International Student Health Insurance

DIANins

BLUE 80 CA

TRAWICK International

DIAN24BLUE80CA

Program Administered by:

DIAN Insurance

INTERNATIONAL STUDENT PLAN SUMMARY

This plan summary contains a description of the insurance benefits provided by the insurance plan you have purchased. The coverage is provided by a group insurance policy issued to the AMD Global Trust by Zurich Insurance Europe AG, Belgian branch. By purchasing this coverage, you have become a participant in the AMD Global Trust and a copy of the subscription agreement is contained herein. Please keep this summary as an explanation of the benefits available. This summary is not intended to be a contract of insurance. Complete provisions pertaining to the insurance coverage are contained in the policy. In the event of any conflict between this plan summary and the policy, the policy will govern. The policy is not designed to cover US citizens or residents, and it is not subject to guaranteed issue or renewal. This insurance is not subject to and does not provide certain insurance benefits required by the United States' Patient Protection and Affordable Care Act ("PPACA").

AUTHORITY No broker, agent or any other person has authority to change the Policy or to waive any of its provisions. No change in the Policy shall be valid unless Approved in writing by the Company or the Plan Administrator and such Approval be endorsed on the Policy or by Amendment signed by an officer of the Administrator.
READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE POLICY. IT IS THE INSURED PERSON'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

SCHEDULE OF BENEFITS
The Schedule of Benefits is a summary outline of the benefits covered under this insurance Plan. Please read the Description of Benefits sections for full details. All benefits described are subject to the definitions, exclusions and provisions.

ELIGIBLE PERSONS

Eligible Person is an individual who meets all the requirements of one of the covered Classes shown below:

Class 1

A registered full time undergraduate or a graduate student attending classes who is a minimum age of 17 years and maximum of 45 years;

1. Student must have a current passport and be travelling outside their Home Country; and
2. Student must have a valid F, J, M, or Q visa. F1 visa holder on OPT are not eligible.

Class 2

The Spouse of a Class 1 Insured Person

Class 3

The Dependent child(ren) of a Class 1 Insured Person

MEDICAL EXPENSE BENEFITS

The following Medical Expense Benefits are subject to the Insured Person's Deductible, Copayment, and Coinsurance amount. After satisfaction of the Deductible and applicable Copayments, the Insurer will pay eligible benefits set forth in this Schedule at the specified Plan Coinsurance and reimbursement level.

POLICY MAXIMUM BENEFITS	
US PROVIDER NETWORK	Aetna
AREA OF COVERAGE	Worldwide excluding Home Country
MAXIMUM BENEFIT PER COVERED ILLNESS OR INJURY LIFETIME BENEFIT	Unlimited Unlimited

INDIVIDUAL DEDUCTIBLE PER PERIOD OF INSURANCE • In-Network Provider • Out-of-Network Provider The deductible for In-Network does not accrue towards the Out-of-Network Deductible	 $500 per Insured Person $750 per Insured Person
COPAYMENTS Copayments do not apply to the Deductible • Student Health Center Copayment • Physician/Specialist Office Visit Copayment • Hospital Copayment per Admission • Urgent Care Center Copayment • Emergency Room Copayment (waived if admitted)	 $0 per visit $25 per visit $0 per visit $50 per visit $150 per visit
OUT-OF-POCKET-MAXIMUM PER PERIOD OF INSURANCE • In-Network or Out-of-Network Deductibles and Copayments apply towards the Out of Pocket Maximum	 $8,700 per Insured Person In-Network Out-of-Network: Unlimited
PRE-EXISTING CONDITION LIMITATION (12 months Lookback Period)	Students and Dependents: Pre-existing Conditions are covered without a Waiting Period.
STUDENT HEALTH CENTER	Deductibles and Copayments are waived when services are rendered at the Student Health Center. Services rendered at the Student Health Center are reimbursed at 100%
WHAT THE INSURANCE PLAN COVERS The following Coinsurance applies for In-Network Providers in the U.S. Coinsurance reduces to 70% of UCR when Out-of-Network Providers in the U.S. are used. Coinsurance outside the USA, excluding M1/M2 visa holders is 80% of UCR	
HOSPITALIZATION AND INPATIENT BENEFITS	
ACCOMODATIONS INCLUDING SEMI-PRIVATE ROOM	80% Preferred Allowance
INTENSIVE CARE/CARDIAC CARE	80% Preferred Allowance
INPATIENT CONSULTATION/VISIT BY A PHYSICIAN, OSTEOPATH OR SPECIALIST	80% Preferred Allowance
DIAGNOSTIC TESTING AND HOSPITAL MISCELLANEOUS EXPENSE AND X-RAY AND LABORATORY	80% Preferred Allowance
PRE-ADMISSION TESTING • Within 3-5 working days prior to admission	80% Preferred Allowance
INPATIENT REHABILITATION	80% Preferred Allowance
OUTPATIENT BENEFITS	
PRIMARY CARE VISIT • Office visit Copayment applies • Maximum Benefit: 1 visit per day per specialty	80% Preferred Allowance
PHYSICIAN VISIT OR CONSULTATION BY SPECIALIST • Office visit Copayment applies	80% Preferred Allowance

• Urgent Care Copayment applies • Maximum Benefit: 1 visit per day per specialty for Treatment of an Injury or Illness	
DIAGNOSTIC TESTING • X-Ray and Laboratory • MRI, PET, and CT Scans • Office visit Copayment applies when testing is done outside an office visit	80% Preferred Allowance
THERAPEUTIC SERVICES • Office visit Copayment applies	80% Preferred Allowance
SURGICAL BENEFITS (INPATIENT/OUTPATIENT)	
INPATIENT, OUTPATIENT OR AMBULATORY SURGERY INCLUDES: • Surgeon's Fees • Assistant Surgeon or Anesthesiologist • Facility fees • Laboratory tests • Medications and dressings • Other medical services and supplies	80% Preferred Allowance
RECONSTRUCTIVE SURGERY • Reconstructive surgery is required as a result of Medically Necessary, non-cosmetic medical condition, to restore or improve function • Must be performed within twelve (12) months from the date of the Illness, Injury or Accident	80% Preferred Allowance
EMERGENCY BENEFITS	
EMERGENCY ROOM AND MEDICAL SERVICES • Copayment waived, if admitted • Non-emergency use of the emergency room is reduced to 30% Coinsurance In Network and 20% Out-of-Network	80% Preferred Allowance
AMBULANCE SERVICES • Emergency local ground ambulance	80% Preferred Allowance
EMERGENCY DENTAL • Limited to accidental Injury of sound natural teeth sustained while covered • Maximum Benefit per Tooth $250 • Maximum Benefit per Period of Insurance: $1,000	80% Preferred Allowance
PALLIATIVE DENTAL CARE • Sudden onset of pain • Maximum Benefit per Period of Insurance: $600	80% Preferred Allowance
MATERNITY CARE	

NORMAL DELIVERY OR MEDICALLY NECESSARY C-SECTION, PRE-NATAL, POST-NATAL CARE, AND COMPLICATIONS OF PREGNANCY • Dependent Spouse: Conception must occur at least ten (10) months after Effective Date • Services must be rendered by an In-Network Physician or In-Network Provider. • Complications of Pregnancy covers the mother only and may be denied if the mother does not obtain the appropriate and recommended pre-natal care as directed by her medical provider • This benefit is subject to Pre-Authorization and notification within 30 days of pregnancy confirmation. The Plan Administrator will determine coverage upon receipt of the Pre-Authorization request.	80% Preferred Allowance
ELECTIVE ABORTION	80% Preferred Allowance
CONGENITAL CONDITIONS	80% Preferred Allowance
NON-HEALTHY NEWBORN INFANT CARE	80% Preferred Allowance
HABILITATIVE SERVICES FOR THE TREATMENT OF CONGENITAL OR GENETIC BIRTH DEFECTS	80% Preferred Allowance
OTHER BENEFITS (INPATIENT/OUTPATIENT)	
MENTAL HEALTH • Outpatient - Office visit Copayment applies	80% Preferred Allowance
PREVENTATIVE CARE AND ANNUAL EXAMS • Newborn to 12 months: 9 visit maximum per Period of Insurance • Child/Adult: Annual exams, immunizations • In-Network or Student Health Center only • Deductible does not apply • No benefits if an Out-of-Network Provider is used	100% Preferred Allowance Student Health Center payable at 100% UCR
ALLERGY TESTING AND TREATMENT • Allergy serum and injection • Office visit Copayment applies	80% Preferred Allowance
ALTERNATIVE MEDICINE (CHIROPRACTIC, HOMEOPATHIC CARE AND ACUPUNCTURE) • Maximum Benefit per Period of Insurance: $500 • Office visit Copayment applies	80% Preferred Allowance
CANCER CARE AND ONCOLOGY	80% Preferred Allowance
HOME HEALTH CARE • Minimum Hospital Stay: 3 consecutive days • Home Health Care must begin within: 3 consecutive days after the Minimum Hospital Stay	80% Preferred Allowance
HOSPICE CARE	80% Preferred Allowance
TRANSPLANT SERVICES (HUMAN ORGAN, BONE MARROW, STEM CELL) • Expenses for Donor are not covered. • Institute of Excellence required in the U.S. • No benefits when an Out-of-Network Provider is used	80% Preferred Allowance

• Maximum Benefit per lifetime: 1 per lifetime for all organs	
AQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) Human Immunodeficiency Virus (HIV+), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions	80% Preferred Allowance
VOLUNTARY HIV SCREENING • Free-Standing only	100%
DURABLE MEDICAL EQUIPMENT • Reimbursement of rental up to the purchase price	80% UCR
ALCOHOL AND SUBSTANCE ABUSE • Rehabilitative treatment only	80% Preferred Allowance
PRESCRIPTION MEDICATIONS • Up to 31-day supply per prescription • Includes oral contraceptives • Global Reach network pharmacy is required • Dispensed by Student Health Center • Out of Network is not covered	Tier 1 $10 Copayment per prescription Tier 2 $20 Copayment per prescription Tier 3 $40 Copayment per prescription
PEDIATRIC DENTAL BENEFITS	See Schedule of Benefits below
PEDIATRIC VISION BENEFITS	See Schedule of Benefits below
RECREATIONAL ACTIVITIES OR AMATUER SPORTS	80% Preferred Allowance

NON-MEDICAL EXPENSE BENEFITS

Non-Medical Expense Benefits do not accumulate towards the Medical Expense Maximum Benefit payable per Period of Insurance or toward the Lifetime Maximum.

