AFS Intercultural Programs

Medical Pamphlet

Information on both the Participant Medical Plan and the Additional Benefits provided to AFS participants.

FOR ALL 2021 PROGRAMS

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Please note that this pamphlet is provided as a brief summary of coverage provided under the Participant Medical Plan (and the Additional Benefits Insurance Program) and is not an insurance policy. If there is any discrepancy between the insurance policy and the pamphlet, the insurance policy will govern. Please note that the Participant Medical Plan has been arranged by AFS Intercultural Programs, Inc. If you want to see the Participant Medical Plan policy, this is available upon request.

AFS Medical Pamphlet Summary of Coverage – Participant Medical Plan

Covered Persons	Participants on AFS programs insured by the Participant Medical Plan arranged by AFS.
Territory	Worldwide except as stated below.
Period of Coverage	Coverage under this Policy applies during the Program and starts when You arrive at the international departure point for embarking on it, such as an airport or a pre-departure orientation in Your Home Country When You assemble with Your AFS group for orientation in Your Home Country in the forty-eight hours or less before international departure, this is called the 'Pre-Departure Period'. During that time, You are covered under this Policy for Medical Expenses caused by accidental Bodily Injury only and Emergency Evacuation. This coverage is secondary, which means that it comes into effect if there is no other applicable insurance covering such medical expenses incurred in Your Home Country. The Pre-Departure Period ends when You board the plane or other Common Carrier for the international journey. Participation in the Program means carrying out the normal activities required of an AFS participant. Coverage ends on the date of the termination of the AFS program, or on the date You elect to terminate the Participation Agreement prior to the completion of the program, or upon the return to the home country, whichever comes first.
Medical Coverage	Medical Expenses per Covered Person per claim: up to USD 500,000 (Coverage limit in Germany & Italy is USD 1,000,000. In the USA it is USD 1,500,000) Emergency Medical Evacuation up to USD 1,000,000 Repatriation of Mortal Remains up to USD 100,000
Deductibles and Co-Payments	None
Major Exclusions	Below are three important exclusions. This is not a comprehensive list. See section IX for a more comprehensive listing of the major exclusions that apply. For Medical Expenses, this policy will not cover any claim, loss, injury, damage or legal liability suffered or sustained directly or indirectly by a Covered Person as the result of: • Pre-existing Conditions (defined on page 13 below). • Dental treatment that is not Emergency Dental Treatment as the result of an accident. • Any non-emergency treatment or surgery, elective surgery, routine physical examinations, check-ups, inoculations, vaccinations, hearing aids, eyeglasses or contact lenses, costs of medicines for chronic conditions.
Filing Medical Claims	In the USA: GMMI 880 SW 145th Avenue, Suite 400 Pembroke Pines, Florida 33027 USA e-mail: customerservice@gmmi.com Phone: 1.888.444.7773 (toll free) Outside USA: Contact your AFS Partner
Medical Emergency Numbers (Refer to medical ID cards for details)	GMMI: In the USA: 1.888.444.7773 (toll-free) Outside USA: +1.954.370.6468 (call collect)

Medical Expenses for Participants on AFS Programs

I. Introduction

AFS provides the Participant Medical Plan, an extensive secondary medical insurance, because healthcare costs and insurance vary so widely from country to country. The purpose of the Plan is to make sure that prompt, suitable medical treatment is given to an AFS participant anywhere in the world, whenever needed. If a Covered Person gets unexpectedly hurt or ill while on an AFS program, AFS seeks to ensure that his or her covered medical expenses will be paid.

The Participant Medical Plan is discussed in the Participation Agreement, which families sign as part of the student admissions process. The purpose of this pamphlet is to describe the medical and other expenses which are covered by the terms of the insurance policy and Participation Agreement as well as to describe those expenses that are not covered.

How the Participation Agreement Governs Eligibility for the Participant Medical Plan

In the event that AFS terminates the Participation Agreement, Covered Persons will no longer meet the coverage criteria for the Participant Medical Program. Reasons for terminating the Participation Agreement are detailed in such agreement; please refer to its terms for the exhaustive list of reasons and related details. Those reasons include a violation of its terms and conditions, or because AFS determines that conditions in the host country are no longer safe for program continuation, or because a Covered Person or sending parents elect to terminate the Participation Agreement for any reason prior to the completion of the program.

Additionally, participation in the AFS program may be terminated at AFS' sole discretion if medical records regarding the Covered Person are not provided to AFS or the Insurers as requested, and the Covered Person will no longer be eligible for coverage through the Participant Medical Plan.

From the date of termination of the Participation Agreement, the Covered Person will no longer be covered by the medical insurance included in the AFS Participant Medical Plan. As of that date, they will be solely liable for all medical and other expenses incurred, including travel.

The insurance policy is arranged by AFS to cover all participants on AFS programs as Covered Persons and is underwritten by XL Insurance Company SE.

II. What is Secondary Insurance?

The concept of "primary" and "secondary" insurance is well established in travel medical insurance. The AFS Participant Medical Plan acts as a form of secondary coverage—it covers medical expenses only if the expenses are not payable through a primary policy first, such as a national health plan or private insurance held by the sending family.

The process of "recovering expenses" helps AFS to control the cost of its travel medical plan. Whenever possible, AFS will seek to have any available primary insurance reimburse AFS for incurred medical claims. When no primary insurance exists the Participant Medical Plan acts as the primary source of payment for medical expense. This makes it possible for the Participant Medical Plan to continue to pay for the expenses in the many cases in which primary insurance is not available, is not sufficient, or does not address the entire medical problem.

