

Collegiate Care Gold	In Network	Out of Network
Maximum for all Medical Expense Per Injury or Sickness	\$250,000 per Sickness or Injury \$600,000 Annual Maximum (Motor Vehicle Accident Maximum: \$10,000 per Period of Insurance)	\$250,000 per Sickness or Injury \$600,000 Annual Maximum (Motor Vehicle Accident Maximum: \$10,000 per Period of Insurance)
Deductible - Per Injury or Sickness	\$40 if first treated by the Student Health Center \$90 if not first treated by the Student Health Center	\$40 if first treated by the Student Health Center \$90 if not first treated by the Student Health Center
Coinsurance	Refer to below for specifics	Refer to below for specifics
Maximum Benefit Period	13 weeks from the date first treated	13 weeks from the date first treated
1) Physician Visit (Inpatient) or Outpatient	100% of the Preferred Allowance up to \$60 maximum; 1 visit per day 30 visits maximum	60% of URC up to \$60 maximum; 1 visit per day 30 visits maximum
2) Specialist Visits	Same as any other Sickness	Same as any other Sickness
3) Consultation Fee	100% of the Preferred Allowance up to \$400 maximum benefit	60% of URC up to \$400 maximum benefit
4) Hospital Room & Board	100% of the Preferred Allowance up to \$1,300 per day, maximum 30 days per Occurrence, subject to a \$100 Co-Pay	60% of URC up to \$1,300 per day maximum, 30 days per Occurrence, subject to a \$100 Co-Pay
5) ICU Room and Board Charges	100% of the Preferred Allowance up to \$1,825 per day maximum 30 days per Occurrence subject to a \$100 Co-Pay	60% of URC up to \$1,825 per day maximum 30 days per Occurrence subject to a \$100 Co-Pay
6) Hospital Miscellaneous	100% of the Preferred Allowance up to \$500 maximum; 30 days maximum per Occurrence	60% of URC up to \$500 maximum; 30 days maximum per Occurrence
7a) Surgeon (In or Outpatient)	100% of the Preferred Allowance up to \$4,000 maximum	60% of URC up to \$4,000 maximum
7b) Day Surgery – Outpatient	100% of the Preferred Allowance up to \$1,000 maximum	60% of URC up to \$1,000 maximum
8) Assistant Surgeon	100% of the Preferred Allowance up to 25% of the Surgeon Allowance	60% of URC up to 25% of the Surgeon Allowance
9) Emergency Room	80% of the Preferred Allowance, \$300 Co-Pay, waived if admitted	60% of URC \$300 Co-Pay waived if admitted
10) Pre-Admission Testing – within 3 days of admission	100% of the Preferred Allowance up to \$900 maximum	60% of URC up to \$900 maximum
11) Anesthesia	100% of the Preferred Allowance up to 25% of the Surgeon Allowance	60% of URC up to 25% of the Surgeon Allowance
12) Diagnostic X-Ray and Lab	100% of the Preferred Allowance up to \$500 maximum; Cat Scan, PET Scan or MRI up to \$850	60% of URC up to \$500 maximum; Cat Scan, PET Scan or MRI up to \$850
13) Physiotherapy – Inpatient or Outpatient	100% of the Preferred Allowance up to \$35 per visit, 1 visit per day, 12 visits maximum	60% of URC up to \$35 per visit, 1 visit per day, 12 visits maximum
14) Ambulance Benefit	100% of the Preferred Allowance up to \$400 maximum	60% of URC up to \$400 maximum
15a) Mental & Nervous Conditions Inpatient	100% of the Preferred Allowance 30 days maximum	60% of URC 30 days maximum
15b) Mental & Nervous Conditions Outpatient	40 visits per year at 100% of the Preferred Allowance up to \$5,000 maximum, per Period of Insurance	40 visits per year at 60% of URC up to \$5,000 maximum, per Period of Insurance
16) Alcohol and Drug Abuse In-Patient or Outpatient	100% of Preferred Allowance Same as any other Sickness	60% of URC Same as any other Sickness
17) Emergency Dental	100% of Preferred Allowance up to \$500 maximum	60% of URC up to \$500 maximum
18) Prescriptions	\$100 per Period of Insurance	
19) Durable Medical Equipment	100% of the Preferred Allowance up to \$1,000 maximum	60% of URC up to \$1,000 maximum
20a) Emergency Medical Evacuation or Repatriation	100% of actual expense up to \$120,000	