MEDICAL EVACUATION	100% of actual costs
MEDICAL REPATRIATION	Actual cost of roundtrip economy airfare
RETURN OF MORTAL REMAINS	100% of actual costs

PEDIATRIC VISION BENEFITS

The following Benefits are provided for covered vision services for Dependent Child.

VISION CARE SERVICE	FREQUENCY OF SERVICE	BENEFIT
ROUTINE VISION EXAMINATION Or refraction only in lieu of a complete exam	ONCE PER YEAR	50% UCR
EYEGLASS LENSES AND FRAMES • Single Vision • Bifocal • Trifocal • Lenticular	ONCE PER YEAR MAXIMUM BENEFIT OF $150	50% UCR
CONTACT LENSES • Covered Contact Lens Selection • Necessary Contact Lenses	LIMITED TO A 12-MONTH SUPPLY	50% UCR

PEDIATRIC DENTAL BENEFITS

The following Benefits are provided for covered dental services for Dependent Child.

DIAGNOSTIC SERVICES • Intraoral Bitewing Radiographs (Bitewing X-ray – two films). Limited to 1 series of films per 6-months • Periodic Oral Evaluation (Checkup Exam) Limited to 2 times per 12-months. Covered as a separate benefit only if no other services were performed during the visit other than X-rays.	50% UCR
PREVENTATIVE SERVICES • Dental Prophylaxis (cleanings) Limited to 2 times per 12-months • Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	50% UCR
MINOR RESTORATIVE SERVICES, ENDODONTICS, AND ORAL SURGERY • Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling. • Simple Extractions (simple tooth removal Limited to 1 time per tooth of lifetime • Palliative care (treatment to relieve pain or to keep an Accidental Dental Injury or dental Condition, such as an abscess from getting worse)	50% UCR

1.0 GENERAL PROVISIONS

The Policyholder is the AMD Global Trust, hereinafter shall be referred to as the "Trust".

The Insurer, Zurich Insurance Europe AG Belgian branch, hereinafter shall be referred to, sometimes collectively, as the "Insurer", "We" "Us", or "Company".

The declarations of the Insured Person 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 Summary of Benefits to the Insured Person expressed in the masculine gender shall be interpreted as including the feminine gender whenever appropriate.

No change may be made to this Summary of Benefits 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 Summary of Benefits or waiver any of its provisions.

This Plan is an international health insurance Policy issued to the Trust. This insurance shall be governed by the Laws of Belgium and subject to the non-exclusive Jurisdiction of the courts of Brussels, and the Insured Person should be aware that laws governing the terms, conditions, benefits and limitations in health insurance policies issued and delivered in other countries 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.

Notwithstanding any other terms under this Plan, the Insurer shall not provide coverage nor make any payments or provide any service or benefit to any Insured Person, 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 Insured Person would violate any applicable trade or economic sanctions law or regulation.

2.0 ELIGIBILITY

2.1 Eligible Classes

International full-time students (as defined by the educational institution) enrolled in an associate, bachelor, master, or Ph.D. program at a university or other accredited higher education institution outside of their Home Country. The full-time requirement is waived for summer if the student was enrolled in this Plan as a full-time student in the immediately preceding spring term. 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.

2.2 Persons Eligible to be an Insured Person

The Insured Person on this Plan who is an Eligible Person as identified in the Schedule of Benefits, a Non-United States Citizen travelling outside their Home Country and travelling to the United States and has their true, fixed and permanent home and principal establishment outside of the United States and holds a current and valid passport, and for whom proper Premium payment has been made when due.

Insured Persons are those persons described as an Eligible Class.

Students who are United States citizens are not eligible for coverage.

2.3 Eligible Dependents

Coverage can be extended to the following members who are traveling with the student who is the Insured Person. Insured Dependents may include:

The spouse or domestic partner up to age 45

Dependent children up to age 19, if unmarried. Dependent children include the Insured Person's natural children, legally adopted children, and stepchildren that reside with the insured.

Dependents who are United States citizens or permanent legal residents of the United States are not eligible for coverage.

2.4 Effective and Termination Dates

The Insured Person's coverage becomes effective on the first day of the period for which premium is received and accepted, provided that the Insured Person is an Eligible Person.

The Insured Person's coverage ends on the earlier of the date that the Insured Person is no longer an Eligible Person, or the end of the period through which premium is paid. Termination of coverage for the Insured Person also terminates coverage for all insured Dependents.

If an Insured Person'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 Insured Person's evacuation to the Home Country.

Termination of coverage of the Insured Person will be without prejudice to any claim incurred prior to the Effective Date of such termination.

Note: The minimum Period of Insurance must be the entire duration the Insured Person 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).

2.5 Addition of a Newborn Baby or Legally Adopted Child

Born Under a Pregnancy Covered by the Maternity Benefit or Adopted as of the Date of Birth:

Newborn babies will be covered as a Dependent, for full coverage according to the terms of the Plan, regardless of medical status from the date of birth provided:

- Written notification is made to the Insurer within 31 days of the date of birth, or in the case of an adopted child, a copy of the legal adoption papers is required. The newborn child shall be accepted from the date of birth
- The newborn baby will be enrolled for the same coverage as the Insured Person.

Any request received beyond the 31-day notification period shall result in coverage only being effective from the date of notification and provisional coverage will be applied for the first 31 days of life, up to a $5,000 maximum. Coverage is not guaranteed and is subject to submission of a medical statement.

Born When an Insured Person is Not Covered by the Maternity Benefit: Newborn babies, that are born, and the Insured Person is not covered by the maternity benefit under this Plan, may be covered subject to the following:

- The Insured Person will provide written notification to the Insurer (Official Copy of Birth Certificate), and
- A Health Statement must be submitted detailing the medical history of the child,
- Coverage will become effective as of the date of notification, provided the Insurer has approved the Health Statement, Coverage is not guaranteed and is based upon the health of the newborn baby,

- Any applicable Pre-existing condition limitation will apply.

2.6 Addition of a Legally Adopted Child After the Date of Birth

A child adopted after the date of birth may be covered providing the following applies:

- The child must be younger than 19 years old, and
- The Insured Person will provide written notification to the Insurer (an official copy of the legal adoption papers is required with the notification), and
- A Health Statement must be submitted detailing the medical history of the child.

Coverage will be contingent based upon the terms and conditions of the Plan. Additionally,

- Coverage will become effective as of the date of notification, and
- Any applicable Pre-Existing Condition limitation will apply.

2.7 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 Insured Persons 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 60 days of additional coverage.

Extended Coverage does not apply to Insured Persons 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 higher education 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, if later,
2. On the first day the qualifying, newly-enrolled and arriving student arrives in the United States.

Students Concluding their Studies

An Insured Person may extend coverage for a maximum of 60 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 Insured Person's coverage, and
2. All Premiums must be paid.

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

1. 60 days following the Insured Person's graduation or completion of an educational program, or
2. The date of departure from the United States.

Dependents of Insured Persons who are covered under the Extended Coverage benefit may also continue coverage under the same terms and conditions as the Insured Person.

Extended Coverage for Short-Term Programs

In the event the Insured Person'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.

3.0 PREMIUM, CANCELLATION, AND PLAN PROVISIONS

3.1 Premium Payment

Your Premium due for coverage under this Policy must be paid in U.S. currency and is due at the time coverage is purchased. The Premium for each Period of Insurance must be paid as a single Premium payment.

3.2 Cancellation

The Insurer may at any time terminate an Insured Person, or modify coverage to different terms, if the Insured Person 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 Insured Person cancels the insurance coverage after it has been issued or reinstated, the Insurer will only refund Premium on a pro rata basis if the Insured Person provides proof of other Health coverage or other valid reason for cancellation as determined by the Company or its Administrator. Premium refunds will not be considered if a claim has been filed during the Period of Insurance. A cancellation fee of $25 will be charged.

3.3 Period of Insurance

The insurance coverage term begins on the Effective Date as shown on the Medical Identification Card and ends at midnight on the date shown, but no longer than 365 days later. The coverage is not subject to guaranteed issuance or renewal.

3.4 Duration of Coverage

Benefits are paid to the extent that an Insured Person 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 Insured Person, or their last date of coverage.

3.5 Compliance with the Plan Terms

The Insurer's liability to an Insured Person will be conditional upon that Insured Person complying with its terms and conditions.

3.6 Fraudulent/Unfounded Claims

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

3.7 Waiver of Terms or Conditions

The waiver of a term or condition by the Insurer in relation to an individual case will not prevent the Insurer from relying on such term or condition thereafter.

3.8 Denial of Liability

Neither the Insurer nor the Policyholder is responsible for the quality of care received from any institution or individual. This insurance coverage does not give the Insured Person any claim, right or cause of action against the Insurer or Policyholder based on an act of omission or commission of a Hospital, Physician or other Provider of care or service.

3.9 Extension of Benefits

If an Insured Person is hospital confined on the termination date of coverage, benefits will continue to be paid until the earlier of 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 from the termination date of coverage.

3.10 Preferred Provider Network

The Insurer provides access to a Preferred Provider Network within the United States.

United States only:

- **In-Network Preferred Provider:** 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 Preferred Allowance as payment in full. 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 Insured Person. The Insurer reimburses such Providers up to an Allowable Charge as determined by the Insurer. The Provider may bill the Insured Person the difference between the amounts reimbursed by the Insurer and the Provider's billed charge. Additionally, the Insured Person 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. In-Network Preferred Provider.

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

4.0 PRE-AUTHORIZATION REQUIREMENTS AND PROCEDURES

Pre-Authorization is a process by which an Insured Person obtains approval for certain medical procedures or treatments prior to the commencement of the proposed medical treatment. During this process, the Insured may also be directed to in-Network Providers capable of providing the appropriate level of care. SureGo Administrative Services must be contacted a minimum of 10 business days prior to a non-urgent scheduled procedure or treatment date, or within 48 hours (or as soon as reasonably possible) after an emergency admission, to initiate the Pre- Authorization process by downloading a form online at https://mysurego.com.