III. Definitions

What is Covered under the Participant Medical Plan

When we refer to the term "coverage" we mean the agreement made to pay for these kinds of expenses for eligible participants:

- ❑ Medical Expenses
- ❑ Emergency Medical Evacuation, including air ambulance
- ❑ Repatriation of Mortal Remains

Each of these types of coverage is explained in a section in this pamphlet.

The Participant Medical Plan or "**Plan**" refers to the insurance policy AFS maintains for its travel medical insurance program.

A "**Covered Person**" is an approved participant on an AFS program who is insured by the Plan. We use this term so that the terminology in the pamphlet matches that used by the insurance policy. Eligibility for coverage ends on the termination of participation in the AFS program, regardless of the reason.

A "**covered loss**" is an accident or illness that is not excluded by the Participant Medical Plan. Losses incurred after the termination of the Participation Agreement are not covered losses. While the Participant Medical Plan pays for a broad array of losses it does not cover every kind of loss. There is a complete list of exclusions that are not covered in Section IX.

Limits of Coverage for an Accident or Illness

As described in the Participation Agreement, the Participant Medical Plan provides a maximum limit of coverage to Covered Persons for the cost of medical expense, up to the limit shown in the Summary of Coverage per covered loss, while they are on an AFS program.

If a Covered Person were to suffer more than one accident or illness, a new medical expense coverage limit would apply to each loss. AFS does not provide coverage beyond the maximum limit for any single covered loss.

In addition, the Participant Medical Plan provides up to a maximum of USD 1,000,000 for the cost of emergency medical evacuation.

There is also a limit of USD 100,000 provided for Repatriation expenses.

Note that the Participant Medical Plan will not pay more than USD 10,000,000 for all losses coming from any one covered event that might involve multiple Covered Persons.

Deductibles and Co-payments

Covered Persons are not asked to pay any deductibles or co-payments under this program.

Territory of Coverage

The Participant Medical Plan covers risks worldwide while a Covered Person is on an AFS Exchange Program at the time of suffering a covered accident or illness.

It does not respond to losses incurred in the home country of the Covered Person. Note that there are special arrangements for coverage when the Covered Person's AFS program orientation takes place in the home country immediately before departure. These are described in the next section.

When Coverage Begins and Ends

Coverage begins as soon as the Covered Person reaches the international departure site for embarking on the AFS program, such as an airport or a pre-departure orientation.

When a Covered Person assembles with their AFS group for orientation while still in his or her own country in the forty-eight hours or less before international departure, this is called the Pre-Departure Period. During that time, he or she is covered under the Participant Medical Plan for medical expenses caused by accidents. This coverage is secondary, which means that it comes into effect if there is no other applicable insurance covering such medical expenses incurred in the Covered Person's home country.

Emergency evacuation and medical assistance services can respond during that time whether there is a covered accident or illness. If the Covered Person is in his/her home country, emergency evacuation means getting the Covered Person to appropriate medical care. However, insurance that pays for the medical expenses of illness through the Participant Medical Plan comes into effect only when the Covered Person boards the plane or other carrier for the international journey to the host country.

This means that if the Covered Person experiences an illness such as appendicitis or influenza during the Pre-Departure Period, medical assistance and medical evacuation services can respond, but their family's insurance coverage or their family is expected to address the costs of the illness.

The Pre-Departure Period ends after the Covered Person boards the plane or other carrier for the international journey. As long as they continue to participate in the AFS program, they are eligible for full coverage under the Participant Medical Plan.

Maintaining Participation in the AFS program

Participation in the AFS program means carrying out the normal activities required of an AFS participant. Participants are required to attend school or participate in their community service project or other structured activities listed in the program description on a full-time basis. Other required activities include, but are not limited to, active participation in the life of the host family, attendance at AFS local and regional events, and engagement in typical extra-curricular and social activities. The final determination on whether the participant is able to remain on the program rests with AFS.

Importantly, participation in the AFS program may be terminated in AFS' sole discretion if requested medical records regarding the Covered Person that are needed by AFS are not provided to AFS, the Insurers or their agents as requested. In addition to determining coverage, these medical records are needed to communicate with medical personnel and identify the best course of treatment, which may include returning the Covered Person to the home country.

Coverage ends on the date of the termination of the AFS program, or on the date a Covered Person or the sending parents elect to terminate the Participation Agreement for any reason prior to the completion of the program, or upon the return to the home country, whichever comes first.

Once the Covered Person has left the AFS program or returned home, the coverage under the Medical Plan ends and medical expenses become the responsibility of the sending family, even if the accident, injury or illness causing them happened during the program. This includes all medical and other expenses, including travel, incurred by or for the Covered Person from the date of termination.

For this reason, sending families should make sure before the departure on an AFS program that other insurance or medical care is available in the home country should their child return requiring medical assistance. Coverage may not always be available in the home country to cover a loss that has already happened. AFS strongly advises that sending families maintain insurance for their child at home while he or she is on an AFS program.

IV. Medical Expenses Coverage

Medical Expenses refers to expenses incurred for appropriate medical care by a Covered Person while they are on an AFS program. The Participant Medical Plan pays only for the emergency medical expenses of covered losses, arising from accidents or sudden illnesses not excluded by the Participant Medical Plan. Coverage only applies for medical expenses incurred for treatment received within 90 days of sustaining injury or suffering illness and end after 52 weeks from the time the need for treatment first arose.