20b) Return of Mortal Remains	100% of actual expense up to \$60,000	
21) Emergency Reunion	100% of actual expense up to \$10,000	
22) Maternity and Prenatal Care (Conception must occur while covered under the current policy)	100% of Preferred Allowance up to \$7,500 maximum for normal delivery; \$10,00 for c section delivery	60% of UCR up to \$7,500 maximum for normal delivery; \$10,000 for c section delivery
23) Radiation/Chemotherapy	100% of Preferred Allowance \$1,000 maximum	60% of URC up to \$1,000 maximum
24) Home Country Coverage	Up to \$500 per Period of Insurance for services rendered in your Home Country.	

Rates Effective August 1, 2018	
Ages 12-24	\$41 per month
25-29	\$61 per month
30-64	\$117 per month
Any Dependent	\$330 per month

This is a short term limited benefit plan.

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Benefits will be provided only for the Coverages listed below and will be paid only up to the amounts shown. Payment for any covered medical expense will be no more than the benefit limits shown below; up to \$50,000 per event. After benefits have been paid up to these amounts, additional covered medical expenses will be paid at 100% of UCR to the Per Sickness/Injury maximum as stated above, subject to the coordination of benefits provision. Covered Expenses are the Preferred Allowance for In Network or UCR for Non Network medically necessary services and supplies incurred within 13 weeks from the date of the accident causing the Injury or the date of the Sickness. Treatment must begin no later than 30 days after the onset to be covered.

Covered Medical Expenses Include:

- 1) Physician visits expense: Inpatient or Outpatient and limited to one visit per day. \$60 per visit 30 visits maximum per Sickness or Injury. Benefit limitations do not apply when related to surgery;
- 2) Specialist visits expense: Inpatient or Outpatient and limited to one visit per day. \$60 per visit 30 visits maximum per Sickness or Injury. Benefit limitations do not apply when related to surgery;
- 3) Consultation fees expense: up to \$400 maximum; When requested and approved by the attending physician if, by reason of Injury or Sickness, a Covered Person requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis. We will pay the amount incurred unless the cost of this service is included in a negotiated case rate with the provider or facility;
- 4) Hospital Room and Board expense: daily semi-private room rate when hospital confined. Subject to a \$100 CoPay, \$1,300 a day maximum, 30 days per Occurrence for the most common semi-private daily room rate for each day of the Hospital Stay. In computing the number of day's payable, under this benefit, the date of admission will be counted, but not the date of discharge. Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation;
- 5) ICU Room and Board expense: Subject to a \$100 Co-Pay, \$1825 per day Maximum 8 days per Occurrence. This payment is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services;
- 6) Hospital miscellaneous expense: while hospital confined. Benefits will be paid for services and supplies such as : the cost of the operating room; laboratory tests; x-ray exams; anesthesia; drugs(excluding take home drugs) or medicines; therapeutic services and supplies up to \$500 per day 30 days maximum; We will pay for services, supplies and charges during a Hospital Stay. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines;

