

**This is a Description of Coverage for
United Work and Travel, Inc.**
a Division of American Pool Enterprises, Inc.

Underwritten By: Insurance Company of the State of Pennsylvania (Herein Referred to as "the Company")

Eligibility: You will be covered under this plan if you are participating in the work & travel programs conducted by United Work and Travel, Inc.

Period of Coverage: Coverage will begin: a) for Accidental Death & Dismemberment Benefits, the time of departure from the Insured's point of last domicile or temporary residence in their Home Country directly to the point of embarkation on the scheduled program of United Work and Travel, Inc; and b) for all other benefits, the time of the insured's departure from their Home Country. Coverage will end: a) for Accidental Death & Dismemberment Benefits, the time of return to the Insured's domicile or temporary residence in their Home Country directly from the point of disembarkation from the scheduled program of United Work and Travel, Inc, for benefits and b) for all other benefits, the time of arrival in the Insured's Home Country. This insurance only covers the participant while he/she is participating in an intern program at the direction and expense of United Work and Travel, Inc.

Definitions: Sickness: Means an illness, disease or condition of the Insured that causes a loss which an insured incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one sickness. **Injury:** means accidental bodily harm sustained by an Insured that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury. **Home Country:** means a country from which the insured holds a passport. If the Insured holds passports from more than one country, his or her Home Country will be that country which the Insured has declared to the Company in writing as his or her Home Country. **Medically Necessary:** means a treatment, service or supply that is: 1) required to treat an Injury or Sickness; prescribed or ordered by a doctor or furnished by a Hospital; 2) performed in the least costly setting required by the Insured's condition; and 3) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. The Company may, at its discretion, consider the cost of the alternative to be the Covered Expense.

Medical Expense Benefits: If a covered Injury or Sickness occurs during the Period of Coverage and the Insured requires medical or surgical treatment, The Company will pay 100% of Covered Expenses incurred, up to a maximum of \$100,000 per covered Sickness or Injury subject to a \$20 deductible for outpatient Prescription Drug expenses. In no event will: (1) the Company's liability exceeds \$100,000 for each covered Injury or Sickness; and (2) Covered Expenses exceed the usual and customary expenses for the geographical area where the services are rendered, as determined by the Company.

To be considered a Covered Expense under this plan, it must: a) have been incurred as the result of and within 52 weeks of a covered Sickness or Injury outside of the Home Country during the Period of Coverage; b) not be excluded by provisions of this Plan; and c) be specifically included in the following list of expenses:

1. Expenses made by a hospital for room and board, including registered nursing services and any other medically necessary hospital services, but not including personal services of a non-medical nature. However, allowable expenses may not exceed the hospital's average charge for semiprivate room and board accommodation.
2. Expenses made for diagnosis, treatment and surgery by a doctor.
3. Expenses made for the cost and administration of anesthetics.
4. Expenses for x-ray services, laboratory tests and services
5. Expenses for durable medical equipment (includes rehabilitative braces and appliances, both inpatient and outpatient).
6. Expenses for Physiotherapy, if recommended by a doctor for the treatment of a specific disablement administered by a licensed physiotherapist, subject to a maximum benefit 20 days per policy year.
7. Expenses for prescription drugs including dressings, drugs, and medicines prescribed by a doctor, 100% inpatient and 100% outpatient subject to a \$20 deductible
8. Expenses for mental and nervous disorders while the insured is confined in a hospital, up to 60 days of inpatient care and treatment. Outpatient Benefit maximum is \$500.
9. Expenses for dental expenses resulting from an injury to sound, natural teeth, up to; \$1,000 maximum benefit per occurrence; Alleviation of Pain; Maximum Benefit \$500 per occurrence

Emergency Medical Evacuation Benefit: The Company will pay Emergency Medical Evacuation Benefits up to the maximum of \$500,000 for expenses incurred for the medical evacuation of an Insured. Benefits are payable if the Insured: 1) is traveling outside his or her Home Country; 2) suffers an Injury or Sickness during the course of the Trip; and 3) requires Emergency Medical Evacuation. Benefits will not be payable unless: 1) the doctor ordering the Emergency Medical Evacuation certifies the severity of the Insured's Injury or Sickness requires an Emergency Medical Evacuation; 2) all transportation arrangements for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible; 3) the charges incurred are Medically Necessary and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and 4) do not include charges that would not have been made if there were no insurance. "Emergency Medical Evacuation" means: 1) the Insured's immediate transportation from the place where he or she suffers an Injury or Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; or 2) the Insured's transportation to his or her Home Country to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Sickness. An Emergency Medical Evacuation also includes Medically Necessary medical treatment, medical services and medical supplies necessarily received in connection with such transportation. An Emergency Medical Evacuation of an Insured to their Home Country will terminate all benefits except Accidental Death and Dismemberment Benefits under the plan. **All arrangements must be made by the Assistance Provider and approved by the Company in order for expenses to be considered eligible.**