As is typical for medical expenses, the Participant Medical Plan pays charges at “reasonable and customary” rates commonly used by physicians in the area where the care is furnished.

Covered medical expenses under the Participant Medical Plan are:

I. Charges for hospital confinement and use of operating rooms; hospital or ambulatory medical-surgical center services
II. Charges made for diagnosis, treatment and surgery by a Treating Medical Professional. This means a licensed practitioner of medical services acting within the scope of their license, such as a physician, surgeon, graduate nurse or osteopath. It does not include a family or household member.
III. Charges made for the cost and administration of anesthetics;
IV. Charges for x-ray examinations, treatments and laboratory tests
V. Charges for physiotherapy, if recommended by a physician for the treatment of a specific disablement and administered by a licensed physiotherapist;
VI. Chiropractic services.
VII. Drugs, medicines, prosthetics and therapeutic services and supplies obtained upon a written prescription by a physician or surgeon.
VIII. Ambulance service

Medical Expenses arising from pregnancy or childbirth are covered but only if necessitated by bodily injury following an accident or incurred for pregnancy related sickness or complications requiring emergency treatment.

Note that the following services are subject to the indicated coverage limits:

- Chiropractic services -- 12 sessions per incident while the Covered Person is participating on an AFS program
- Mental/nervous therapy -- 12 sessions per incident while the Covered Person is participating on an AFS program
- Rehabilitation therapy (physical, speech or occupational) -- 12 sessions combined services per incident while the Covered Person is participating on an AFS program.

Refer to Section IX for a listing of expenses that are not covered under the Participant Medical Plan.

It is the responsibility of the sending family to provide for the coverage of those medical expenses of the Covered Person that are excluded under the Participant Medical Plan. If AFS pays for these expenses up front in order to assist the Covered Person at the time of illness or injury, sending parents will be required to reimburse the Participant Medical Plan.

There may be times when we will need your cooperation to make a recovery under another insurance policy. An example is when a car accident is responsible for causing an injury to Covered Person.

V. Medical Identification Cards

AFS provides Covered Persons with a medical ID card that they can use to certify that they have medical expense coverage for the duration of the Covered Person's time on an AFS program. Each card lists the 24-hour telephone number which a treating medical professional or hospital can call to confirm coverage for a Covered Person when the national hosting office is closed or in the case of emergency.

VI. Medical Assistance Service

In order to fulfill its responsibilities to Covered Persons, AFS and the Insurer work with GMMI, which provides medical assistance. GMMI helps to *obtain* or *qualify* medical care around the world and also to arrange for medical evacuation, when needed.

Obtaining medical care means finding personnel and facilities that are appropriate for managing a Covered Person's medical condition while they are in their host country. It also means getting medical evaluations or providing Covered Persons with medicine while they are on the AFS program. GMMI contracts with a network of medical providers around the world to offer excellent, cost-effective options for care to AFS Covered Persons.

When GMMI advises that there is a viable and appropriate option for a Covered Person to use an in-network medical provider, coverage will be provided that way. In the event that a Covered Person's sending family wishes to use a different provider than the one arranged by GMMI, those arrangements would need to be made by the sending family outside the AFS program at the expense of the sending family.

Qualifying medical care means determining that the facility in the host country where a Covered Person may already be hospitalized is appropriate for their care. It can also mean getting a second opinion from a local medical professional or from a medical professional employed by the assistance network.

GMMI is both a claims administrator and the medical assistance provider for the Participant Medical Plan. GMMI has access to medical expertise and resources worldwide on a 24-hour basis. They complement the existing network of AFS Partners and volunteers around the world when there is a medical problem. Medical assistance allows AFS International as well as the AFS Hosting Partner and Sending Partner to confer with medical specialists in the time of an emergency. They can also jointly get assessments on the case and keep in touch on its developments.

If another kind of medical care or facility is recommended for the Covered Person, the assistance network will arrange for the Covered Person's transfer within the host country, or to a facility in the Covered Person's home country.

VII. Emergency Medical Evacuation

Emergency Medical Evacuation refers to the expenses of transporting a seriously ill or injured Covered Person and sometimes an escort required by medical order. It typically results in a return to the Covered Person's home country. It can take place when the Insurer and GMMI, in conjunction with the Treating Medical Professional, determines that the Covered Person can safely travel, or is "Fit to Fly". This means the end of the Covered Person's AFS program stay and the termination of medical coverage once the Covered Person has been taken to their home or the required medical facility.

Until a Covered Person is Fit to Fly and can return home, they can continue to be covered under the Participant Medical Plan. If the Covered Person or Sending Family decides not to follow through with the emergency medical evacuation after the Fit to Fly determination is made, they will be responsible for all medical expenses incurred after that date.

In the event that a Covered Person who has left the program because of a medical evacuation or medical release is permitted by AFS to rejoin the AFS program, return travel costs to the host country from the home country are not covered under the Participant Medical Plan. These costs are the responsibility of the Covered Person's family.

Sometimes a Covered Person may need to be transported to another location in the host country to receive suitable medical care while they continue on the AFS program. The Participant Medical Plan will pay for medical costs occurring after this evacuation only if the Covered Person can stay actively involved in AFS program activities. AFS makes the determination regarding whether the Covered Person can stay actively involved in AFS program activities based on, among other things, a review of the pertinent medical records.

In very unusual cases, a treating medical professional may suggest transfer to a medical care facility that is neither in the home country nor in the host country. AFS defines this to be a termination of the Covered Person's program stay. In this case, the Participant Medical Plan will cover the cost of the medical evacuation, but medical coverage will terminate after the Covered Person's arrival at the medical facility and medical expenses will revert to the sending parents.