Seeking medical care at a Hospital emergency room is advised only if the Insured is suffering a Medical Emergency. When a Medical Emergency exists, the SureGo Administrative Services team must be contacted no later than 48 hours after seeking care. Within the United States, use of the emergency room for non-emergency services may result in higher Out-of-Pocket costs to the Insured Person.

The following services require Pre-Authorization:

- Any Hospitalization;
- Outpatient or Ambulatory Surgery;
- All Cancer Treatment (Including Chemotherapy and Radiation);

- Prescription medications in excess of $3,000 per refill; and
- Medical Evacuation/Repatriation and all other Non-Medical Expense benefits;
- Any condition, which does not meet the above criteria, but are expected to accumulate over $10,000 of medical treatment per Period of Insurance.

Failure to obtain pre-authorization will result in a 30% reduction in payment of covered expenses. Any such penalty will apply to the entire episode of care and does not apply to the Out-of-Pocket maximum. If treatment would not have been approved by the pre-authorization process, all related claims will be denied.

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

In the event of an emergency that requires **medical evacuation,** you must contact SureGo Administrative Services in advance in order to approve and arrange such emergency medical air transportation and to have coverage. SureGo Administrative Services, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. Approved medical evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment. If the person chooses not to be treated at the facility and location arranged by SureGo Administrative Services, then transportation expenses shall be the responsibility of the Insured Person. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

5.0 MEDICAL EXPENSE BENEFIT DESCRIPTIONS

THE FOLLOWING PROVIDES AN EXPLANATION OF THE BENEFITS OFFERED BY THE INSURER. PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR THE SPECIFIC BENEFITS COVERED UNDER THIS PLAN OF INSURANCE.

All benefits provided under this Plan for a covered Illness or Injury must be:

- Ordered or recommended by a licensed Health Care Provider and under the scope of the Physician's licensing;
- Medically necessary; and
- Delivered in an appropriate medical setting.

EXCESS PROVISION

No benefit under this Plan is payable for any Covered Expense incurred for Injury or Illness which is paid or payable by Other Valid and Collectible Medical Insurance except under an automobile insurance policy.
Covered Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with Plan provisions or requirements.

5.1 HOSPITALIZATION AND INPATIENT BENEFITS

5.1.a Accommodations

Benefits are provided for room and board, special diets, and general nursing care. All charges more than the allowable semi-private room rate are the responsibility of the Insured.

Benefits are also provided for treatment in the Intensive Care or Coronary Care Unit if it is the most appropriate place for the Insured to be treated, the care provided is an essential part of the Insureds treatment, and the care provided is routinely required by patients suffering from the same type of Illness or Injury or receiving the same type of treatment.

The Insurer will pay costs if:

- Treatment is Medically Necessary for the Insured Person to be treated on an Inpatient or Daycare basis,
- The stay in the Hospital is for a medically appropriate period of time, and
- The treatment received is provided or managed by a Physician or specialist

Not Covered Under this Benefit

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.

Expense for items that are provided solely for personal comfort or convenience such as television, private rooms, housekeeping services, guest meals and accommodations, added charges for dietary preferences, telephone charges, and take-home supplies are not covered.

5.1.b Medical Treatment, Medicines, Laboratory, Diagnostic Tests, and Hospital Miscellaneous Expense

Ancillary expenses charged by a Hospital or ambulatory surgical center for Outpatient surgery. Miscellaneous expenses include, but are not limited to: X-ray, laboratory, in-Hospital physiotherapy, orthopedic appliances, pre-admission tests, and all other necessary charges, other than room and board, for services received during a Hospital stay.

5.1.c Inpatient Consultation/Visit by a Physician or Specialist

Benefits are provided for the reimbursement of one Physician visit per day while the Insured Person is a patient in a Hospital or 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, the Insurer may elect to pay more than one visit of different Physicians on the same day if the Physicians are of different specialties. The Insurer will require submission of records and other documentation of the Medical Necessity for the intensive services.

5.1.d Pre-Admission Testing

Benefits are provided for any service related to an Insured Person's planned Inpatient Admission or same day surgery that is performed on the day of, or within the period specified in the Schedule of Benefits prior to the day of, an Insured Person's planned Inpatient Admission or same day surgery service.

Pre-Admission Testing services are considered related to an Inpatient Admission or same day surgery if the Outpatient principal diagnosis is similar to, or the same as, the Inpatient or same day surgery diagnosis.

5.1.e Extended Care, Skilled Nursing Facility and Inpatient Rehabilitation

Benefits are provided 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 or Injury. Care provided must be at a skilled level and is payable in accordance with the current Schedule of Benefits. 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 or Injury.

Not Covered Under this Benefit

Intermediate, custodial, rest and homelike care services will not be considered skilled and are not covered.

5.2 OUTPATIENT BENEFITS

5.2.a Primary Care Visit

One (1) visit per day per specialty for Treatment of an Injury or Illness. Includes physicians, osteopaths, general or family practitioner and gynecologist when designated as the primary care physician (who provides the first contact for an individual with an undiagnosed health issue). All Services conducted at a Physician's or Osteopath's office and billed as an office setting or Outpatient visit setting.

5.2.b Physician Visit or Consultation by a Specialist

Benefits are provided for medical visits to a Physician or Specialist, in their office, if Medically Necessary. Benefits are limited to one visit per day per Insured Person. The Insurer may elect to pay more than one visit to different Physicians on the same day if the Physician or Specialist are of different specialties.

5.2.c Diagnostic Testing

Benefits are provided for diagnostic testing including echocardiography, ultrasound, and other specialized testing to diagnose an Illness or Injury.

5.2.d Therapeutic Services

Benefits are provided for Medically Necessary therapeutic services rendered to an Insured Person as an Outpatient of a Hospital or Provider's office. Services must be pursuant to a Physician's written treatment plan, which contains short- and long-term treatment goals and is provided to Insurer for review. The following services must either:

- Produce significant improvement in the Insured Person'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.

5.3 SURGICAL BENEFITS

5.3.a Surgical Services

Benefits are provided for covered surgical services received in a Hospital, outpatient facility, daycare treatment facility, Physician's office, or other approved facility. Surgical services include the surgeon's fee, use of operation room and recovery room, operative and cutting-procedures, treatment of fractures and dislocations, surgical dressings, and other Medically Necessary services.

5.3.b 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.

5.3.c Reconstructive Surgery

Benefits are provided for reconstructive surgery to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit, (excluding abnormalities of the jaw or conditions related to TMJ disorder) provided that:

- Reconstruction is required as a result of Medically Necessary non-cosmetic medical condition, to restore or improve function.
- If such surgery is the result of an Accident, then the Accident must have occurred while covered under this Plan.

Benefits are provided for reconstructive surgery for an Insured Person who has a mastectomy while covered under this Plan. Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance are also included. If the Insured Person chooses to not have reconstructive surgery following a mastectomy, the Insurer allows for two breast prosthetics and mastectomy bras limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered.

5.4 EMERGENCY BENEFITS

5.4.a Emergency Room

Benefits are provided for a Medical Emergency when incurred in a Hospital's emergency room. The Insurer retains the right to deem a true Medical Emergency. Admission to the Hospital is not required for benefit consideration. Within the United States, use of the emergency room for non-emergency services may result in higher Out-of-Pocket costs to the Insured Person.

5.4.b Emergency Ground Ambulance Services

Benefits are provided for Medically Necessary emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care. This includes transporting the Insured Person from the scene of an Accident or Illness to a Hospital, from one Hospital to another, or from the Insured Person's home to a Hospital.

Not Covered Under this Benefit

The use of ambulance services for the convenience of the Insured Person will not be considered a covered service.

5.4.c Emergency Dental

Benefits are provided for Emergency Dental treatment and restoration of sound natural teeth required as a result of an Accident. All treatment must begin within 72 hours of the Accident.

Not Covered Under this Benefit

Routine dental treatment is not covered. Damage to teeth caused by chewing foods or a toothache, does not qualify under this benefit.

5.4.d Palliative Dental Care

Benefits are provided for pain relief treatment to natural teeth or gums for an eligible palliative dental condition. Benefits are payable in accordance with the Schedule of Benefits. All treatment must begin within 72 hours of the Accident.

5.5 MATERNITY CARE

The following maternity benefits are covered and are applicable to any condition related to pregnancy, including but not limited to prenatal care, childbirth, postnatal care, miscarriage and premature birth, and Complications of Pregnancy.

For a pregnancy related to a Dependent spouse, conception must occur at least 10- months after the Effective Date for the pregnancy to be covered.

Maternity Care benefits are only available to the primary Insured Person or Spouse.

Complications of Pregnancy that arise within the ten (10) month Waiting Period are not covered.

Benefits in a Hospital length of stay in connection with childbirth for the mother or newborn child, in no event, will be less than: (i) 48 hours after a non-Cesarean delivery; or (ii) 96 hours after a Cesarean Section. This does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). Your Provider is required to obtain authorization for prescribing an Inpatient Hospital stay that exceeds 48 hours (or 96 hours).

Complications of Pregnancy covers the mother only and may be denied if the mother does not obtain the appropriate and recommended pre-natal care as directed by her medical provider.
This benefit is subject to Pre-Authorization and notification within 30 days of pregnancy confirmation. The Plan Administrator will determine coverage upon receipt of the Pre-Authorization request.

Not Covered under this Benefit:
Maternity benefits for an insured Dependent child are not covered. Fertility/infertility services, including but not limited to tests, treatments, medications, and/or procedures, complications of that pregnancy, delivery, postpartum care, and care or treatment for an individual acting as a surrogate including delivery of the child are not covered under this benefit.

5.5.a Physician and Obstetrical Services

Benefits are provided for the following maternity related benefits:

- Obstetrical and other services rendered in a licensed Hospital or approved birthing center, including anesthesia, delivery, Medically Necessary C-section, prenatal and postnatal care for any condition related to pregnancy, including but not limited to childbirth and miscarriage;
- All prenatal and postnatal Physician's office visits, laboratory and diagnostic testing; and
- Prenatal vitamins are covered during the term of the pregnancy only, if prescribed by a Physician.

Not Covered Under this Benefit

Elective C-sections are not covered.

5.5.b Newborn Infant Care Services

Benefits are provided for Hospital nursery services and medical care provided by the attending Physician for newborn infants in the Hospital are covered. Such services include but are not limited to general exams, immunizations, hearing tests, blood test for Phenylketonuria (PKU), and circumcision. Charges for Hospital nursery services and professional services for the newborn infant are covered separately from the mother's Maternity benefits and are subject to satisfaction of the Individual Deductible and Coinsurance. Refer to Addition of a Newborn Baby.

