replaced and the repair and replacement of such devices are not covered.
32. **Sanctions** - Notwithstanding any other terms under this plan, 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 plan 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.
33. **Skin Conditions** - Acne, rosacea, skin tags, and any other treatment to enhance the appearance of the skin, except for cystic or pustular acne.
34. **Sleep Studies** - Sleep studies and other treatments relating to sleep apnea.
35. **Smoking Cessation** - Treatments whether or not recommended by a Physician.
36. **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.
37. **Self-Inflicted Illnesses or Injuries** - Treatment for Suicide, attempted suicide (including drug overdose) self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane in excess of benefits provided on the Schedule of Benefits, if any.
38. **Specialty Drugs** - Specialty, Compound, and Experimental drugs

EXCLUSIONS AND LIMITATIONS (CONTINUED...)

39. **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.

40. **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, unless covered under the Optional Vision coverage,
- 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.

41. **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.

Accidental Death and Dismemberment Exclusions: In addition to the Exclusions and Limitations shown above, the following exclusions also pertain to the Accidental Death and Dismemberment Benefit:

1. Any loss caused directly or indirectly from extortion, kidnap & ransom or wrongful detention of the Plan Participant or hijacking of any aircraft, motor vehicle, train or waterborne vessel on which the Plan Participant is traveling.
2. Any loss resulting as a fare-paying passenger in a scheduled aircraft or in an employer owned or hired jet or helicopter for transportation of employees.

DEFINITIONS

Certain words and phrases used in this plan are defined below. Other words and phrases may be defined where they are used.

Accident: Any sudden and unforeseen event occurring during the insurance coverage year period, resulting in bodily injury, the cause or one of the causes of which is external to the Plan Participant's own body and occurs beyond the Plan Participant's control.

Activities of Daily Living (ADL): Activities of daily living are those activities normally associated with the day-to-day fundamentals of personal self-care, including but not limited to: walking, personal hygiene, sleeping, toilet/continence, dressing, cooking/feeding, medication, and getting in and out of bed.

Acute Care: Medically Necessary, short-term care for an illness or injury, characterized by rapid onset, severe symptoms, and brief duration, including any intense symptoms, such as severe pain.

Admission: The period from the time that a Plan Participant's enters a Hospital, Extended Care Facility or other approved health care facility as an inpatient until discharge.

Air Ambulance: An aircraft specially equipped with the necessary medical personnel, supplies and Hospital equipment to treat life-threatening illnesses and/or injuries for Plan Participant's whose conditions cannot be treated locally and must be transported by air to the nearest medical center that can adequately treat their conditions. This service requires Pre-Authorization. A commercial passenger airplane does not qualify as an air ambulance.

Allowable Charge: The fee or price the Insurer determines to be the Usual, Customary and Reasonable Charges for health care services provided to Plan Participants. 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.

Ambulatory Surgical Center: A facility which (a) has as its primary purpose to provide elective surgical care; and (b) admits and discharges a patient within the same working day; and (c) is not part of a Hospital. Ambulatory Surgical Center: does not include: (1) any facility whose primary purpose is the termination of pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained by a Dentist for the practice of Dentistry.

ATM: An automatic electronic device designed to permit the Plan Participant to interface with a financial institution without teller assistance using a Registered Card.

Birth Center: A facility that: a) is mainly a place for the delivery of a child or children at the end of a normal pregnancy; b) and meets one or both of the following tests: (1) it is licensed as a Birth Center under the laws of the jurisdiction where it is located; and/or (2) it meets all the following requirements: (i) it is operated in accordance with the laws of the jurisdiction where it is located; (ii) it is equipped to perform all necessary routine diagnostic and laboratory tests; (iii) it has trained staff and equipment required to properly treat potential emergencies of the mother and of the child; (iv) it is operated under the full-time supervision of a Physician or a Registered Nurse (R.N.); (v) it has at all times a written agreement with at least one Hospital in the area for immediate acceptance of a patient in the event of a complication; (vi) it maintains medical records for each patient; (vii) and it is expected to discharge or transfer each patient within 48 hours after the delivery.

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.

DEFINITIONS (CONTINUED...)