The Participant Medical Plan will address the arrangements and expenses of a covered medical evacuation including medical escort up to a limit of USD 1,000,000 when a Treating Medical Professional gives written orders that a Covered Person requires one. These arrangements must be made through GMMI. They can range from an early return on a commercial airliner to a specially equipped jet with medical facilities and personnel. Emergency Medical evacuation does not cover the cost of travel for any other persons or for any other reasons.

VIII. Repatriation of Mortal Remains Expenses

This coverage relates to the special travel arrangements that must be made when someone covered by the Plan has died. In that event, AFS will make all necessary arrangements with GMMI.

The Participant Medical Plan pays for repatriation expenses up to a limit of USD 100,000 when they arise from a covered loss

IX. Exclusions to the Participant Medical Plan

Not every medical expense is the responsibility of the Participant Medical Plan. Some kinds of expenses, such as those that Covered Persons can expect, elect, or control are not intended to be covered by the Plan.

Other types of excluded expenses are those not considered medically necessary. The Participant Medical Plan is designed only to cover the expenses of the unexpected medical services and items which a treating medical professional says are needed to restore a Covered Person's health.

Finally, some types of expenses can't be covered because they can't be adequately evaluated, like the risk of war in the home country of the Covered Person.

However, terrorism is covered.

Routine Vision and Dental Expenses

As described in the Participation Agreement, the Participant Medical Plan does not pay for certain types of medical expenses which are expected as part of daily life. These include routine vision care, such as routine eye exams, glasses or contact lenses. Dental coverage under the Participant Medical Plan is limited to dental treatment needed as a result of an accident, as recommended by a treating medical professional. However, coverage is included for surgical extraction of wisdom teeth when it is required to prevent the spread of infection.

Expenses for Routine Physical Exams or Preventative Care

The Participant Medical Plan does not pay for routine physicals, inoculations, vaccinations, or examinations, even if required by schools or government entities. As an example, schools often require sports physical examinations prior to allowing Covered Persons to engage in school sports. Covered Persons and/or sending parents are expected to pay for these expenses directly because they are not caused by an accident or sudden illness. If the host family or AFS pays for these expenses, AFS will seek reimbursement from the sending family.

What is a Pre-Existing Condition?

As presented in the Participation Agreement and the insurance policy, the Participant Medical Plan does not pay for medical expenses that result from pre-existing illnesses or injuries. A pre-existing condition is one for which treatment has been sought or provided in the eighteen-month period prior to the Covered Person's arrival at the international departure site.

There is a special consideration for conditions where the use of prescription drugs or medicines prescribed by a medical practitioner is well controlled. The exclusion includes any conditions that require taking

prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled for a 45-day period before the Covered Person's arrival without any change in the required prescription.

This means that if the 45-day period of control is adequately met, then some medical conditions may not be subject to the pre-existing conditions exclusion. An example is a person with diabetes whose prescription for insulin has not changed in the 45 days before departure on the AFS program. Emergency care for this person could be covered under the medical plan without the diabetes being considered a pre-existing condition.

To clarify, this refers specifically to coverage for a medical emergency that may arise that is related to or caused by the chronic illness. In our example, it could be a Covered Person with controlled diabetes who experiences an unexpected complication from that illness while overseas.

It does not mean that this Covered Person is covered under the medical plan for the expected expenses of caring for their chronic illness during the AFS program. The cost of insulin every day for the regular care of someone with diabetes, for example, would be an expected expense and would not be covered.

As this Medical Pamphlet states in the section above, travel medical insurance typically excludes expenses or care that are routine or can be anticipated.

When the Participant Medical Plan pays for medical expenses which are determined to have been a result of a pre-existing condition, this will require reimbursement by the sending family. If a Covered Person has a condition which qualifies as pre-existing or produces routine or expected expenses, the sending family should make arrangements to pay for the expenses relating to this condition should they arise during the course of the AFS program. If there is an insurance policy in effect which covers the condition, the sending family should keep the coverage in force during the course of the AFS program.

Expenses for Non-Emergency Surgery

Non-emergency surgery is not covered by the Plan and is defined as:

- ❑ elective surgery or treatment and/or
- ❑ a procedure that can be performed after the end of the Covered Person's Program that does not involve a medical emergency and/or
- ❑ a surgical procedure that is not considered urgent or emergency and does not need to be performed while the Covered Person is on the Program.

If there is any question about whether surgery meets the criteria for emergency necessity, that determination will be made by the Insurer and/or Administrator in consultation with the Covered Person's Treating Medical Professional.

List of Key Exclusions to the Participant Medical Plan

This policy will not cover any claim, loss, injury, damage or legal liability suffered or sustained directly or indirectly by a Covered Person as the result of:

- ❑ Your failure to obtain any recommended vaccines, inoculations or medications prior to the start of your program.