- 7) Surgery/Surgeon's Expense – Inpatient or Outpatient: a) physician's fees for surgery. Covered Expenses will be paid under this benefit or the Outpatient benefit but not both. \$4,000 maximum; We will pay charges for: A Physician, for primary performance of a surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries; b) Day Surgery-Outpatient expense: excluding nonscheduled surgery and surgery performed in a hospital emergency room, trauma center physician's office or clinic. Covers the cost of the operating room; laboratory tests; x-ray exams; anesthesia; drugs(excluding take home drugs) or medicines; therapeutic services and supplies up to \$1,000 maximum; We will pay charges for: A Physician, for primary performance of a surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries;
- 8) Assistant Surgeon expense – Inpatient or Outpatient: 25% of the Surgeon's benefit payable; If, in connection with such operation, the services of an Assistant Surgeon are required, We will pay the Covered Expense incurred;
- 9) Emergency room expense: includes attending Physician charges, x-rays, laboratory test and procedures, use of emergency room and supplies. Subject to a Co-Pay of \$300 per Occurrence. If admitted after the Emergency Room visit the Co-Pay is waived. We will pay if the Covered Person requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident or Sickness. Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people Emergency treatment on an Outpatient basis. An Emergency Room is not a clinic or Physician's office;
- 10) Pre-admission testing expense: \$900 maximum and Inpatient confinement must occur within 3 days of testing;
- 11) Anesthesia expense: 25% of the paid Surgeon's expense; We will pay benefits for pre-operative screening and administration of anesthesia during a surgical procedure whether on an Inpatient or Outpatient basis;
- 12) Diagnostic x-rays and lab services: \$500 maximum. Cat Scan, PET scan or MRI up to \$850;
- 13) Physiotherapy: \$35 per visit, 1 visit per day, 12 visits maximum per Period of Insurance; We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Covered Person. In no event will the Company's Maximum liability exceed the Maximum stated in the Schedule of Benefits, as to Eligible Expenses during any Period of Insurance. For the purpose of this section, Physiotherapy means charges for physiotherapy if recommended by a Physician for the treatment of a specific Disablement or following hospitalization and administered by a licensed physiotherapist as an Outpatient, up to up to the Maximum amount shown in the Schedule of Benefits for the Outpatient Physiotherapy benefit. Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, or any form of physical therapy;
- 14) Ambulance expense: When Injury or Sickness requires the use of a community or Hospital Ambulance in a Medical Emergency, We will pay up to \$400 for transportation, within the metropolitan area in which the Covered Person is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered up to \$350 when Medically Necessary because of a life threatening Injury or Sickness or if the Covered Person is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered a Eligible Expense. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for Inpatient care. Search and rescue charges are not covered;
- 15) Mental and Nervous a) Inpatient: maximum of 30 days per Period of Insurance; If a Covered Person requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows: Benefits for Inpatient Hospital Confinement -When a Covered Person requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement. Such confinement must be in a licensed or certified facility, including Hospitals. Biologically Based Mental Sickness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness; b) Mental and Nervous Outpatient: maximum of 40 visits per year, \$5,000 maximum; Benefits for Outpatient Services - We will pay the Eligible Expenses incurred for the Outpatient treatment of Mental and Nervous Conditions as defined. The Mental and Nervous Condition must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary. Outpatient treatment and Physician services include charges made by an Outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician's office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law. Biologically Based Mental Sickness means a mental, nervous, or emotional

disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness;

- 16) Alcohol and Drug Abuse Inpatient or Outpatient: same as any other Sickness; If a Covered Person requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows: Benefits for Inpatient Hospital Confinement - When a Covered Person is confined as an Inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement. Such Confinement must be in a licensed or certified facility, including Hospitals. Benefits for Outpatient Services - We will pay the Covered Percentage of the Eligible Expenses incurred for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency. Outpatient Treatment and Physician services include charges for services rendered in a Physician's office or by an Outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Physician or a licensed psychologist who certifies every three months that a Covered Person needs to continue such treatment. Alcohol Abuse means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psychosocial. Drug Abuse means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social. Detoxification Facility means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by: monitoring the amount of alcohol and other toxic agents in the body of the individual; managing withdrawal symptoms; and motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse;
- 17) Emergency dental expense: up to \$500 maximum. We will pay for expenses for emergency dental treatment due to Injury to Natural Teeth;
- 18) Prescription drugs: \$100 per Period of Insurance; Prescription Drug means a drug which: 1. Under Federal law may only be dispensed by written prescription; and 2. is utilized for the specific purpose approved for general use by the Food and Drug Administration. The Prescription Drug must be dispensed for Outpatient use by the Covered Person: 1. on or after the Covered Person's Effective Date and 2. Dispensed by a licensed pharmacy provider;
- 19) Durable medical equipment: \$1,000 per Period of Insurance maximum. If, by reason of Injury or Sickness, a Covered Person requires the use of Durable Medical Equipment, We will pay the Eligible Expenses incurred by a Covered Person for such Durable Medical Equipment. We pay the Eligible Expenses incurred by a Covered Person for the purchase or rental of such item. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied toward the cost of the purchase price if the equipment is purchased at a later date. If Durable Medical Equipment is purchased, it is Our property and is to be returned to Us, at Our expense, upon completion of a Covered Person's need, if so requested by Us. We do not pay for the replacement of Durable Medical Equipment. Durable Medical Equipment means medical equipment that: 1. is prescribed by the Physician who documents the necessity for the item including the expected duration of its use; 2. can withstand long-term repeated use without replacement; 3. is not useful in the absence of an Injury or Sickness; and 4. can be used in the home without medical supervision. Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items;
- 20) Emergency Medical Evacuation and Repatriation: up to \$120,000 When You suffer loss of life for any reason or incur a covered Sickness or Injury during the course of Your Period of Insurance, the following benefits are payable: a) Emergency Medical Evacuation: If the local attending Legally Qualified Physician and the Program Medical Advisor authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment. Medical Repatriation: If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for You to return to Your primary place of residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred within 30 days from the date of the Covered Loss, will be paid for Your return to Your primary place of residence or to a Hospital or medical facility closest to Your primary place of residence capable of providing continued treatment via one of the following methods of transportation, as approved, in writing, by the authorized travel assistance company: one-way Economy Transportation; commercial air upgrade (to Business or First Class), based on Your condition as recommended by the local attending Legally Qualified Physician and verified in writing and considered necessary by the authorized travel assistance company; or other covered land or air transportation including, but not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been preapproved and arranged by the authorized travel assistance company. Transportation must be via the most direct and economical route; b) Return of Mortal Remains: In the event of Your death during the Period of Insurance, the expense incurred within 30 days from the date of the Covered Loss will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your primary place of residence;