5.5.c Complications of Pregnancy and Congenital Conditions

Benefits are provided for health complications as a result of a pregnancy and are subject to the Annual Maximum Benefit and not the Maximum Benefit under Maternity shown on the Schedule of Benefits.

5.5.d Congenital Conditions

This benefit provides coverage for the Treatment of Congenital Conditions on an Inpatient or Outpatient basis, which manifest themselves before the newborn's 18th birthday. This benefit is only available to infants born of a covered pregnancy under the Policy and the newborn is added to the Policy within 30 days of the birth. Coverage may be denied if the mother does not obtain the appropriate and recommended pre-natal care as directed by her medical provider. This benefit is effective as of the newborn infant's date of birth as long as the infant is enrolled within thirty (30) days from date of birth. Failure to add the newborn infant within the specified time will result in a maximum benefit of $5,000 and the infant will be subject to underwriting review.

5.5.e Non-healthy newborn infant care

This benefit provides coverage for Hospital Services and medical care provided for a sick newborn infant in the Hospital (not related to the Treatment of Congenital Conditions). This benefit is only available to infants born of a covered pregnancy under this Policy and the newborn is added to the Policy within 30 days of the birth. Coverage may be denied if the mother does not obtain the appropriate and recommended pre-natal care as directed by her medical provider. This benefit is effective as of the newborn infant's date of birth as long as the infant is enrolled within thirty (30) days from date of birth. Failure to add the newborn infant within the specified time will result in a maximum benefit of $5,000 and the infant will be subject to underwriting review.

5.5.f Habilitative Services for the Treatment of Congenital or Genetic Birth Defects

Benefits will be paid the same as any other Illness for Habilitative Services for the treatment of Congenital or Genetic Birth Defects for an Insured Person up to age 21. Congenital or Genetic Birth Defect means a defect existing at or from birth including a hereditary defect including autism or an autism spectrum disorder or cerebral palsy. Habilitative Services include occupational, physical, and speech therapy for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the individual's ability to function.

5.5.g Elective Abortion

Benefits are provided for the voluntary termination of pregnancy if performed at a licensed facility and meets the guidelines of the state where performed.

Coverage may be provided for a medication, aspiration or D&E abortion depending on how many weeks the woman is into her pregnancy. A woman is eligible for a medication abortion (the abortion pill) if she is less than 10 weeks into her pregnancy. If a woman is 10 weeks up to 15 weeks into her pregnancy, she can have an aspiration abortion, while D&E abortions are typically performed at 15 weeks or after.

5.6 OTHER BENEFITS (INPATIENT/OUTPATIENT)

5.6.a Mental Health Benefits

Benefits are provided for both Inpatient mental health treatment in a Hospital or approved facility and for Outpatient mental health treatment. A Physician, licensed clinical psychologist, social worker, or licensed professional counselor must provide all mental health care services. Treatment must be provided for a psychiatric disease identified in the most recent edition of the International Classification of Diseases (ICD).

5.6.b Preventive Care and Annual Exams

Preventive care includes health services like screenings, check-ups, and patient counseling that are used to prevent Illnesses, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best. Getting recommended preventive services and making healthy lifestyle choices are key steps to good health and well-being.

Adult Wellness Visit and Preventive Services

• Your Physician will measure your height, weight, take your blood pressure and take other routine measurements; review your medical and family history; assess your risk factors for preventable diseases; check vital signs; perform head and neck exam, lung exam, abdominal exam and look for signs of cognitive impairment; test your reflexes; review your health risk assessment questionnaire; update your list of providers and prescriptions; and set up a screening schedule for appropriate preventive services

• Immunizations and vaccinations: Diphtheria, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus (HPV), Influenza (flu shot), Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rubella, Tetanus, Varicella (Chickenpox), COVID-19 (immunizations and vaccinations must be obtained at the Student Health Center or at a Global Reach In-Network pharmacy)

• Preventive screenings (1 per year)

  ○ Papanicolaou (PAP) screening

  ○ Mammogram (eligible age: 40 years and over)

  ○ PSA screening test (eligible age: 50 years and over)

Well childcare visits (children 0-12 months, 9 visits maximum per policy period)

Periodic age specific physical examinations and developmental assessments; office visit; health history; hearing examinations; age related diagnostic tests (up to 12 months only); vaccination and immunization necessary for prevention; and track growth and development in accordance with pediatric guidelines

5.6.c Allergy Testing and Treatment

Benefits are provided for specific allergy testing and allergy immunotherapy that is Medically Necessary with clinically significant allergic symptoms. Coverage is provided for testing and treatment including allergy serums and injections administered in a Physician's office.

5.6.d Alternative Medicine (Chiropractic, Homeopathic Care and Acupuncture)
Benefits are limited to the following:

- Acupuncture, homeopathy, and Traditional Chinese Medicine, where such are provided as treatment for an Illness covered under this Plan;
- Treatment is covered only by certified acupuncture and homeopathy Specialist.

5.6.e Cancer Care and Oncology
Benefits are provided for the prevention and treatment, including any prescribed medications, of tumors, growths, cancer, and malignant neoplasms.

5.6.f Home Health Care including Nursing Services
Benefits are provided for Home Nursing and other Home Health Care services. Nursing care is defined as prescribed care that can only be provided by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) which is Medically Necessary to treat identified medical conditions on a temporary, limited basis. These services need to meet specified medical criteria to be covered. Home nursing is provided immediately following treatment as an Inpatient on Physician recommendation. Home nursing is not provided solely for the convenience of the family caregiver.
Not Covered Under this Benefit
Intermediate, custodial, rest and homelike care services will not be considered skilled and are not covered.

5.6.g Hospice Care
Benefits are provided for hospice approved by the Insurer to provide a centrally administered program of palliative and supportive services to a terminally ill Insured Person and their family. Terminally ill refers to the Insured Person having a prognosis of 240 days or less. Covered services are available in home, outpatient and Inpatient settings. The Hospice care guidelines are:

- Must relate to a medical condition that has been the subject of a prior valid claim with the Insurer, with a diagnosis of terminal Illness from a medical doctor;
- Benefit is payable only in relation to care received by a recognized hospice.

5.6.h Transplant Services (Human Organ, Bone Marrow, Blood & Stem Cell)

Benefits are provided for Medically Necessary blood, organ, or stem cell transplants and services. In the United States, the use of the Institutes of Excellence for Transplants approved by Surego Administrative Services is mandatory. This transplant benefit begins once the need for transplantation has been determined by a Physician and has been certified by a second surgical or medical opinion, and includes:

- Pre-transplant care, including those services directly related to evaluation of the need for transplantation, evaluation of the Insured Person for the transplant procedure, and preparation and stabilization of the insured for the transplant procedure.

- Pre-surgical workup including all laboratory and X-ray exams, CT scans, Magnetic Resonance Imaging (MRI's), ultrasounds, biopsies, scans, medications and supplies.

- The hospitalization, surgeries, Physician and surgeon's fees, anesthesia, medication and any other treatment necessary during the transplant procedure.

- Post-transplant care including, but not limited to any Medically Necessary follow-up treatment resulting from the transplant and any complications that arise after the transplant procedure, whether a direct or indirect consequence of the transplant.

- Medication or therapeutic measures used to ensure the viability and permanence of the transplanted organ, stem cell or tissue.

- Home Health care, nursing care (e.g. wound care, infusion, assessment, etc.), emergency transportation, medical attention, clinic or office visits, transfusions, supplies, or medication related to the transplant.

Not Covered Under this Benefit

Donor search and medical services are not covered under the Transplant benefit.

5.6.i HIV/AIDS

Benefits are provided for Medically Necessary, non-Experimental services, supplies and medications for the treatment of Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV +), AIDS Related Complex (ARC), sexually transmitted diseases and all related conditions that are not Pre-Existing Conditions.

5.6.j Voluntary HIV Screening (free-standing only)

Benefits will be paid for the cost of a voluntary HIV screening test, other than HIV screening, whether or not the HIV screening test is necessary for the treatment of the underlying medical condition. Benefit includes one HIV screening test, the cost of administering such test, all laboratory expenses to analyze the test, the cost of communicating to the Insured Person the results of the test and any applicable follow-up instructions for obtaining healthcare and supportive services.

5.6.k Durable Medical Equipment

Benefits are provided for items which are designed for and able to withstand repeated use by more than one person and customarily serve a medical purpose. Such equipment includes but is not limited to, wheelchairs, Hospital beds, respirators, and dialysis machines. Such Durable Medical Equipment (DME) must be:

- Prescribed by a Physician,
- Customarily and generally useful to a person only during a covered Illness or Injury,
- Equipment must be appropriate for use in the home and are not disposable, and
- Determined by the Insurer to be Medically Necessary and appropriate.

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.

Not Covered Under this Benefit

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

High performance devices for sports or improvement of athletic performance, and power enhancement or power-controlled devices, nerve stimulators, and other such enhancements are not covered. Prosthetic 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.

5.6.l Alcohol and Substance Abuse Rehabilitative Treatment
Benefits are provided for Inpatient and Outpatient services including diagnosis, detoxification, counseling, and other medical treatment 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 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 that the Insured Person needs to continue such treatment.

5.6.m Prescription Medications

Benefits are provided for medications which are prescribed by a Physician and which would not be available without such Prescription.

Not Covered Under this Benefit

Certain treatments and medications, such as vitamins, herbs, aspirin, cold remedies, over the counter medicines, Experimental and/or Investigational medications, or supplies, even when recommended by a Physician, do not qualify as Prescription Medications. Any medication that is not scientifically or medically recognized for a specific diagnosis or that is considered as off label use, Experimental, or not generally accepted for use will not be covered, even if a Physician prescribes it.

5.6.n Recreational Activities or Amateur Sports Benefit
Benefits are provided for leisure sports and activities that are for relaxation or fun and 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 15 meters.

Not covered: professional sports or activities, Intercollegiate, and Interscholastic sports

5.6.o Pediatric Vision Benefits
Benefits are provided for the following covered vision services and frequency as shown in the Schedule of Benefits for a Dependent Child.