The policy will not cover any Medical Expenses claim, loss, injury, damage or legal liability suffered or sustained directly or indirectly by you as the result of:

- ❑ Pre-existing Conditions;
- ❑ Suicide or attempted suicide;
- ❑ War in the Covered Person's Home Country;
- ❑ Participation in any military maneuvers or training exercises;
- ❑ Piloting or learning to pilot or acting as a member of the crew in any aircraft;
- ❑ Hangliding, gliding, paragliding or parachuting;
- ❑ Participating in semi-professional or professional sports;
- ❑ Dental treatment that is not Emergency Dental Treatment.
- ❑ Any non-emergency treatment or surgery, elective surgery, routine physical examinations, check-ups, inoculations, vaccinations, hearing aids, eyeglasses or contact lenses, costs of medicines for chronic conditions;
- ❑ Elective abortion;
- ❑ Hernia unless resulting from an Accidental Injury that occurs during the Program;
- ❑ Traveling for the purpose of receiving medical treatment;
- ❑ Care or treatment which is not deemed medically necessary and reasonable by the Insurer or the Treating Medical Professional;
- ❑ Care or treatment that is payable under any other insurance policy or governmental health program;
- ❑ Traveling against the advice of a Treating Medical Professional;
- ❑ Cosmetic surgery except for reconstructive surgery incidental to or following surgery for trauma, or infection for covered benefit or other covered disease of the part of the body reconstructed, or to treat a congenital malformation of a child;
- ❑ Any Sickness, disease, or other condition, event or circumstance which occurs at a time when you are not on the Program.

X. Filing Medical Claims for Medical Plan Expense

Medical Expense claims are processed in two ways, according to the location in which they are incurred, or produced. Please submit claims as soon as possible, preferably within 90 days of incurring the medical expenses. Claims submitted after one year of first being incurred may not be payable.

Please note that if a Covered Person exaggerates or makes a fraudulent claim the Insurer is not liable to pay it and may exclude them from the Plan.

Complaints

AFS and the Insurer are dedicated to providing a high-quality service and want to ensure that this is maintained at all times.

If you have any questions or concerns about the Policy or the handling of a claim, please first contact your local AFS office as outlined in your Participation Agreement.

If the matter is not resolved effectively, you may be able to refer your complaint to an independent organization for review. We will advise you on the relevant organization at the time, depending on the nature of your complaint and your country of residence. In some cases, it may be the Financial Services and Pensions Ombudsman (FSPO).

If you would like further information about the Irish Financial Services and Pensions Ombudsman you may:

- write to them at Lincoln House, Lincoln Place, Dublin 2, Ireland
- call them on +353 1 567 7000
- find more details on their website www.fspo.ie

Filing Claims incurred in the USA

When a Covered Person incurs a medical expense in the USA, please ask the treating medical professional or hospital to send the original bill with their claim form directly to GMMI:

GMMI (Global Medical Management Inc.)
880 SW 145th Avenue, Suite 400
Pembroke Pines, Florida 33027 USA

e-mail: customerservice@gmmi.com

If the medical expense is paid by the Covered Person or the host family, they can claim reimbursement by submitting the bill to GMMI. In this case, it is important that they use the claim form provided by AFS. Care should be taken to fill out the entire AFS claim form detailing the nature of the treatment required.

We advise that GMMI be contacted when a Covered Person has to be admitted to the hospital in the USA for more than 72 hours as an in-patient. GMMI must always be involved in conjunction with AFS when an emergency medical evacuation is involved.

Balance Billing

The claims administrator, GMMI, negotiates with medical providers to reduce their costs even after they have provided the medical service. Medical providers often agree to forgo part of their fee, but sometimes they may still send the part of the bill that was not paid to the sending family. This practice is called "balance billing". If you receive a bill for all or part of a medical expense that you thought was covered under the Covered Person Medical Plan, let GMMI know. Send them an email (customerservice@gmmi.com) with the details of the claim and describe the bill you received.

GMMI makes it possible for AFS families to view the medical bills that GMMI has received. You can also see the bills that have been processed for payment to the medical providers.

If you receive a "balance bill" or a statement by mail, you can log on to the GMMI web site at: www.gmmi.com. Press the "Insured Patients" button located in the upper right hand corner of the screen. Follow the directions by entering the Policy ID, First Name, Last Name and Date of Birth before pressing "View Patient Info". *(The Policy ID number is found on both ID Cards provided to the Covered Person by AFS USA and begins with the 3 letter country code of the Covered Person's home country: e.g. CRC for Costa Rica, GER for German, ITA for Italy, JPN for Japan, THA for Thailand, etc.)*

On the next page you will be able to view a listing of all the bills that have been received by GMMI. The first column lists the Internal Tracking Number at GMMI for a specific bill. The second column lists the medical provider's name. The third column lists the treatment date. The fourth column lists the total charges billed. The fifth column lists the payment date (which is printed in green if it has been already paid or printed in red if payment is pending or has been denied), and the last column lists the date the bill was processed

If the statement you have received is listed online with GMMI for the same amount you do not have to do anything further.

If the statement you have received is not listed online with GMMI, please first contact the provider and inform them of the insurance information and GMMI's billing address so that they can send the proper claim form to GMMI for handling. Then please e-mail or fax a copy of the statement to GMMI at: customerservice@gmmi.com or via fax number 1.954.370.8130.

If you have any questions or are not able to access your information online, please call GMMI at 1.954.370.6468 or 1.888.444.7773

Calling for information about medical expenses in the USA

Treating medical professionals, host families or Covered Persons can talk to GMMI about claims or coverage by calling 1.888.444.7773. Their office hours are 9 a.m. to 4:30 p.m. Monday through Friday.

Questions that arise about medical emergencies in the US after office hours should be directed to AFS-USA at 1.212.299.9000.

Filing Claims incurred in countries other than the USA

The national office of the hosting partner determines how claims will be handled in that country. Covered Persons and host families should contact the national office for information on how to file medical claims.