- 21) Emergency Reunion: If You are traveling alone and will be hospitalized for more than 7 consecutive days and Emergency Evacuation or Medical Repatriation is not imminent, benefits will be paid to transport one person, chosen by You, by Economy Transportation, for a single visit to and from Your bedside. Reasonable travel and accommodation expenses incurred in relation to the Emergency Medical Reunion for hotel and meals to a Maximum of \$50 per day up to the Maximum stated in Schedule of Benefits, Emergency Medical Reunion;
- 22) Maternity and Pre Natal expense: \$7,500 maximum for normal delivery and \$10,000 maximum for C section delivery. After a 12 month waiting period and conception must occur after the waiting period and while covered on the plan. LMP is used to determine conception date. In no event will the Company's Maximum liability as to Eligible Expenses during any one period of individual coverage. Benefits will be payable for expenses incurred before, during, and after delivery of a Child, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Covered Person and her newborn Child in a Hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Perinatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Covered Person's attending Physician determines further Inpatient postpartum care is not necessary for her or her newborn Child provided the following are met: In the opinion of the Covered Person's attending Physician, the newborn Child meets the criteria for medical stability in the guidelines for Perinatal Care prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of: The antepartum, intrapartum, postpartum course of the mother and infant; The gestational stage, birth weight, and clinical condition of the infant; The demonstrated ability of the mother to care for the infant after discharge; and The availability of post discharge follow up to verify the condition of the infant after discharge; and One (1) at-home post-delivery care visit is provided to the Covered Person at her residence by a Physician or Registered Nurse performed no later than forty-eight (48) hours following discharge of the Covered Person and her newborn Child from the Hospital. Coverage for this visit includes, but is not limited to: Parent education; Assistance in training in breast or bottle feeding; and Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Covered Person or newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At the Covered Person's discretion, this visit may occur at the Physician's office. Any newborn child must be enrolled in the coverage within 30 days of birth;
- 23) Radiation therapy or chemotherapy: \$1,000 maximum per Period of Insurance;
- 24) Up to \$500 per Period of Insurance for services rendered in your Home Country.

ACCIDENTAL DEATH AND DISMEMBERMENT PRINCIPAL SUM

For Injury resulting in the loss of:

Both hands or both feet or the sight of both eyes ;or One hand and one foot, one hand or one foot and the sight of one eye:

\$20,000 One hand or one foot or the sight of one eye: \$7,500

"Loss of hand or foot" means severance at or above the wrist or ankle joint. "Loss of sight" must be entire and irrecoverable.