1. Routine Vision Examination or Refraction only in lieu of a complete exam
2. Eyeglass Lenses

- Single Vision
- Bifocal
- Trifocal
- Lenticular

3. Eyeglass Frames

- Eyeglass frames with a retail cost up to $150

4. Contact Lenses

- Covered Contact Lens Selection

- Necessary Contact Lenses

5.6.p Pediatric Dental Benefits Services
Benefits are provided for the following covered dental services for a Dependent Child. Plan Participant's under the age of 19.

Diagnostic Services:
1. Intraoral Bitewing Radiographs (Bitewing X-ray)
   Limited to 1 series of films per 12-months
2. Periodic Oral Evaluation (Checkup Exam)
   Limited to 2 times per 12-months. Covered as a separate benefit only if no other services were performed during the visit other than X-rays.

Preventive Services:

1. Dental Prophylaxis (cleanings)
   Limited to 2 times per 12-months
2. Fluoride Treatments
   Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.

Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery:

1. Amalgam Restorations (Silver Fillings)
   Multiple restorations on one surface will be treated as a single filling.
2. Simple Extractions (simple tooth removal)
   Limited to 1 time per tooth of lifetime
3. Palliative care (treatment to relieve pain or to keep an Accidental Dental Injury or dental Condition, such as an abscess from getting worse)

6.0 NON-MEDICAL EXPENSE BENEFIT DESCRIPTIONS

ALL NON-MEDICAL EXPENSE BENEFITS MUST BE ARRANGED THROUGH SUREGO ADMINISTRATIVE SERVICES. FAILURE TO DO SO WILL RESULT IN NON-PAYMENT OF BENEFITS. PLEASE CONTACT SUREGO ADMINISTRATIVE SERVICES IN ADVANCE IN ORDER TO FACILITATE ADMINISTRATION OF THESE BENEFITS.

6.1 Medical Evacuation/Repatriation

In the event of an Emergency that requires **medical evacuation or repatriation,** contact NFG Assistance in advance in order to approve and arrange such emergency medical air transportation. NFG Assistance, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. Approved medical evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment. If the Insured Person chooses not to be treated at the facility and location arranged by NFG Assistance, then transportation expenses shall be the responsibility of the Insured Person. Failure to arrange transportation as indicated will result in non-payment of transportation costs. The cost of a person accompanying an Insured Person is covered under this Plan, with expenses subject to pre-approval by NFG Assistance.

6.2 Medical Repatriation: In the event the Insured Person suffers an Illness or Injury and is no longer able to carry out his/her daily activities, the Insured Person will be repatriated back to his/her Home Country for Services and

any rehabilitation. The Insurance Company reserves the right to review and repatriate any case in which the Insured Person is medically stable. Upon advice of NFG Assistance and the Attending Medical Doctor, the Insured Person may be repatriated at the Insurance Company's sole discretion to the Insured Person's Home Country. In such case, any Services, Treatment or Procedures may be delayed until the Insured Person returns to his/her Home Country. Refusal to accept repatriation when medically stabilized will result in the denial of further medical coverage and benefits. NFG Assistance will coordinate the repatriation of the Insured Person back to his/her Home Country. The benefits payable will be the cost of roundtrip economy airfare which: (i) must be used within three (3) months from the date of the Illness or Injury; (ii) within the program period; and (iii) you must return to the Host Country to take an examination required for future studies. The NFG Assistance must organize and coordinate the medical repatriation until the Insured Person is safely in his/her Home Country. In the event that transportation Services are not organized by NFG Assistance, all costs incurred will not be covered.

6.3 Return of Mortal Remains

A benefit for either Repatriation of mortal remains, or Local Burial is included. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar personal burial preferences. The necessary clearances for the return of an Insured Person's mortal remains by air transport to the Home Country will be coordinated by NFG Assistance.

7.0 EXCLUSIONS AND LIMITATIONS

Sanctions Limitation Clause

Notwithstanding any other terms under this agreement, the insurer shall not provide coverage or will not make any payments or provide any service or benefit to any insured or other party to the extent that such cover, payment, service, benefit and/or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation **(including, but not limited to: UN, EU, UK, US (OFAC) sanctions law(s)/regulation(s)).**

7.1 MEDICAL EXPENSE BENEFITS EXCLUSIONS AND LIMITATIONS

All services and benefits described below, including expenses for medical treatment not expressly indicated in the Medical Expense Benefit section, are either excluded from coverage or limited under this Plan of Insurance.

1. **Breast Reduction**: All services and treatments.
2. **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; d) Services provided normally without charge by the Health Services Center of the institution attended by the Insured Person, or services covered or provided by a student health fee.
3. **Cosmetic and Elective Surgery for Non-Medical Reasons:** Treatments, procedures or medications 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.
4. **Dental Care:** a) Except for Accidental injury to sound, natural teeth b) unless pediatric dental is shown on the Schedule of Benefits.
5. **Experimental or Off-Label Services:** Services, supplies or treatments, including medications, which are deemed to be Experimental or Investigational or that is not medically recognized for a specific diagnosis.
6. **Fertility/Infertility Treatments and Birth Control:** Any services, procedure or treatment including medications used to: a) Treat infertility including In-vitro Fertilization (IVF), 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. b) Vasectomies and sterilization, and any expenses for male or female reversal of sterilization.

7. **Gender Identity Disorder:** Medical, surgical, and mental health expenses including prescription medications, and the medical complications arising from any treatments or procedures related to gender identity or gender dysphoria.
8. **Genetic Screening:** Counseling, screening, testing, or treatment in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
9. **Hearing Care:** Hearing exams, hearing aids or devices, unless due to an Injury/Illness covered under the Plan. Surgical implantation of, or removal of bone anchored hearing devices and cochlear implants.
10. **Home Country:** a) All medical charges incurred in the Insured Person's Home Country, in excess of the amount shown on the Schedule of Benefits.
11. **Illegal Activities:** Injuries or Illnesses resulting or arising from or occurring during the commission of an assault or felony.
12. **Immunizations for Travel:** Vaccines and preventive medications recommended or required for travel to specific countries.
13. **Motor Vehicle:** Medical expenses; 1) Resulting from a motor vehicle Accident unless the benefit is provided for on the Schedule of Benefits; 2) If the operator of a motor vehicle is the Insured Person and does not possess a valid motor vehicle operator's license in the jurisdiction in which the motor vehicle Accident occurred, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor; 3) The operating of any type of vehicle or conveyance while under the influence of alcohol or any illegal substance, drug, poison, gas, or fumes including prescribed drugs for which the Insured was provided a written warning against operating a vehicle or conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the jurisdiction in which the Covered Loss occurred.
14. **Nasal Surgery:** Deviated septum, submucous resection and/or other surgical correction thereof, nasal and sinus surgery except for treatment of a covered Injury.
15. **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 Insured Person's home or permanent abode.
16. **Podiatric Care:** Routine foot care, including the paring and removing of corns, calluses, or other lesions, or trimming of nails or other such services not resulting from an Illness or Injury. Orthopedic shoes or other supportive devices such as arch supports, orthotic devices, or any other preventative services or supplies to treat the diagnosis of weak, strained, or flat feet or fallen arches.
17. **Prescription Medications:** Prescription Medications, services or supplies as follows:
    a) Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in this Plan, b) Immunization agents, except as specially provided, biological sera, blood or blood products administered on an Outpatient basis, c) Refills in excess of the number specified or dispensed after one year of the date of the prescription, d) Growth hormones, e) Medications used to treat or cure baldness or thinning hair.
18. **Services for Administrative Purposes:** health check-ups, inoculations, immunizations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.), *other than as provided for under the Wellness and Preventive Services benefit*.
19. **Sexual Dysfunction:** Any procedures, supplies, or medications used to treat male or female sexual enhancement or sexual dysfunction such as erectile dysfunction, premature ejaculation, and other similar conditions.
20. **Sexually Transmitted Diseases** services, supplies and medications for sexually transmitted diseases and all related conditions.
21. **Skin Conditions:** rosacea, skin tags, and any other Treatment to enhance the appearance of the skin (except for acne Prescription Medication as covered under the Outpatient Medication Program).
22. **Sleep Studies:** Sleep studies and other treatments relating to sleep apnea.
23. **Smoking Cessation:** Treatments and other expenses, whether or not recommended by a Physician.
24. **Sports and Activities:** (i) participating in or providing instruction for Intercollegiate, Interscholastic, semi or Professional Sports or competitive sports, as well as attempts to break records; traveling to or from such sports, contests or competition as a participant; or while participating in any practice or conditioning program for such sport, contest or competition; (ii) any activity relating to flying either as a pilot in command, student pilot, sport flying or the business or trade of flying (except while traveling as a passenger in a fully-licensed passenger carrying aircraft); (iii) the use of any type of firearms (any device that discharges a projectile of any type); (iv) racing or speed testing any motorized vehicle or conveyance; or any other powered devices whether the vehicle is in motion or not; or (v) any sport or activity that

is in violation of any applicable laws, rules or regulations, away from prepared and marked in-bound territories/boundaries, and/or against the advice of the local authoritative body.

25. **Vision Care:** Expenses including examinations, eye refractions, frames, lenses, contact lenses, fitting of frames or lenses, or vision correction surgery, unless the pediatric vision benefit is shown on the Schedule of Benefits.
26. **War and Terrorism:** a) Any loss sustained while participating in, or training for, or as a consequence of war (declared or not), or warlike operations; b) voluntary, active participation in a riot or insurrection; c) Terrorist activity including the use of armaments, the detonation of any form of explosive or nuclear devices, the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent, including the poisoning via the air or water supplies or food products and deliberate destruction of buildings and transportation. This exclusion extends to any action taken in controlling, preventing, suppressing or in any way relating to any terrorist activity; d) Ionizing radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel, or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
27. **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.
28. Services or treatment rendered by any person who is: a) living in the Insured Person's household, b) an Immediate Family Member of either the Insured Person or the Insured Person's spouse, or c) the Insured Person.
29. Services or treatment related to or arising from or in connection with all trips to the United States undertaken for the purpose of securing medical treatment or supplies.
30. **Services or treatment** provided in a military or veterans hospital or a hospital contracted for or operated by a national government or it's agency unless a. the services were rendered on a medical emergency basis and b. a legal liability exists for the charges made on behalf of a n Insured Person for the services given in the absence of insurance

7.2 NON-MEDICAL EXPENSE BENEFITS EXCLUSIONS AND LIMITATIONS

The Insurer shall not be responsible for providing the following non-medical expense benefits to an Insured Person in a situation arising from or in connection with any of the following.