Repatriation of Remains: The Company will pay the usual and customary covered expenses, up to a maximum of \$500,000, to return an Insured's body home to his or her Home Country if he or she dies while covered by this plan. Covered expenses include, but are not limited to, expenses for embalming, cremation, coffins and transportation. **All arrangements must be made by the Assistance Provider and approved by the company in order for expenses to be considered eligible.**

Emergency Remion Benefit:

For Hospital Stay or Felonious Assault	
Total Benefit Maximum:	\$12,500
Daily Benefit Maximum:	\$300
Maximum Number of Days:	10
For Repatriation of Remains	
Total Benefit Maximum:	\$2,500

Accidental Death and Dismemberment Benefit: If an insured's covered Injury results in any of the following losses within 365 days after the date of accident, the Company will pay the sum shown opposite the loss. The Company will not pay more than the Principal Sum for all losses due to the same Accident.

Principal Sum: \$15,000

Description of Loss

Life, Both Hands or Both Feet or Sight of Both Eyes, One Hand and
One Foot, Either Hand or Foot and Sight of One Eye
Either Hand or Foot or Sight of One Eye
Thumb and Index Finger of the same hand

Indemnity

Principal Sum
One-Half the Principal Sum
One-Quarter the Principal Sum

The term "loss" as used herein shall mean, with regard to hands and feet, actual severance through and or above wrist or ankle joint and with regard to eyes, entire irrecoverable loss of sight. "Severance" means complete separation and dismemberment of the part of the body.

Excess Benefits: All benefits, except Accidental Death and Dismemberment, shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted.

Exclusions and Limitations:

With Respect to Medical Expense, Emergency Evacuation & Repatriation of Remains, Emergency Reunion, Benefits, no benefit shall be payable with respect to expenses incurred:

1. For pre-existing conditions (defined as a Sickness, disease or other condition, of the Insured, that in the 6 month period before the Insured's coverage became effective under the Policy: 1) first manifested itself, worsened, became acute or exhibited symptoms that would have caused a person to seek diagnosis, care or treatment; or 2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or 3) was treated by a doctor or treatment had been recommended by a doctor. Losses incurred for Pre-existing Conditions are covered under this plan provided the Insured demonstrates that they had continuous insurance coverage for 6 months prior to becoming insured under this plan. After the Pre-Existing Condition requirement is met, coverage will be considered continuous provided there is not a break in coverage. (This pre-existing condition exclusion does not apply to the Emergency Medical Evacuation, Emergency Reunion or Repatriation of Remains Benefits).
2. For services, supplies, or treatment including any period of hospital confinement, which was not recommended, approved and certified as necessary and reasonable by a doctor, or expenses which are non-medical in nature.
3. For loss incurred as a result of war or any act of war, whether declared or not.
4. For Injury sustained while participating in professional, intercollegiate sports or interscholastic sports.
5. For routine physicals.
6. For cosmetic surgery, except as the result of an injury.
7. For elective surgery.
8. For dental care, except as provided in the Policy.
9. For eye refractions or eye examinations for the purpose of prescribing corrective lenses for eyeglasses or for the fitting thereof, unless caused by accidental bodily injury while insured hereunder.
10. For expenses as a result of, or in connection with, intentionally self-inflicted injury.
11. For suicide or attempted suicide while sane or insane.
12. For expenses as a result of, or in connection with, the commission of or attempt an assault or a felony.
13. For scuba diving, jet and water skiing, mountain climbing (where ropes or guides are normally used), skydiving, and professional or amateur racing.
14. For treatment furnished under any mandatory government program or facility set up for treatment without cost to any individual.
15. Injury or Sickness covered by Worker's Compensation, Employer's Liability Laws or similar occupational benefits.
16. For treatment by an immediate family member.
17. For alcoholism or drug addiction or use of any drug or narcotic unless prescribed by a doctor.

For the Accidental Death and Dismemberment Benefit, this Plan does not cover any loss, fatal or non-fatal; caused by or resulting from:

1. Intentionally self-inflicted injury.
2. Suicide or attempted suicide, while sane or insane.
3. War or act of war, whether declared or not.
4. Service in the military, naval, or air service of any country.
5. Sickness, Disease, or infection of any kind, except bacterial infections due to an accidental cut, wound, botulism or ptomaine poisoning.
6. Piloting or acting as a crewmember or riding in any aircraft; except as a fair paying passenger on a scheduled airline.