The Claims Processor for claims in Europe is Aon Consulting, Admiraliteitskade 62, Rotterdam, Netherlands. They are also available during normal working hours to help with answering questions on coverage by calling +31.10.448.8238. E-mail: afs@aon.nl. In some instances, certain questions may need to be referred by AON Consulting to the Insurer for their consideration and guidance.

In addition, AON Consulting helps to coordinate queries concerning medical insurance to Covered Persons in the European Union who are traveling in countries with European Union (EU) insurance arrangements. Please contact AON as soon as medical care is required for these Covered Persons so that they can arrange for any claim approved by the Insurer to be properly paid through EU channels. Often these arrangements must be followed before medical care is sought, in order to be properly covered. When a Covered Person has to be admitted to the hospital for more than 72 hours as an in-patient outside the US, GMMI should be advised. GMMI must always be involved in conjunction with AFS when an emergency medical evacuation is involved. They can be reached by email at customerservice@gmmi.com or by telephone in Florida, USA at 954.370.6468

In the event of a car accident

If a Covered Person has been injured in a car accident, it is important that an accident report is provided with the claim information. This report is usually obtained from the police. The accident report should show the names, addresses and relevant insurance information of all drivers involved in the accident.

Please note that when medical expenses are incurred by Covered Persons as the result of an automobile accident, responsibility for the expenses is often governed by local law.

In many countries, automobile insurance is mandatory, and the Participant Medical Plan will look to that coverage first for the payment of claims. This means that the person(s) who owns the car(s) involved in the accident will be asked by the claims administrator for their insurance information.

In the USA, expenses are the responsibility of:

- ❑ the owner of the vehicle in which the Covered Person Covered Person was a passenger, if the accident happened in a state with no-fault laws

- ❏ the auto insurance of the driver at fault, if the accident happened in a state without no-fault laws.

About the Insurer for the Participant Medical Plan

The Insurer for the Participant Medical Plan is:

XL Insurance Company SE

Policy no. NT6000726998

Registered Office: 8 Stephen's Green, Dublin, 2 D02 VK30, Ireland.

Registered in Ireland No. 641686

XL Insurance Company SE (the Insurer) is a European public limited liability company regulated by the Central Bank of Ireland.

Further details can be found on the Central Bank of Ireland register at www.centralbank.ie

IX. Additional Benefits Coverage Summary - insured by Berkley

AFS provides a package of additional travel-related benefits for AFS participants. This insurance is provided by Berkley Accident and Health and is in effect for all participants on AFS programs.

This program offers seven kinds of benefits that can be helpful with illness or injury that happens during travel, but that are not covered under the Participant Medical Plan.

1. **AD&D - $10,000** - Benefit paid in event of death caused by accident. Lesser benefits paid for other kinds of losses, such as loss of limb or faculties. Coma and paralysis benefit also provided.

2. **Emergency Dental Up to $500** - For dental treatment for the alleviation of pain

3. **Emergency Reunion - Up to $5,000** - Airfare and/or lodging for an immediate family member to visit a participant hospitalized for at least 24 consecutive hours and at the recommendation of the attending physician.

4. **Trip Interruption Benefit - Up to $5,000** - Airfare for a participant to return home due to life- threatening illness, injury, or death of an immediate family member.

5. **“Tail” Medical” - Up to $100,000** - Covers medical expenses incurred up to one year after return to home country as a result of an accident (but not illness, other than endemic disease) incurred while on the AFS program.

6. **Permanent Disability - Up to $100,000** - Benefit for permanent and total disability arising from an accident (not illness) incurred while on an AFS program.

7. **Bereavement and Trauma Counseling - Up to $1500** - Up to 10 sessions at a maximum of $150 per session as a result of a covered accident suffered by the participant. (Available to participant and/or family)

Additional Benefits are provided in addition to coverage provided under the Participant Medical Plan. The terms and conditions of coverage for these benefits are different from the terms and conditions of the coverage for The Medical Plan, which covers medical expenses, medical evacuation and repatriation. No deductibles or co-pays are payable by the participant.

Additional Benefits provide “secondary” coverage and are not payable if there is primary insurance available either through private or national health insurance. Additional Benefits are paid as reimbursements for expenses for which a claim is made.

All seven Additional Benefits are subject to the exclusions listed at the end of this pamphlet. Some exclusions apply specifically to certain benefits. A more detailed description of the seven benefits follows.

1. Accidental Death and Dismemberment (AD&D)

In the event of a participant's death, the Participant Medical Plan will provide a benefit of $10,000 in addition to the limit provided for covered medical expenses. Please note that the Accidental Death coverage is payable only as a result of a loss occurring within 365 days of a covered accident. No benefit is payable from losses caused by illness.

In the event of a loss of limbs, eyes, hearing or speech, or a combination of these losses, the Participant Medical Plan will provide a benefit of up to $10,000, depending on the exact nature of the loss and based on the schedule of payments as stipulated in the insurance policy. Please contact AFS if more details are needed about these benefits.

Paralysis: The AD&D benefit will pay 100% of the AD&D benefit in the event of complete and irreversible quadriplegia resulting from a covered loss from injury. It will pay 75% of the benefit in the event of paraplegia (complete and irreversible paralysis of lower limbs) or hemiplegia (complete and irreversible paralysis of one side) or 25% for uniplegia, which applies to one limb. If more than one kind of AD & D benefit, or both a disability and an AD&D benefit are payable arising from the same accident, only one benefit will apply, which will be the larger one.