Coinsurance: The percentage of Eligible Expenses for which the Company is responsible for a specified covered service after the Copay or Deductible, if any, has been met.

Common Carrier: An individual, a company, or public utility which is in the regular business of transporting people and for which a fair has been paid.

Complications of Pregnancy: A condition;

- Caused by pregnancy; and
- Requiring medical treatment prior to, or subsequent to termination of pregnancy; and
- The diagnosis of which is distinct for pregnancy; and
- Which constitutes a classifiably distinct complication of pregnancy.

A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

Confinement: Inpatient stay at an approved extended care facility for necessary skilled treatment or rehabilitation in accordance with the contract.

Congenital Condition: Any heredity condition, birth defect, physical anomaly and/or any other deviation from normal development present at birth, which may or may not be apparent at that time. These deviations, either physical or mental, include but are not limited to, genetic and non-genetic factors or inborn errors of metabolism.

Copay or Copayment: That portion of a covered service or covered benefit that a Plan Participant is required to pay out of his or her pocket before benefits will be paid for any remaining portion. The Copay is separate from and is not a part of Coinsurance or a Deductible.

Cosmetic Surgery: Surgery or therapy performed to improve or alter appearance for self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

Custodial Care: Includes: (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and (3) rest cures, respite care and home care provided by family Insureds. Upon receipt and review of a claim, the Insurer or an independent medical review will determine if a service or treatment is Custodial Care.

Deductible: The amounts of covered Allowable Charges payable by the Plan Participant during each Period of Insurance before the plan benefits are applied. Such amount will not be reimbursed under the plan. The Deductible is not considered part of the Out-Of-Pocket Maximum.

Durable Medical Equipment: Orthopedic braces, artificial devices replacing body parts and other equipment customarily and generally useful to a person only during an illness or injury and determined by Insurer on a case by case basis to be Medically Necessary including motorized wheelchairs and beds. See DME Section for more details and services that are not consider eligible benefits.

Eligibility: The requirements that a Plan Participant, including the primary Plan Participant must meet at all times in order to be covered 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.

DEFINITIONS (CONTINUED...)

Emergency Dental Treatment: Emergency dental treatment is urgent treatment necessary to restore or replace sound natural teeth damaged as a result of an Accident. Sound teeth do not include teeth with previous crowns, fillings, or cracks. Damage to teeth caused by chewing foods does not qualify for emergency dental coverage.

Experimental and/or Investigational: Any treatment, procedure, technology, facility, equipment, drug, drug usage, device, or supplies not recognized as accepted medical practice by Insurer.

Extended Care Facility: A nursing and/or rehabilitation center approved by 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.

Home Country: The country from which the Plan Participant holds a passport. In the event that a citizen of the United States holds more than one passport, the United States shall be deemed the Home Country.

Hospital: Includes only acute care facilities licensed or approved by the appropriate regulatory agency as a hospital, and whose services are under the supervision of, or rendered by a staff of physicians who are duly licensed to practice medicine, and which continuously provides twenty-four (24) hour a day nursing service under the direction or supervision of registered professional nurses. The term Hospital does not include nursing homes, rest home, health resorts, and homes for the aged, infirmaries or establishments for domiciliary care, custodial care, care of drug addicts or alcoholics, or similar institutions.

Illness: A physical sickness or disease of a Plan Participant.

Inpatient: A Plan Participant admitted to an approved Hospital or other health care facility for a Medically Necessary overnight stay.

K-12 Institution: An educational institution which educates children between and including the grade levels of kindergarten to twelfth grade.

LewerMark 24/7 Nurse Line: A medical hotline for students to speak with a registered nurse about their health, illness, or where to go if they feel sick or are injured.

Lifetime Maximum: Payment of benefits is subject to a lifetime aggregate maximum per individual Plan Participant as indicated in the Schedule of Benefits, as long as the plan remains in force. The Lifetime Maximum includes all benefit maximums specified in the plan, including those specified in the Schedule of Benefits.

Master Policy: The agreement between the Insurer and the International Benefit Trust.

Maximum Benefit: The payment specified in the Schedule of Benefits, for specific services, which is the maximum amount payable by Insurer per person, 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.

DEFINITIONS (CONTINUED...)