1. Travel costs that were neither arranged or approved in advance by the Insurer or authorized vendor or affiliate.
2. Taking part in military or police operations.
3. Insured Person's failure to properly procure or maintain visa, permits, or other documents.
4. The actual or threatened use or release of any nuclear, chemical, or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of the contributory cause.
5. Any evacuation or Repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.
6. Medical evacuation from a marine vessel, ship, or watercraft of any kind.
7. Medical evacuation directly or indirectly related to a natural disaster.
8. Subsequent medical evacuations for the same or related Illness, Injury, or emergency medical evacuation event regardless of location.

7.3 Pediatric Vision Exclusions

Benefits are not provided for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional lens extras not listed under the benefits for pediatric vision care services
5. Missed appointment charges
6. Applicable sales tax charged on vision care services

7.4 Pediatric Dental Exclusions

Benefits are not provided for the following:

1. Any dental service or procedure not listed as a covered benefit.
2. Dental Services that are not Necessary
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
9. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue. including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this endorsement to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved Abscess tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

8.0 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 Surego Administrative Services 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.

8.1 Medical Claims

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

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

If the Insured Person has paid the Health Care Provider, the Insured Person will submit the claim form along with the original paid receipts directly to the Insurer. Photocopies will not be accepted unless the Claim is submitted electronically. The Insurer will reimburse the Insured Person directly according to the Schedule of Benefits and Plan terms.

8.2 Submit Claims By:

Online: https://mysurego.com/claims/submit-claim/

Mail: SureGo Administrative Services, PO Box 2069, Fairhope AL 36533

Fax: 251-666-1806

Email: claims@mysurego.com

8.3 Reimbursement Options

Claims reimbursements will be made by:

- Electronic Direct Deposit for the Insured Person where the receiving bank is located in the U.S.,
- Wire Transfer for the Insured Person's and overseas Providers where the receiving bank is located outside of the U.S., or
- Check sent to the Insured Person or Provider where electronic payment is not possible.

8.4 Settlement of Claims

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

If the Plan has an Out-of-Pocket Maximum, once it is met the Plan will begin paying 100% of Allowable Charges for the remainder of insurance coverage, subject to the benefit maximums. The Out-of-Pocket Maximum does apply to any expenses covered under the Prescription Medications benefit.

8.5 Status of Claims

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

8.6 Releasing Necessary Information

It may be necessary for the Insurer to request a complete medical file on an Insured Person for the 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 Insured Person.

8.7 Coordination of Benefits

The Coordination of Benefits (COB) provision applies when an Insured has health care coverage under more than one health insurance policy or health insurance plan (a "Plan"). This includes group and non-group insurance contracts, medical benefits under group or individual automobile contracts, and any other federal government plan.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan pays benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that the payments from all Plans does not exceed 100% of the total Allowable Expense.

Order of Benefit Determination Rules

When an Insured is covered by two or more health care plans or policies, the rules for determining the order of benefits are as follows:

- If a Plan does not have a Coordination of Benefits provision, it will always be the Primary Plan.
- The Plan that covers the claimant as the Primary Insured, (in case of this Policy, a Class 1 Eligible Person shown on the Schedule of Benefits) is the primary Plan and the Plan that covers this Person as a dependent is the Secondary Plan.
- The Plan that covers the claimant as a Dependent Spouse or Child (in the case of this Policy other than as a Class 1 Eligible Person shown on the Schedule of Benefits) is the Secondary Plan and the Plan that covers this person other than as a Dependent is the Primary Plan.
- If two plans cover the claimant as a Primary Insured, the Plan that has covered this person for the longer period of time is the Primary Plan.
- If two Plans cover the claimant as a Dependent Child, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

If an educational institution, Sponsoring Organization, or any other entity provides health coverage for organized sports and activities, such coverage is the Primary Plan and this coverage will be a Secondary Plan.

8.8 Subrogation, Reimbursement, and Assignment of Rights

Benefits paid under the Plan are paid on the condition that We are entitled to pursue subrogation and receive reimbursement for an Injury or Illness for which We have provided benefits when You have accrued a right of action against a third party for causing Injury or Illness for which i) We have paid benefits; and ii) You have received a judgement, settlement, or other compensation on the basis of that Illness or Injury. We have the right to be reimbursed whether the recovery You receive, or to which You are entitled, is made in a single payment or incrementally over time. Our reimbursement and subjugation rights extend to all amounts available to You or that You have received by judgement, settlement, or other recovery, including but not limited to benefits from policies of insurance issued to You and/or in the name of a covered family member or that otherwise insure to Your benefit. We automatically have a lien on any payment You receive or are entitled to receive from any person or entity because of a claim for which We have paid benefits. The lien may be enforced against any party who acquires funds arising out of or attributable to the claim.

Our obligation to pay benefits is always secondary to any automobile No-Fault/Personal Injury Protection or medical payments coverage. To the extent that We have paid a benefit for an amount that is payable by any automobile No-Fault/Personal Injury Protection or medical payments coverage, We shall have the right to collect any such amount from the automobile insurer.

You and any of Your legal representatives shall fully cooperate with Our efforts to recover the benefits We have paid. You must notify Us within 30 days of the date when notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to the Illness, Injury, or condition for which We have paid benefits. You shall do nothing to prejudice Our subrogation or recovery interests or Our ability to enforce the terms of these provisions. We have the sole authority and discretion to decide whether to pursue any right of recovery under this provision.

We are entitled to and may pursue any and all parties which may be liable to provide compensation to You for the claims at Our expense and may bring such action in Our name as Your subrogee/assignee. You agree to fully assist Us in pursuit of Our rights and subrogation if We do so by assignment.

9.0 APPEALS PROCEDURE

If a claim is wholly or partially denied, a written notice will be sent to the Insured Person containing the reason for the denial. The notice will include a reference to the provision in the Plan description and a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal, along with any additional information or comments, may be sent within 6 months after notice of denial. In preparing the appeal, the Insured Person, or their representative, may review all documents related to the claim and

submit written comments and issues related to the denial. After the written notice is filed **and all relevant information is presented**, the claim will be reviewed, and a final decision sent within 60 days after receipt of the notice of the appeal. Under special circumstances, an extension for further review will be granted, but not for longer than 60 additional days.

You can download an appeal form online at MySureGo Forms

Email: claimsappeals@mysurego.com

10.0 COMPLAINTS PROCEDURE

Trawick International is committed to providing Insureds with an exceptional level of service and customer care. Sometimes things can go wrong or there may be occasions when the service provided to you was not adequate. If you feel you have not received adequate service, please contact Trawick International so we can address your concerns.

Who to Contact?

The most important factors in getting Your complaint dealt with as quickly and efficiently as possible are:

- Be sure You are talking to the right person; and
- That You are providing the necessary information.

When You Contact Us

Please provide the following information:

- Your name, telephone number, and email address;
- Your Plan and/or claim number and the plan of benefits (medical, travel, disability) You are insured for; and
- Please explain clearly and concisely the reason for Your complaint.

Step One: Making a Complaint

If Your complaint relates to:

1. **The sale of the Plan You purchased or any information You were given during the sales process:**
   a. If You purchased the Plan using a broker or other intermediary, please contact them first.
   b. If You purchased the Plan directly from Us either from a local representative, using the website, or through a group plan of benefits, please contact Us directly at:

Toll Free	**Phone**	**Email**
+1 888-301-9289 (within the U.S. and Canada)	+1 251-661-0924 (outside the U.S. and Canada)	complaints@trawickinternational.com

2. **A claim for benefits, the terms and conditions of the Plan, or other benefit related information:**
   a. Complaints related to a claim denial should be submitted as soon as possible. We will review the information and provide a response within four weeks or will request additional time, if needed.
   b. Claims and benefits related complaints should be referred to Our Complaints Department:

Toll Free	**Phone**	**Email**
+1 866-264-7299 (within the U.S. and Canada)	+1 251-322-7404 (outside the U.S. and Canada)	complaints@trawickinternational.com

3. We always aim to resolve Your complaint and provide a final response within four weeks, but if it looks like it will take Us longer than this, We will let You know the reasons for the delay and inform You of the options available to You. We always aim to resolve Your complaint and provide a final response within four weeks, but if it looks like it will take Us longer than this, We will let You know the reasons for the delay and inform You of the options available to You.

Step Two: Beyond Your Insurer

If Your complaint is not resolved in the appropriate timeframe or if You are unhappy with Our final response, You may be eligible to refer Your complaint to an alternative dispute resolution body. The details of the appropriate body will be provided on request or as required.

Alternatively, if your Home Country is a member of the European Economic Area (EEA) You may be eligible to submit Your complaint to the Online Dispute Resolution (ODR) Platform set up by the European Commission. This service has been set

up to help consumers who have bought goods or services online get their complaint resolved. You can access the ODR Platform at www.ec.europa.eu/consumers/odr.

If **your** complaint cannot be resolved satisfactorily as per above please contact **us**:

Zurich Insurance Europe AG Belgian Branch
Buidlign Caprese
Da Vincilaan 5
1930 Zaventem
Belgium

Or submit an online complaints form via our website: Klacht | Zurich Benelux

11.0 COMPENSATION

This section of Your Plan is only applicable if Your Home Country IS a member of the European Economic Area (EEA)

In the unlikely event that the Insurer is unable to pay its share of any claim under this Plan, You may be entitled to compensation from an insurance compensation fund.

Details of the fund will be provided on request or as required (where applicable).

12.0 LAW AND JURISDICTION

This insurance is governed by the laws of Belgium and subject to the non-exclusive jurisdiction of the courts of Brussels.

Any laws governing the terms, conditions, benefits and limitations in health insurance policies issued and delivered in other countries are not applicable.14.0

13.0 FAIR PROCESSING AND PRIVACY NOTICE

Purpose and Scope of this Notice

Zurich Benelux ("The Company") values Your business and Your trust. In order to administer insurance policies and provide You with effective customer service, We must collect certain information including nonpublic personal information about our customers and claimants. Nonpublic personal information means information that allows someone to identify or contact You. We are committed to protecting such information and We will comply with all applicable federal and state laws and regulations. This notice describes how We collect, use, and share Your information, Your rights with respect to insurance products issued by the Company and Our legal duties and privacy practices. State laws require that We provide this notice. Please review this notice and keep a copy of it for Your records.