Felonious Assault: There is a benefit payable of $10,000 for an AD&D loss that occurs as a result of a violent crime or felonious assault. There must be a police report filed that shows an intentional assault. The crime must be classified as a felony in the location where the assault occurred, such as an actual or attempted robbery or holdup. Coverage does not extend to assault committed by the participant, a family member, or member of the same household.

Home Alteration and Vehicle Modification: There is a benefit payable of up to $10,000 when the insured suffers a covered loss, other than loss of life, which results directly from a covered accident and requires adaptive devices or adaptations to residence or vehicle in order to maintain an independent lifestyle. This requirement must occur within one year of the date of the covered accident, and the insured must not have needed these adaptations before. Expenses must be directly attributable to alterations that are strictly necessary.

Note that the AD&D benefit does not cover any loss resulting from sickness or disease. This includes bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment, except for bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.

2. Emergency Dental

This provides coverage up to $500 for the immediate alleviation of pain. Coverage applies for 30 days after the covered sickness or accident occurs. Expenses can be paid for up to 26 weeks from the date of the sickness or accident.

Alleviation of pain and infection to teeth and alleviation of pain and infection to gums is covered. This includes treatment of abscesses and impacted wisdom teeth. Removal of impacted wisdom teeth is covered under this benefit unless it is required to prevent the spread of infection, in which case the procedure is addressed under the Medical Plan.

Most dental restoration services, such as the fixing of fillings, crowns, or bridges, are not covered, unless the procedure must be done for the direct alleviation of pain. Routine restorations and amalgams are not covered.

Services, supplies, or treatment, including any period of hospital confinement that is not recommended, approved, and certified as medically necessary are not covered. Treatment by a family member is not covered, nor expenses which would not be payable in the absence of this insurance.

Routine dental care and treatment is not covered. Damage to or loss of dental braces is not covered.

Accidental injury to sound, natural teeth is covered under the Participant Medical Plan to policy limits, as long as the expenses arise as a direct result of a covered injury.

See the full listing of exclusions that apply to this benefit on page 24.

3. Reunion Benefit

This provides coverage up to $5,000 for economy travel and/or lodging for an immediate family member to visit a participant who has been hospitalized for more than 24 consecutive hours due to a covered injury or sickness, and where the attending physician believes it would be beneficial to have the family member at the participant's side.

In the case of grave injury or sickness, where the participant's life is in danger, the benefit can be extended to accommodate two family members. This is subject to the approval of the administrator and is subject to the benefit maximum of $5,000.

"Immediate Family Member" means a person who is related to the Participant in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister)

or child (includes legally adopted child or stepchild), grandchild and grandparent, including step-grandparent.

All travel arrangements must be made in consultation with or by the AFS Partner. Reimbursement of expenses will not be made until approved by AON, the Administrator of the program.

4. Trip Interruption Benefit

This benefit provides reimbursement of up to $5,000 for an economy air and/or ground transportation ticket (such as train or bus). This applies if the participant must return because an immediate family member has died or is experiencing a life-threatening illness or injury, as determined by a physician in writing. The illness or injury must be so disabling as to reasonably cause the trip to be interrupted.

The benefit also provides for economy transportation to return the participant to the AFS program as determined by AFS. Both the travel home and the return cannot exceed the limit of $5,000.

“Immediate Family Member” means a person who is related to the Participant in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister) or child (includes legally adopted child or stepchild), grandchild and grandparent, including step-grandparent.

This benefit may also be used when the participant is ill or injured, has been medically evacuated to a medical facility, and needs to continue the journey home from that place.

All travel arrangements must be made in consultation with or by the AFS Partner. Reimbursement of expenses will not be made until approved by AON, the Administrator of the program. Any existing tickets must be used first.

5. “Tail” Medical Insurance

This provides coverage for eligible medical expenses up to $100,000. It applies to expenses incurred up to one year after a participant returns to the home country as a result of injuries sustained in a covered accident or an endemic disease contracted while on an AFS program.

Treatment must be for the recurrence or continuation of treatment for an injury or endemic illness that originated on the AFS program. For example, if a participant broke an arm while on an AFS program and obtains surgery or treatment recommended by a physician upon return home, these expenses could be covered under this benefit.

Tail Medical expenses arising as a result of illness while on an AFS program are not covered, unless caused by endemic disease. An endemic disease is one belonging exclusively or confined to a particular place or people living in the locale that the participant was visiting, such as malaria. All related conditions and recurrent symptoms of the same or similar condition will be considered one covered sickness.

Expenses covered under the Tail Medical benefit are:

- ❏ Hospital semi-private room and board or use of an ambulatory medical center
- ❏ Services of a physician or registered nurse;
- ❏ Anesthetics and administration
- ❏ Laboratory tests and radiological services
- ❏ Blood products and transfusions
- ❏ Oxygen and its administration
- ❏ Rental of durable medical equipment
- ❏ Artificial limbs or other prosthetic appliances (but not replacement of these items)
- ❏ Casts, splints, trusses, crutches and braces (but not replacement of these items, or dental braces)
- ❏ Physiotherapy, if recommended by a physician for the treatment of a specific disablement and administered by a licensed physiotherapist;
- ❏ Drugs and medicines that can only be obtained upon a written prescription of a physician or surgeon.

In some cases the coverage offered under Additional Benefits is not as broad as that provided under the Participant Medical Plan. For example, expenses from a mental/nervous illness would be covered under the Participant Medical Plan. These expenses would not be covered under the Tail Medical Benefit.