Medically Necessary: Those services or supplies which are provided by Hospital, Physician or other approved medical providers that are required to identify or treat an illness or injury and which, as determined by Insurer, are as follows:

- Consistent with the symptom, or diagnosis and treatment of condition, disease or injury;
- Appropriate with regard to standards of accepted professional practice;
- Not solely for the Insured Person's convenience, the Physician's convenience or any other provider's convenience, and
- The most appropriate supply or level of service, which can be provided. When applied to an inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an outpatient;
- Is not a part of or associated with the scholastic education or vocational training of the patient;
- Is not Experimental or Investigative.

Nurse: A person licensed as a Registered Nurse, (R.N.) or Licensed Practical Nurse, (L.P.N.) by the appropriate licensing authority in the areas which he or she practices nursing.

Outpatient: Services, supplies or equipment received while not an inpatient in a hospital, or other health care facility, or overnight stay.

Participating Organization: An educational institution that has applied for membership under the Trust, offers coverage to eligible Plan Participants, and agrees to abide by the terms of the Certificate.

Period of Insurance: The start and end date for which insurance coverage is in effect as shown on the Face Page. When multiple Certificates are issued during a School Year, the Maximum Benefit is an accumulation of all Certificates issued during the School Year.

Physician: Any person who is duly licensed and meets all of the laws, regulations, and requirements of the jurisdiction in which he practices medicine, osteopathy or podiatry and who is acting within the scope of that license. This term does not include; (1) an intern; or (2) a person in training.

Pre-Authorization: A process by which a Plan Participant obtains written approval for certain medical procedures or treatments from the Insurer prior to the commencement of the proposed medical treatment. Certain medical procedures will require the Pre-Authorization process to be followed in order for the service to be covered and to maximize the benefits of the Plan Participant.

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.

Preferred Allowance: The amount a Network Provider will accept as payment in full for Eligible Expenses.

Preferred Provider Organization (PPO): Refers to a participating provider, such as Hospital, clinic or Physician that has entered into an agreement to provide health services to Plan Participants.

Premium(s): The consideration owed by the Plan Participant to the Insurer in order to secure benefits for its Plan Participant's under this plan.

DEFINITIONS (CONTINUED...)

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 or Investigative drugs, or medical supplies even when recommended by a physician, do not qualify as prescription drugs.

Professional Sports: Activities in which the participants receive payment for participation.

Provider: The organization or person performing or supplying treatment, services, supplies or drugs.

Rehabilitation: Therapeutic services designed to improve a patient's medical condition within a predetermined time period through establishing a maintenance program designed to maintain the patient's current condition, prevent it from deteriorating and assist in recovery.

Repatriation or Local Burial: This is the expense of preparation and the air transportation of the mortal remains of the Plan Participant from the place of death to their Home Country, or the preparation and local burial of the mortal remains of a Plan Participant who dies outside their home country. This benefit is excluded where death occurs in their Home Country.

Schedule of Benefits: The summary description of the benefits, payment levels and maximum benefits, provided under this plan.

School Year: The 12-month period when the educational institution begins classes, usually starting in late summer and may conduct classes on a quarterly, semester, or other regularly scheduled basis.

Subrogation: Circumstances under which the Insurer may recover expenses for a claim paid out when another party should have been responsible for paying all, or a portion of that claim.

Terrorism: Terrorist activity means an act, or acts, of any person, or groups of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization or government.

Usual, Customary and Reasonable Charge: 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 Injury or Illness 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.

Waiting Period: The period of time beginning with the Plan Participant's Effective Date, during which limited or no benefits are available for particular services. After satisfaction of the Waiting Period, benefits for those services become available in accordance with this plan.