This notice applies to you because you have taken out international student health insurance coverage and have been issued with a summary of benefits through the policyholder, AMD Global Trust ("**Policyholder**"). For the purposes of your plan summary, Trawick International GmbH is an appointed agent who acts on behalf of us. Your Coverage is underwritten by Zurich Benelux.

What type of information do we obtain about you?

The personal information we obtain about you may include:

- Name, address, phone number, email
- Gender
- Marital status

- Date and place of birth
- Government identification numbers - National Insurance, Social Security, passport, tax, driver's license
- Banking information – account and credit card details
- Coverage benefits (medical, travel, disability)
- Visa information
- Family information – spouse/co-habiting partner, dependent(s)/child(ren)
- Health information/medical history
- Travel history/information
- Claims/Coverage numbers

Please note that, in the context of claims, we may ask for further or different types of personal information depending on the claim. For example, your travel arrangements and your location at the time your claim arose.

How do we obtain information about you?

We obtain personal information about you from the Policyholder in the following instances:

- When you take out your Coverage: we underwrite your Coverage in conjunction with our appointed agent, Trawick International, GmbH. Your Certificate of Coverage is held by the Policyholder for your benefit
- When you bring a claim pursuant to the terms of your Coverage: we manage any claims that you bring under your Coverage. To manage your claims, we engage with our claims handler, SureGo Administrative Services, Inc., who oversees the claims handling process on our behalf.

We may also collect or obtain information about you from your family members, credit reference agencies, anti-fraud databases, sanctions lists, relevant government agencies, and those who may be involved in a claim – claimants, witnesses, experts, adjusters, and others.

Where you provide personal information to us other than your own (via our appointed agent, Trawick International, GmbH), you confirm that you will explain to the person(s) in question that you have provided his/her personal information to us (via our appointed agent, Trawick International, GmbH) and that he/she understands that his/her personal information will be processed in line with this notice.

Why do we obtain your personal information?

We may collect your personal information for the following purposes:

- Account setup, including background checks
- Evaluating risks to be covered
- Customer service communications
- Payments to/from individuals
- Managing insurance or reinsurance claims
- Defending or prosecuting legal claims
- Investigating or prosecuting fraud
- Complying with legal or regulatory obligations.

What is the legal basis for us obtaining your personal information?

When we process your personal information, we do so on the following grounds:

- To perform the terms of your Coverage
- To pursue our legitimate interests: to train our staff in how to perform their duties/our services, to improve our service, to carry out statistical analysis, to enhance our product offerings and to assist in regulatory inquiries. Before processing your personal information to pursue our legitimate interests, we carefully assess the impact of our processing activities on your rights and freedoms. On balance, we consider that our legitimate interests do not override your rights and freedoms which require the protection of your personal information
- To comply with laws or regulations to which we are subject

- To exercise, establish or defend legal claims or proceedings to which you may be a party.

When we process special categories of your personal information (e.g. health information), we do so on the following grounds:

- For the purposes of your Coverage, where it is necessary and proportionate, subject to suitable and specific measures being taken to protect your personal information
- To exercise, establish or defend legal claims or proceedings to which you are or may be a party.

Who receives your personal information?

We will share your personal information with various representatives of Zurich Benelux along with our appointed agent, (Trawick International, GmbH) and, claims handler (SureGo Administrative Services) affiliates, reinsurers, agents or contractors.

Where does your information go?

If you are ordinarily resident in the European Economic Area (**EEA**), you should be aware that we will need to transfer your personal information to some of our recipients (e.g. our appointed agent (Trawick International, GmbH), claims handler (SureGo Administrative Services) and affiliates). Some of these recipients are located outside the EEA in countries which may not have laws that protect your personal information in the same way as the data protection laws in the EEA. Where these transfers occur, we ensure that: (a) they do not occur without our prior written authority (where applicable); and (b) an appropriate transfer mechanism or agreement is in place to protect your personal information (e.g. the European Commission's Standard Contractual Clauses, the EU-US Privacy Shield or the Swiss-EU Privacy Shield). For more information on these transfers, please contact the Data Protection Officer.

How long do we keep your information?

We will keep your personal information only so long as is necessary to provide service to you under your Coverage. Specifically, we will keep your information for so long as a claim may be brought under your Coverage, or where we are required to keep your personal information to satisfy legal or regulatory obligations.

Your Rights

Under certain circumstances, you have the right:

- To receive a copy of the personal information we have collected from you
- To receive further details of the use we make of your personal information
- To update or correct the personal information we hold about you
- To require us to delete any personal information we no longer have a lawful purpose to use
- To restrict our use of your personal information
- To object to our processing of your personal information
- To transfer your personal information from us to another provider
- If you are not satisfied with our processing of your personal information, to file a complaint with the appropriate supervisory authority.

There are specific circumstances where we may need to restrict the rights described above, in order to safeguard the rights of others (e.g., individuals), the public interest (e.g., the prevention or detection of crime) or our interests (e.g., to maintain legal privilege).

How to Contact Us

Address any questions regarding our privacy practices or this Notice to:

Trawick International Inc.

Post Office Box 2284

Fairhope Alabama USA 36533

888-301-9289

14.0 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 Insured Person's own body and occurs beyond the Insured Person'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 an Insured Person enters a Hospital, Extended Care Facility, or other approved health care facility as an Inpatient until discharge.

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

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.

Benefit Period: A period, shown in the Schedule of Benefits and commencing with the date of the first expense incurred for treatment of an Injury sustained in an Accident or the date of the first treatment of illness, during which benefits are payable.

Club Sports: Any sports offered at a university or college in the United States that compete with other universities, or colleges, and do not have varsity status.

Coinsurance: The percentage amount of the Allowable Charges that the Insured Person and the Insurer will share after the Deductible and Copayment is met.

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

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

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.

Covered Expense: Charges that are Medically Necessary and that are:

1. Not in excess of the maximum amount payable for services as specified in the Schedule of Benefits;
2. In excess of any Deductible amount; and
3. Incurred while the Insured Person's coverage under this Plan is in force.

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

Dentist: A person who is: 1) Licensed to practice dentistry in the state where the dental procedure is performed; and 2) Operating within the scope of his or her license; or 3) Licensed or certified to perform dental procedures in the state where the dental procedure is performed.

Dependent: Refers to a member of the Insured Person's family who is enrolled under the Plan with the Insurer after meeting all the Eligibility requirements and for whom Premiums have been received.

Dependent Child: The Insured Person's unmarried child who meets the following requirements:

a child from birth to 19 years old;

A dependent child, for purposes of this definition, includes the Insured Person's:

i. natural child;
ii. adopted child;
iii. stepchild who resides with the Insured Person**.**

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 considered eligible benefits.

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

Eligible Person: An individual as defined in the Schedule of Benefits.

Eligibility: The requirements that all Insured Persons including Eligible Dependents, must meet at all times in order to be covered under this Plan.

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, medication, medication 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 homes, health resorts, homes for the aged, infirmaries or establishments for domiciliary care, Custodial Care, care of substance abuse addicts or alcoholics, or similar institutions.

Extreme Sports: Any high-risk non-team sport or recreation activity that is dangerous and if performed optimally, even by the highly skilled, risks loss of life or limb. Extreme Sports often involve speed, height, a high level of physical exertion and/or highly specialized gear. Extreme Sports include but are not limited to: skydiving, BASE jumping, hang gliding, Parachuting, bungee jumping, caving, rappelling, spelunking, white or black water rafting above Grade 3, Skiing or snowboarding outside marked trails or in an area accessed by helicopter, Rock Climbing, any high-altitude activity, personal combat or fighting sports, rodeo, racing or practicing to race any motorized vehicle, bicycle or watercraft, free diving, and scuba diving at a depth greater than sixty (60) feet or without a dive master.

Force Majeure: Means an act of God, fire, earthquake, flood, explosion, war, invasion, insurrection, riot, mob violence, governmental actions or shutdowns, civil disturbances, pandemics, epidemic, quarantines, health crisis, viral outbreaks (including, without limitation, the coronavirus referred to as COVID-19, sabotage, inability to procure or a general shortage of labor, equipment, facilities, materials or supplies in the open market, failure or unavailability of transportation, strike, lockout, action of labor unions, a taking by eminent domain, requisition, laws, orders of government or of civil, military or naval authorities, or any other cause, whether similar or dissimilar to the foregoing not within the reasonable control of Insurer.

Health Care Provider: An individual health professional or a health facility or organization licensed to provide health care diagnosis and treatment services including medication, surgery, and medical devices.

HIV: Acquired Immune Deficiency Syndrome (AIDS) and all diseases caused by and/or related to the HIV Virus.

Home Country: The country from which the Insured Person holds a passport. If the Insured Person holds passports from more than one country, the Home Country will be the country declared to us in writing as their Home Country.

Home Health Agency: an entity engaged in arranging and providing nursing services, home health services or other therapeutic and related services. The entity must be certified by a competent governmental authority in the jurisdiction where the services are rendered and meeting the requirements of Title XVIII of the Social Security Act, as amended, for home health agencies.

Home Health Care Plan: A program: 1) for the care and treatment of an Insured Person in his home; 2) established and approved in writing by his attending Physician; and 3) Certified, by the attending Physician, as required for the proper treatment of the Injury or Illness, in place of Inpatient treatment in a Hospital or in an Extended care Facility.

Hospice: An agency which provides a coordinated Plan of home and Inpatient care to a terminally ill person and which meets all of the following tests: 1) has obtained any required state or governmental license or Certificate of Need; 2) provides service 24-hours-a-day, 7 days a week; 3) is under the direct supervision of a Physician; 4) has a Nurse coordinator who is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.); 5) has a duly licensed social service coordinator; 6) has as its primary purpose the provision of Hospice services; 7) has a full-time administrator; and 8) maintains written records of services provided to the patient.

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 homes, health resorts, and

homes for the aged, infirmaries or establishments for domiciliary care, Custodial Care, care of substance abuse addicts or alcoholics, or similar institutions.

Illness: Any disease, sickness or infection, other than those related to psychiatric illness or mental stress, contracted after the Effective Date of an Insured Person's coverage.