Claims Administrators: Diversified Group Administrators, Inc.; PO Box 6540; Harrisburg, PA 17112 1-800-427-9308 Fax 717-652-8328.

Preferred Provider Organization: NHBC/Beechstreet – 888-621-7900. <http://providers.nhbc.com> Access code: AMA611

Emergency Assistance: ATG Assist, Inc. 1-800-626-2427. In addition to this health insurance program is access to the 24-hour Assistance network for emergency assistance anywhere in the world. Simply call the assistance center at ATG Assist, Inc. toll-free, direct or collect using the telephone listed above. The multilingual staff will answer your call and provide reliable, professional and through assistance. The following services are included in the program: referral to the nearest most appropriate medical facility and/or provider, medical monitoring by board-certified emergency doctors in the United States; urgent message relay between family, friends, personal doctor, school, and insured; guarantee of payment to provider and assistance in coordinating insurance benefits; arranging and coordinating Emergency Medical Evacuations, and Repatriation of Remains; Emergency travel arrangements for disrupted travel as the consequence of a medical emergency; referral to legal assistance; assistance in locating lost or stolen items including lost ticket application processing.

Program Arranged By: Insurance Company of the State of Pennsylvania. www.amastudentplans.com
Claim forms and instruction are available from the website. Policy Number: GLB9112748

This Description of Coverage is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in GLB9112748; issued to: Sun Trust Bank as Trustee in Washington, DC. The policy is subject to the laws of the state in which it was issued. Coverage may not be available in all states or certain terms or conditions may be different if required by state law. Please keep this information as a reference.

PROOF OF LOSS

Insurance Company of the State of PA
C/O Diversified Group Administrators, Inc
P.O. Box 6540
Harrisburg, Pa 17112
1-800-427-9308

NAME OF GROUP: UNITED WORK & TRAVEL INC.
A Division of American Pool Enterprises, Inc.
POLICY NUMBER: GLB9112748

ACCIDENT AND SICKNESS CLAIM FORM/ GLOBAL

INSTRUCTIONS:

- 1.) This form is to be used when filing a claim for reimbursement of Medical Expenses.
2.) Section A must be completed by the Insured in full.
3.) One of the following must be provided:
- Section B Fully Completed by the Attending Physician, or
- Fully Itemized Bills showing Claimant's Name, Nature of Illness/Injury, Description and Charge for each service provided.
4.) This form must be signed and dated in all applicable sections.
5.) This form and all attached bills must be submitted to the address indicated above.
The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A

Coverage Effective Date: ___/___/___ Coverage Termination Date: ___/___/___ Certificate Number: ___ (If applicable)

Social Security #: _____

1.) Name of Claimant: _____ Claimant's Date of Birth: ___/___/___ Sex: Male Female
(PLEASE PRINT)

2.) Current Residence Address: _____

3.) Date of arrival in U.S.: ___/___/___ Daytime phone number: () _____

4.) Permanent Address (In Home Country): _____

5.) If injury, give date injury occurred and details of the injury/accident: _____

6.) If illness, advise when and where symptoms first occurred: Country _____ Date _____
Please indicate nature of the illness and/or describe your symptoms: _____

7.) Have you been treated for this illness or injury prior to the effective date of this insurance?
If yes, provide name and address of the treating Physician(s) and date(s) first consulted. _____

9.) Provide Name and Address of your Regular Physician in your Home Country: _____

10.) Were you taking any medications prior to the effective date of this insurance? If yes, please provide the following:
Drug Name: _____ Drug Name: _____ Drug Name: _____
Prescribed for: _____ Prescribed for: _____ Prescribed for: _____
Physician Name: _____ Physician Name: _____ Physician Name: _____
Date 1st Prescribed: _____ Date 1st Prescribed: _____ Date 1st Prescribed: _____

11.) Do you have other health insurance? Yes ___ No ___ If yes, please provide the name, address and policy number of the Insurance: _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. YES NO
Optional Limited Assignment

I hereby make a limited assignment to _____ (my "Assignee") of the right to receive the benefits due for those covered medical expenses incurred by me and actually paid directly to the provider of those services by my Assignee. I understand that the Company bears no responsibility or liability for the validity or effect of this assignment or for any payments made by the Company prior to receipt of satisfactory proof of payment by the Assignee. I hereby specifically release, and agree to indemnify, the Company from any and all liability incurred for any such payments made.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE: _____

DATE: _____