APPENDIX OF SPORTS AND OTHER ACTIVITIES

Covered Sports and Activities The following sports and activities are covered provided the Plan Participant meets the Eligibility Criteria and participates in these sports as part of a sanctioned school activity.	Excluded Hazardous and Extreme Sports and Activities
Abseiling	BMX cycling
Aerobics	Base Jumping
American Football	Boxing
Archery	Bungee Jumping
Athletics	Canoeing/Kayaking (white water)
Badminton	Canyoning
Baseball	Caving / Cave Diving
Basketball	Cheerleading (Competitive)
Bowls	Cross channel swimming
Calisthenics	Gaelic Football (non-competitive)
Camel/Elephant Riding / Trekking	Gliding
Canoeing/Kayaking (inland/coastal)	Hang Gliding
Cheerleading (non-competitive)	Heptathlon
Clay pigeon shooting	High Diving
Cricket	Horse Jumping
Cross country running	Horse Racing
Gymnastics	Hunting-on-horseback
Cycling	Ice Hockey
Curling	Kite surfing/Landboarding/Buggyng
Dry skiing	Martial Arts (Competition)
Fencing	Martial Arts (Training only)
Fell running	Microlighting
Field Hockey	Motor Racing (all types)
Fishing (Fresh water and deep sea)	Motorcycling (any)
Flying as a passenger (private/small aircraft)	Mountain Boarding
Go Karting (recreational use)	Mountaineering
Golf	Mountain Biking
Ice Hockey – School only.	Orienteering
Handball	Parachuting
Horse riding (no Polo, Hunting, Jumping or Dressage)	Parasailing
Hot Air Ballooning	Parascending (over land)
Hurling	Parascending (over water)

APPENDIX OF SPORTS AND OTHER ACTIVITIES (CONTINUED...)

Covered Sports and Activities The following sports and activities are covered provided the Plan Participant meets the Eligibility Criteria and participates in these sports as part of a sanctioned school activity.	Excluded Hazardous and Extreme Sports and Activities
Jet Boating	Parkour
Jet Skiing	Point-to-point
Jogging	Polo
Kickball	Potholing
Lacrosse	Professional Sports
Netball	Quad Biking
Paintballing	Rambling
Roller Blading (Line Skating / Skate boarding)	Rock Climbing
Roller Hockey/Street Hockey	Rock Scrambling
Rounder's	Rugby - Contact
Rowing (inland/coastal)	Sandboarding
Rugby – Touch Only	Scuba Diving (greater than 30 meters)
Running, Sprint / Long Distance	Shark feeding/cage diving
Safari (organized - no guns)	Sky Diving
Sailboarding	Steeple chasing
Sand Yachting	Tombstoning
Scuba Diving (max depth 30 meters)	Trekking/Hiking (over 4,500 meters altitude)
Skate boarding	Skiing/Snowboarding
Snorkeling	Windsurfing
Squash	White/Black Water Rafting (Grade 4 to 6)
Surfing	Weight-Lifting (Competitive)
Tennis	Yachting (crewing) - outside territorial waters
Trekking/Hiking (under 4,500 meters altitude)	Yachting (racing)
Triathlon	Zorbing/Hydrozorbing
Volleyball	
Wake Boarding	
Water Polo	
Wrestling	
Water Skiing	
White/Black Water Rafting (Grade 1 to 3)	
Yachting (crewing) - inside territorial waters	

ELIGIBILITY

The **Policyholder** is the Multi-National Benefit Trust, hereinafter shall be referred to as the “Trust”.

Participating Organization, the educational institution whose name as indicated on the Face Page as “Participating Organization”.

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 Participating Organization and Plan Participant 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 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 health insurance Policy issued to the Trust. As such, this Policy 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. GIL is licensed by the GFSC - this is a regulatory requirement. 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.

The **Insurer** has appointed the **Program Manager** to administer the plan on its behalf. References to the Insurer throughout this Certificate are considered to include the Program Manager where appropriate. Any notice delivered to the Program Manager shall be considered received by the Insurer.

CLASSES OF ELIGIBLE PERSONS:

All international, full-time students enrolled in and attending a recognized K-12 Institution outside of their Home Country. 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 investigate 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.

Plan Participants are those persons described as an Eligible Class.

- Student minimum age is 5 years and maximum is 20 years,
- Student must be travelling outside their Home Country.

Students who are United States citizens living in the United States are not eligible for coverage.