Immediate Family Member: A person who is related to the Insured Person in any of the following ways: Spouse, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child or granchild (includes legally adopted or stepchild/grandchild).

In-Network Provider: A specific list of approved doctors, healthcare providers, hospitals or healthcare facilities that the plan contracts with to provide medical care to members.

Injury: means bodily harm caused by an Accident. The Accident must occur while the Insured Person's insurance is in force under this Plan. All Injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single covered Injury. The Injury must be the direct cause of an Accident covered under this Plan and must be independent of all other causes. The Injury must not be caused by or contributed to by Illness.

Innocent Bystander: An individual who is judged to be not involved with, participating in, or related to their work, any activity associated with any war, conflict or terror related activity. This includes any hostilities or warlike operations (whether war be declared or not), invasion, civil war, riot, rebellion, overthrow of the legally constituted government, military or usurped power and any terrorist activity.

Inpatient: An Insured Person admitted to an approved Hospital or other health care facility for a Medically Necessary overnight stay.

Insured Person: Any person who is listed as an Eligible Person on the Schedule of Benefits, for whom an enrollment form has been accepted by the Insurer and required Premium has been paid when due and for whom coverage under this Plan remains in force. May include Insured Spouse and/or Insured Dependent covered under this Plan as Eligible Dependents.

Intercollegiate Sport: A sport that:

1. has been accorded varsity status by the participating School;

2. is administered by such School's department of intercollegiate athletics for which the eligibility of the participating student athlete is reviewed and certified in accordance with the applicable intercollegiate sports organization's legislation, rules or regulations;

3. entitles qualified participants to receive the participating School's official awards;

4**.** Includes travel, only within the contiguous United States, including Alaska and Hawaii and only directly and without interruption between home, School and the premises of the Intercollegiate Sporting event.

Interscholastic Sport: A sport played between secondary schools.

Intramural Sport: A sport that:

1. is approved by the sports director or athletic director of the School; and
2. involves only students at the same School; and
3. takes place within the walls, boundaries and grounds of said School.

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

Lifetime Maximum: Payment of Medical Expense benefits is subject to a lifetime aggregate maximum per individual Insured Person 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.

Lookback Period: The amount of time that will be reviewed to determine if a claim is related to a Pre-Existing Condition.

Master Policy: The agreement between the Insurer and the AMD Global Trust.

Maternity Care: Prenatal care, childbirth, postnatal care, miscarriage, and premature birth, and Complications of Pregnancy.

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 Insured Person 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.

Medical Identification Card: The card provided to each Insured Person. This card contains limited benefit information including the Effective Date of coverage, as well as contact information for submitting claims and emergency medical treatment.

Medically Necessary: A service or supply is necessary and appropriate for the diagnosis or treatment of an Illness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:

> a. it is provided only as a convenience to the Insured Person or provider; b. it is not the appropriate treatment for the Insured Person's diagnosis or symptoms; c. it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Nurse: A licensed graduate registered nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not:

1. the Insured Person; 2. an Immediate Family Member of either the Insured Person or the Insured Person's spouse; or 3. a Member of the Same Household.

Optician: A person or business licensed by the state which renders services to manufacture, grind and or dispense vision lenses and vision frames prescribed by either an Optometrist or an Ophthalmologist, who is not: 1. the Primary Insured; 2. an Insured Dependent; 3. an Immediate Family Member; or 4. retained by the Insured.

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

Out-of-Network Provider: Any Hospital, Physician, or other provider of health care services who has not agreed to any pre-arranged fee schedules.

Out-of-Pocket Maximum: The maximum dollar amount an Insured Person is responsible to pay during a Period of Insurance. After an Insured Person has reached the Out-of-Pocket Maximum, the Plan covers benefits at 100% for the remainder of the Period of Insurance. Some benefits, however, will always remain payable at the percentage shown in the Schedule of Benefits. The Out-of-Pocket Maximum is met by accumulated Coinsurance. Co-payments are applied to the Out-of-Pocket Maximum. Penalties and amounts above the Usual, Customary, and Reasonable Charge do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown in the Schedule of Benefits. In no instance will We pay more than the Lifetime Maximum Benefit as shown in the Schedule of Benefits.

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

Physician: A licensed Health Care Provider and/or Licensed Therapist practicing within the scope of their license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not:

1 the Insured Person;
1. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
2. a person living in the Insured Person's household; member of the same household
3. a person employed or retained by the Insured;

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

Pre-Authorization: A process by which an Insured Person 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 Insured Person.

Pre-Existing Condition: A pre-existing condition is a disease or physical condition for which medical advice or treatment has been received within 12 months immediately prior to becoming covered under the Plan. A Pre-Existing Condition is considered stable, which in the 12 months before the Effective Date, there have not been:

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

Preferred Allowance: Refers to the amount an In-Network Provider will accept as payment in full for covered medical expenses.

Preferred Provider: The providers and Hospitals who have contracted with a Preferred Provider Organization to provide specific medical care at negotiated prices.

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 Insured Persons.

Premium(s): The consideration owed by the Insured Person to the Insurer in order to secure benefits for its Insured Persons under this Plan.

Prescription Medications: Prescription medications 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 medications, or medical supplies even when recommended by a Physician, do not qualify as prescription medications.

Professional Sports: Activities in which the participants receive payment for participation, or athletic competitions sponsored by or representing the participant's college or university.

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

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.

Rehabilitation Facility: A legally operating institution or part of an institution which has a transfer agreement with one or more Hospitals and which:

- is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation inpatient care; and
- is duly licensed by the appropriate government agency to provide such services; and
- is required to be accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation of Rehabilitation Facilities.

A Rehabilitation Facility does not include institutions which provide only minimal care, custodial care, care for the terminally ill, part-time care, or services or facilities for drug abuse or alcoholism.

Repatriation or Local Burial: This is the expense of preparation and the air transportation of the mortal remains of the Insured Person from the place of death to their Home Country, or the preparation and Local Burial of the mortal remains of an Insured Person 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: The college or university where the Insured Person is enrolled. The School must be licensed or accredited, as applicable, by the jurisdiction where it is located, to provide the care, education or training for which the Insured Person is enrolled.

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.

Skilled Nursing Facility: means an institution which meets all the following requirements;

- it must be operated pursuant to law;
- it must be primarily engaged in providing, in addition to room and board accommodations, nursing services
- under a licensed Physician's supervision;
- Registered or License Practical Nurses must supervise 24 hours a day; and
- a daily record for each patient must be maintained.

This definition does not include:

- Rest home or similar facility;
- Home or facility for the aged;
- Home or facility for drug addicts and alcoholics;
- Home or facility for care and treatment of mental diseases and disorders; or
- Home or facility for custodial or educational care.

Spouse: means the Insured Person's lawful spouse or domestic partner.

Student Health Center: A facility that meets all of the following requirements: 1) located in or near a School facility and open during School hours; 2) organized through the School, community, and healthcare Provider relationships; and 3) staffed by qualified healthcare Providers.

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.

Summary of Benefits: The document provided to the Insured Person that includes the Schedule of Benefits and the terms of the Master Policy issued to the Trust.

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.

Trip: Round trip travel by air, land, or sea from the Insured's Home Country.

Usual, Customary and Reasonable Charge (UCR): Fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

Vision Examination: An examination of principal vision functions. A Vision Examination includes but is not limited to case history, examination for pathology or anomalies, job visual analysis, refraction, vision field testing and tonometry, if indicated. The exam will be consistent with the community standards, rules and regulations of the jurisdiction where the provider practice is located and administered by an Optician.

Waiting Period: The period of time beginning with the Insured Person'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.

We, Us, Our and Insurer: Zurich Benelux

15.0 SUBSCRIPTION AGREEMENT

I hereby apply to be an Insured Person of the AMD Global Trust established in the Cayman Islands (the "Trust") and to participate in the insurance coverage extended by Zurich Insurance Europe AG, Belgian branch (the "Insurer") to Insured Persons under the Trust (the "Coverage"). I understand that the Coverage is not a general health insurance product but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country (for purposes of this Agreement, Home Country means the country from which the Insured Person holds a passport. In the event that a citizen of the United States holds more than one passport, the Home Country will be the country declared to in writing as their Home Country). I understand that the Coverage extended to me will terminate upon my return to my Home Country unless I qualify for a benefit period or Home Country coverage. I understand that I may obtain full details of the Coverage by requesting a copy of the master policy from the Plan Administrator. I understand that the liability of the Insurer as underwriter of the Coverage is as provided in the master policy.

By acceptance of Coverage and/or submission of any claim for benefits, the Insured Person ratifies the authority of the undersigned to so act and bind the Insured Person.

The Insured Person undertakes to make all Premium payments as they fall due in respect of the Coverage extended. AMD Global Trust (the "Trustee") shall not be responsible for the administration of such payments.

If the Insured Person fails to make any Premium payment due in respect of the Coverage extended, subject to the discretion of the Insurer, such Coverage will lapse.

The Insured Person hereby confirms the accuracy of all information and validity of all representations and warranties provided to the Trustee in connection with its participation in the Plan and/or the subscription for the insurance coverage, howsoever provided, including the terms of this Subscription Agreement, (together "Representations & Warranties"). The Insured Person acknowledges that certain of such information will be relied upon by the Insurer as Provider of the Coverage and that any inaccuracy therein may result in the invalidity of such Coverage as it relates to the Insured Person, the loss of Coverage and all monies paid in relation thereto. The Insured Person hereby undertakes to inform the Trustee of any change to any matter that forms the subject of any of the Representations & Warranties. The Insured Person hereby undertakes to

indemnify and hold harmless the Trustee against any loss or damage (including attorney's fees) occasioned by any inaccuracy in any Representations & Warranties or failure to advise the Trustee of any change in any matter that forms the subject of any of the Representations & Warranties. The Insured Person agrees that the Trustee shall be entitled to rely on and to act in accordance with any written instruction purported to be provided by the Insured Person and the Insured Person hereby undertakes to indemnify and hold harmless the Trustee against any loss or damage (including attorney's fees) occasioned by the Trustee acting in accordance with any such instruction.

Payments under the terms of the Coverage shall be paid by the Insurer to the Insured Person or directly to a Provider if assignment of benefits has been authorized. The Trustee shall not be responsible for the administration of such payments.

I confirm that I have satisfied myself that the Coverage is appropriate for me and that I meet the Eligibility criteria.