Accidental Death Benefit – the plan pays \$20,000 when your death occurs as a result of accidental Injury. Loss of life must result within 90 days of the date of the accident causing such loss. Your coverage under the Policy must be in force on the date of the accident and when loss of life occurs.

Dismemberment Benefit - If you sustain accidental Injury that results in loss of a limb or sight the plan will pay the portion of the Principal Sum shown below. Loss must occur within 90 days of the accident causing such loss. In the event of more than one loss only one sum, the largest, will be paid.

DEFINITIONS

Benefit Period means the period of time from the date of the Accident causing the Injury or Sickness for which benefits are payable, and the date after which no further benefits will be paid.

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

Co-Pay means a specified charge that the Covered Person is required to pay when a medical service is rendered.

Covered Percentage means the percentage of a billed expense that would be considered to be the allowable amount for the particular service.

Deductible means the dollar amount of Eligible Expenses which must be incurred and paid by the Covered Person before benefits are payable under the Policy. It applies separately to each Covered Person.

Home Country means the country where a Covered Person has his or her true, fixed and permanent home and principal establishment.

Network Provider means a Physician, Hospital and other healthcare providers who have contracted to provide specific medical care at negotiated prices. The availability of specific providers is subject to change without notice. You should always confirm that a Network Provider is participating at the time services are required by GBG Assist or by asking the provider when you make an appointment for services.

Maximum Benefit means the largest total amount of Eligible Expenses that the Company will pay for the Covered Person as shown in the Covered Person's Schedule of Benefits for an incident.

Non-Network Provider means a Physician, Hospital and other healthcare providers who have not agreed to any pre-arranged fee schedules. A Covered Person may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Covered Person's responsibility.

Period of Insurance means the period of time following the Covered Person's Effective Date until the last date for which premium has been paid or 364 days whichever is lesser.

Pre-Existing Condition means an Injury, Sickness, disease, or other condition during the 365 day period immediately prior to the date the Covered Person's coverage is effective for which the Covered Person : 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. Item (2) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 180 day period before coverage is effective under the Covered Person's Plan.

We, Our, Us means GBG Insurance Limited underwriting this insurance.

EXTENSION OF ACCIDENT AND SICKNESS MEDICAL BENEFIT AND BENEFIT PERIOD

If a Covered Person is hospital confined at term of coverage, benefits will continue to be paid until the earlier of either discharge from the hospital they are confined to or until the Maximum benefit has been paid, whichever occurs first. In no event will benefits continue beyond 30 days beyond the term of coverage or beyond the 13 week benefit period.

COORDINATION OF BENEFITS PROVISION

If a Covered Person is covered for Benefits under the Policy, and is also covered for these Benefits under one or more other Plans, the benefits payable under the Policy will be coordinated with the benefits payable under all other Plans. Coordination of Benefits will be used to determine the benefits payable for a Covered Person for any Claim Determination Period if, for the Allowable Expenses incurred in that period, the sum of (1) and (2) below would exceed those Allowable Expenses: The benefits that would be payable under the Policy without coordination; and The benefits that would be payable under all other Plans without the coordination of benefits provisions in those Plans. The benefits that would be payable under the Policy for Allowable Expenses incurred in any Claim Determination Period without Coordination of Benefits will be reduced to the extent required so that the sum of: Those required benefits; and All the benefits payable for those Allowable Expenses from all other Plans will not exceed the total of those Allowable Expenses. Benefits payable under all other Plans include the benefits that would have been payable had proper claim been made for them. However, the benefits of another Plan will be ignored when the benefits of the Policy are determined if: The Benefit Determination Rules would require the Policy to determine its benefits before that Plan; and The other Plan has a provision that coordinates its benefits with those of the Policy and would, based on its rules, determine its benefits after the Policy. When Coordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a Covered Person, each benefit that would be payable in the absence of Coordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of the Policy. We reserve the right to release to or obtain from any other insurance company or other organization or person, any information that, in Our opinion, We or it needs for the purpose of the Coordination of Benefits. When payments that should have been made under the Policy based on the terms of this provision have been made under any other Plans, We have the right to pay to any other organization making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered benefits paid under the Policy. We will be released from all liability under the Policy to the extent of these payments. When an overpayment has been made by us, at any time, We will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as We may determine.

Payment of loss under this Policy shall only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").

EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS

The "Pre-Existing Condition Waiting Period" is 6 months. If you receive treatment or service for a Pre-Existing Condition: a) No benefits will be paid for such condition until the day after a 6 consecutive month period has passed from your effective date; and b) The plan will pay only for Covered Expenses incurred after such 6 consecutive month period.

EXCLUSIONS

No benefits will be paid for loss or expense caused by or resulting from:

1. Suicide, attempted suicide (including drug overdose) self-destruction, attempted self- destruction or intentional self-inflicted Injury while sane or insane;
2. War or any act of war, declared or undeclared;
3. Injury sustained while in the service of the armed forces of any country;
4. Voluntary, active participation in a riot or insurrection;
5. Medical expenses resulting from a motor vehicle accident in excess of that which is payable under any other valid and collectible insurance; 6. Treatment for an Injury or Sickness resulting from the Covered Person's intoxication or use of illegal drugs or any drugs or medication that is intentionally not taken in the dosage recommended by the manufacturer or for the purpose prescribed by the Covered Person's Physician;
7. Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
8. Eligible Expenses for which the Covered Person would not be responsible in the absence of the Policy; 9. Treatment of acne;
10. Charges which are in excess of Usual, Reasonable and Customary charges;
11. Charges that are incurred outside of the Period of Insurance either prior to coverage commencing after coverage has terminated;
12. Charges that are not Medically Necessary; charges provided at no cost to the Covered Person;

13. Expenses incurred for treatment while in Your Home Country which exceed 30 days or \$1000;
14. Expenses incurred for an Accident or Sickness after the termination date of coverage;
15. Regular health checkups, routine physical, immunizations or other examination where there are no objective indications or impairment in normal health;
16. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources;
17. Pre-Existing conditions; however a Pre-Existing condition will be covered after the Covered Person has been continuously insured for 6 months under the same insurance plan;
18. Unless covered herein, Pregnancy or childbirth, elective abortion, or any complications of any of these conditions;
19. Dental care or treatment other than care, of sound Natural Teeth and gums, required for Injury resulting from an Accident while covered under the Policy, and rendered within 6 months of the Accident;
20. Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;
21. Travel in or upon a snowmobile, a water jet ski, any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel, or any off road motorized vehicle not requiring licensing as a motor vehicle;
22. Injury sustained while taking part in: mountaineering; hang gliding; parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; snowmobiling; motorcycle/motor scooter riding; scuba diving, involving underwater breathing apparatus; snorkeling; water skiing; snow skiing; spelunking; parasailing; white water rafting; surfing, and snowboarding; or other hazardous activities as determined by the insurance company;
23. Practice or play in any amateur, club, intramural, interscholastic, intercollegiate, professional or semiprofessional sports, contest or competition;
24. Rest cures or custodial care;
25. Elective or Cosmetic surgery and Elective Treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body. Correction of a deviated nasal septum is considered Cosmetic Surgery unless it results from a covered Injury or Sickness.

TIME LIMITS FOR COVERED LOSS

Covered expenses will be paid as shown in the Schedule.

1. Due to Injury when:
 - a. The accident causing the Injury occurs before the end of your term of coverage;
 - b. Treatment by a doctor begins within 30 days after the date of the accident causing Injury;
 - c. Treatment and services received are included under the definition of covered expenses; and
 - d. All treatment is received during the period in which the covered person is eligible.
2. Due to your Sickness provided:
 - a. Treatment by a doctor begins during the Period of Insurance;
 - b. Treatment and services received are included under the definition of covered expenses; and
 - c. All treatment is received during the period in which the covered person is eligible.

GENERAL PROVISIONS

RIGHT OF REIMBURSEMENT / SUBROGATION

If a Covered Person recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to first reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents if the Covered Person is a minor, or the Covered Person's legal representative as a result of that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability. We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

PRE-AUTHORIZATION USA/Canada Toll Free: 1-877-916-7920 Upon completion Fax Authorization Form To: 1-905-669-2524

Pre-authorizations are subject to certification by the Plan Administrator. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. Certain medical procedures or treatments will require a request form to be received by the Company or the Company's authorized representative. This must be received a minimum of 5 business days prior to the scheduled procedure date if the procedure is elective, or within 48 hours after the initial admission if the admission is due to an emergency.