APPLICATION AND EFFECTIVE DATE:

The Plan Participant’s coverage becomes effective on the effective date shown on the Face Page. Coverage under the plan ends on the earlier of:

- On the expiration date of the insurance coverage. However, if a Plan Participant’s return is delayed due to unforeseeable circumstances beyond their control, the insurance coverage will be extended until such trip can be completed, but no later than seven days from the original insurance coverage expiration, or
- If medical evacuation was necessary, upon the Plan Participant’s evacuation to the Home Country.
- Termination of coverage of the Plan Participant.

Note: The minimum period of insurance must be the entire duration the Plan Participant actively attends classes. Eligible individuals may enroll onto the plan no earlier than 30 days prior to the start of their classes and terminate coverage no later than 30 days after classes have ended (See Extended Coverage).

PREMIUM, CANCELLATION, AND POLICY PROVISIONS

EXTENDED COVERAGE:

The Extended Coverage benefit is available to newly enrolled students who arrive in the United States prior to the beginning of the first term of study in the United States, or Plan Participants who have completed their final term of study in the United States and are preparing to return to the Home Country. The Extended Coverage benefit provides up to 30 days of additional coverage.

Extended Coverage does not apply to Plan Participants who are continuing their studies or returning to studies in the United States whether at the same or different institutions.

Newly-Enrolled and Arriving Students

In order to be eligible for the Extended Coverage Benefit and before any benefits will be paid:

1. A newly-enrolled and arriving student must have enrolled in Full-Time Studies at the K-12 Institution, and
2. All premiums must be paid.

Coverage under the Extended Coverage Benefit will become effective on the later of:

1. 30 days prior to the beginning of the term, or
2. The first day the qualifying, newly-enrolled and arriving student arrives in the United States.

Students Concluding their Studies

A Plan Participant may extend coverage for a maximum of 30 days while remaining in the United States following graduation or completion of an educational program. To be eligible for the Extended Coverage benefit and before any benefits will be paid:

1. The Insurer must receive the request for Extended Coverage prior to the termination of the Plan Participant's coverage, and
2. All premiums must be paid.

Coverage under the Extended Coverage Benefit will terminate on the earlier of:

1. 30 days following the Plan Participant's graduation or completion of an educational program, or
2. The date of departure from the United States.

Extended Coverage for Short-Term Programs

In the event the Plan Participant's entire program of study is less than 60 days, the applicable Extended Coverage benefit will be limited to seven days. All other Extended Coverage benefit provisions will apply as indicated herein.

PREMIUM PAYMENT:

All Premiums are payable before coverage is provided.

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;
- Knowingly claimed benefits for any purpose other than are provided for under this plan;
- Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the Insurer's detriment;
- 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.

The Insurer may refuse to continue in force the coverage under this plan for a Participating Organization by providing written notice to it at least 30 days prior to the date of termination in the event of fraud or intentional misrepresentation of a material fact by the Participating Organization.

PREMIUM, CANCELLATION, AND POLICY PROVISIONS (CONTINUED...)

RATE MODIFICATIONS:

The plan term begins on the Effective Date of the plan as shown in the face page and ends at midnight 365 days later. The plan is not subject to guaranteed issuance or renewal.

The Insurer has the right to modify Premium, or rate basis, applying such changes to an entire Class of Plan Participants not any one Plan Participant on any anniversary date, unless there is a change in the number of Plan Participants or change in residence location of the Plan Participants. The Insurer must notify the Participating Organization of the change at least 30 days prior to the change.

CHANGE OF RISK:

The Participating Organization must inform the Insurer as soon as reasonably possible, of any changes related to Plan Participants (such as change of address or eligibility status) or of any other material changes that affect information given in connection with the application for coverage under this plan. The Insurer reserves the right to alter the plan terms or cancel coverage for a Plan Participant following a change of risk.

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.

COMPLIANCE WITH THE POLICY TERMS:

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

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.

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, the privacy policy can be viewed at <https://www.gbg.com/#/AboutGBG/PrivacyPolicy>.

WAIVER:

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

DENIAL OF LIABILITY:

Neither the Insurer, nor the Policyholder, nor the Program Manager is 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, the Participating Organization, or the Program Manager based on an act of omission or commission of a Hospital, Physician, or other provider of care or service.

GEOGRAPHIC AREAS OF COVERAGE

AREAS OF COVERAGE:

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

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 tier 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 it 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 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.