The Tail Medical benefit responds only to sickness that arises from endemic illness. It does not respond to other disease or infection other than bacterial infection arising from a cut or a wound, or accidental ingestion of contaminated food.

Expenses arising from cosmetic surgery are not covered, except for reconstructive surgery needed as a result of an injury. Suicide, attempted self-destruction, or intentional self-inflicted injury is not covered.

See page 24 of this pamphlet for more clarification about exclusions that apply to the Tail Medical benefit.

6. **Permanent Total Disability Insurance**

This provides a benefit of up to $100,000 as a result of permanent and total disability due to an accident that occurs while on the AFS program. Disability attributable to illness, including mental or nervous conditions, is not covered.

Permanent total disability means that, because of an injury from a covered accident that happens on the AFS program, the participant is unable to perform the normal and customary activities of a healthy person of like age and sex, and is expected to remain so disabled, as certified by a physician, for the rest of his or her life.

If the participant is employed: After the first 12 months, it means they are unable to perform the material and substantial duties of any occupation for which they are, or may become, qualified by reason of education, experience or training, which would provide them with substantially the same earning capacity as their prior earning capacity prior to the start of disability

There is no coverage for disability that is permanent but not total, or for disability that is total but not permanent. For example, a permanent disability to part of the body, such as a hand or foot, is not considered total permanent disability.

Coma. There is a benefit payable of $10,000 if the insured becomes comatose within 31 days of a covered accident and remains in a coma for 31 days. Coma arising from illness is not covered. 1% of the benefit is payable monthly for 11 months and then as a lump sum after 12 months

See page 24 of this pamphlet for more exclusions that apply to the Disability benefit.

7. **Bereavement and Trauma Counseling Benefit**

This benefit covers a maximum of ten sessions at a maximum of $150 per session. The sessions may be for the participant and/or one or more of his immediate family members, as a result of a covered accident to the participant that caused the loss. Illness is not a covered cause of loss. The counseling must be provided under the care, supervision or order of a physician, and is covered only if there would have been a charge for the service had this benefit not existed.

The expenses must be incurred within one year from the date of the covered accident causing the loss. This benefit can be used in conjunction with the Tail Medical benefit.

“Immediate Family Member” means a person who is related to the Participant in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister)

or child (includes legally adopted child or stepchild), grandchild and grandparent, including step-grandparent.

GENERAL EXCLUSIONS TO ALL "ADDITIONAL BENEFITS" insured by Berkley: AD&D, Dental, Reunion, Trip Interruption, Tail Medical, Permanent Total Disability, and Bereavement & Trauma Counseling.

These exclusions apply in addition to those stipulated in the descriptions of the seven Additional Benefits.

Note that these exclusions are separate and distinct from those that apply to the Medical Plan. Those are described in a separate section in this pamphlet.

This insurance does not cover any event which either in origin or extent, directly or indirectly, proximately or remotely is to be attributed to or is a consequence of:

- ❑ Routine physicals, vision or dental care
- ❑ Travel incurred for the purpose of seeking medical care or expenses incurred on travel not part of the AFS program
- ❑ Flight in any vehicle for aerial navigation except as a fare-paying passenger on a regularly scheduled commercial airline, or as a passenger in a non-scheduled private aircraft; not while in an aircraft not intended for the transportation of passengers, or aircraft being used for test or experimental purposes, or aircraft leased by AFS.
- ❑ Routine nursery care
- ❑ Pregnancy or childbirth, unless treatment required as the result of a medical emergency
- ❑ Suicide, self-destruction, or attempted self-destruction while sane or insane
- ❑ Intentional self-inflicted injury
- ❑ Military service
- ❑ Sickness or disease except for bacterial infection arising from external cut or wound or accidental ingestion of contaminated food (this exclusion does not apply to coverage for endemic disease provided under the tail medical benefit)
- ❑ Treatment by an immediate family or household member
- ❑ Mental or nervous illness or rest cures
- ❑ Cosmetic surgery except for reconstructive surgery required as a result of an accident.
- ❑ Eye exams for corrective lenses; eyeglasses, contact lenses, hearing aids
- ❑ Procedures that are not considered to be medically necessary, or non-medical in nature
- ❑ Treatment or services by a private duty nurse
- ❑ War or any act of war, declared or undeclared

For a full description of the all terms and conditions governing these additional benefits, please refer to the Policy Wording for details. This is available from the local AFS national office.

Please note that this pamphlet is provided as a brief summary of coverage provided under the AFS Medical Plan and is not an insurance policy. If there is any discrepancy between the insurance policy and the pamphlet, the insurance policy will govern.

Claims Submission for the Additional Benefits program:

Claims should be submitted directly to Aon in the Netherlands. AON is the claims administrator for Berkley, the insurance company. Please note that expenses for the Additional Benefits program should not be sent to GMMI, as they are the claims administrators for the Medical Plan only, not for these benefits.

Reimbursement payment for Additional Benefit claims will be made in the local currency where possible.

Original receipts and a description of the incident must accompany the claim. In some cases, a doctor's opinion or letter may be required to substantiate the claim or further treatment. Claims must be submitted to AON within 90 days after the date of the incident to:

Aon Consulting
AFS Claims Team
Ronald Enderman
Admiraliteitskade 62, Rotterdam
Postbus 1005, 3000 BA Rotterdam, Netherlands

email: afs@aon.nl
telephone: +31.10.448.82.38
fax: +31.10.448.87.24

Please note that claims submitted later than 90 days after the date of the occurrence may not be payable.