Approval from the Company must be given prior to the commencement of the proposed medical treatment. If certification is received, covered charges will be paid as shown in the Schedule of Benefits.

Failure to comply with prior authorization procedures will result in a 20% reduced benefit penalty, provided that the care is determined to be a procedure that would have been approved by the Plan Administrator. If upon review of medical records, it is determined to be a medical procedure which would not have been approved, the entire claim and all related charges will be denied.

Pre-authorization is based on information provided to the Company at the time of request, and does not guarantee payment of benefits nor verify eligibility. Payment for services is subject to all terms, conditions, limitations and exclusions related to the member's eligibility and subsequent medical review. Regardless of pre-authorization status, medical decisions concerning a course of treatment are solely between the doctor and you.

Services requiring prior authorization are:

1. All Inpatient admissions and/or treatments, including but not limited to Admissions to an Inpatient Facility or Partial Hospitalization Unit; Emergencies must be post-certified within 48 hours of discharge or as soon as reasonably possible;
2. Any surgeries requiring general anesthesia (Outpatient or Inpatient);
3. Accidental Dental treatment for emergency dental repair of Natural Teeth damaged in an Accident;
4. Purchase or rental of Durable Medical Equipment;
5. RSV Immunization and other medications priced in excess of \$1,000 per refill;
6. All cancer treatments/therapies;
7. Hemodialysis and Peritoneal Dialysis for renal failure;
8. Substance Abuse treatments/therapies;
9. Any condition, including chronic conditions that do not meet the above criteria, but are expected to accumulate \$3,000 or more in Covered Expenses per Period of Insurance.

CLAIMS STATUS, ELIGIBILITY VERIFICATION AND COVERAGE QUESTIONS



GBG Administrative Services
26741 Portola Pkwy Ste. 1E #527
Foothill Ranch, CA 92610

For claim status or questions please call
Toll Free: 877-916-7920 email: eclaims@gbg.com

For a list of providers please visit: <https://www.trawickinternational.com/resources/healthcare-provider-search>

Provide the hospital or doctor with a copy of your ID card so they can bill us for the services provided to you. This shows your member ID and how to find you in our system to verify benefits. Failure to give the correct information to the provider could result in bills getting sent to you, instead of the insurance company.

In most cases, you are only required to pay your deductible and the cost for any services which may not be covered under your Policy. However, if you are required to pay for services in full, then you will need to provide the necessary documentation for reimbursement: a. Signed medical statement which includes medical coding for service performed by the service provider; b. Proof of payment (receipts) and c. Copy of your ID card. If you get a bill from a provider call them to make sure they have your insurance information. Failure to contact them with your information will delay the processing of your claim and could result in you being solely responsible for the charges.

All claims, regardless of submission date, must be received in our office within 90 days of treatment or they will be denied. Initial treatment must occur within 90 days of the Accident or Sickness.

Once a claim has been reviewed, additional documentation may be required for processing. This request will be made in writing to the address on file or via email. Please make sure your mailing address and email address are current.

Your Insurance ID is the number beginning with 999...

After a claim has been processed you and the provider will receive an explanation of benefits (EOB). The EOB has a claim number, date of service, paid date, amount paid, amount applied to your deductible and an explanation as to why/how the claim was processed. The EOB will also state if you owe the provider anything for the service. If a reimbursement is due to you, a check or direct deposit to your account will be noted on the EOB. If you get a bill from a provider and do not get an EOB from us within 60 days, please contact us at the number above for claim status.

If a claim is denied you will receive a written explanation on the EOB. If you feel the decision is wrong, you have the right to appeal the decision. You can request the appeal form by calling the claim office at 877-916-7920.

PLAN ADMINISTRATOR

Trawick International Inc.

PO Box 2284

Fairhope, Alabama 36533

Toll Free: 888-301-9289 Direct: 251-661-0924

Email: info@trawickinternational.com

Website: www.trawickinternational.com



This is a brief description of coverage provided under this short term limited benefit group policy number SS17-15243-18 and is subject to the terms, conditions, limitations and exclusions of the policy. Please see the policy and certificate for details. Coverage may vary or may not be available in all states.