VISITORS CARE®

IMG®

GLOBAL *peace of mind*®

Travel medical insurance for non-U.S. residents traveling to the United States

WWW.IMGLOBAL.COM

LARGE COMPANY RESOURCES.
SMALL COMPANY ATTITUDE.

Since 1990, **IMG®** has provided global benefits and assistance services to millions of customers in nearly every country around the world. Owned by Sirius Group, a multibillion-dollar, AM Best "A-" rated insurance industry leader, IMG is uniquely positioned to deliver the **Global Peace of Mind®** our members need.

- **24/7 medical and travel assistance services**
- **Multilingual staff & claims administrators**
- **Highly trained customer service professionals**
- **Core values driven by a commitment to customers**
- **Customer service centers located in the U.S. and U.K.**
- **Financial security to fulfill our promise when you need it most**

Global presence.
Local care.

GET COVERED AWAY FROM HOME.

Most people don't realize they're at risk when they're traveling, and assume they're already covered by their standard medical plan. While some traditional plans may offer some domestic coverage, they aren't designed for international travel. Fill the gaps in your travel medical coverage with a **Visitors Care®** plan that meets your needs and spend more time enjoying your international experience—not worrying about your medical coverage.

Visitors Care offers a broad package of scheduled benefits for non-U.S. residents traveling to the United States. There are nine separate options based on deductible levels and maximum limits. Simply select the option that best fits your needs.

SUMMARY OF BENEFITS

	PLAN A	PLAN B	PLAN C
Period of Coverage	5 days to 2 years	5 days to 2 years	5 days to 2 years
Period of Coverage Limit	$25,000 per illness/injury	$50,000 per illness/injury	$100,000 per illness/injury
Area of Coverage	Non-U.S. residents traveling to the U.S.	Non-U.S. residents traveling to the U.S.	Non-U.S. residents traveling to the U.S.
Deductibles	$0, $50, $100	$0, $50, $100	$0, $50, $100
Acute Onset of Pre-Existing Conditions*	$25,000 max per coverage period *(subject to sub-limits below)*	$50,000 max per coverage period *(subject to sub-limits below)*	$100,000 max per coverage period *(subject to sub-limits below)*
Emergency Medical Evacuation *Arises or results directly or indirectly from a covered acute onset of a pre-existing condition*	$25,000 max per period of coverage	$25,000 max per period of coverage	$25,000 max per period of coverage
Physician Visits/Services	$40 max per visit 30 max visits per period of coverage	$60 max per visit 30 max visits per period of coverage	$85 max per visit 30 max visits per period of coverage
Urgent Care Center	$40 max per visit/10 max visits	$60 max per visit/10 max visits	$85 max per visit/10 max visits
Hospital Emergency Room	$200 max per visit	$330 max per visit	$550 max per visit
Hospitalization/Room & Board *Average semi-private room rate Includes nursing, misc., and ancillary services*	Up to $825 max per day 30 day max per period of coverage	Up to $1,400 max per day 30 day max per period of coverage	Up to $2,000 max per day 30 day max per period of coverage
Intensive Care	Up to an additional $400 max per day, 8 day max per period of coverage	Up to an additional $660 max per day, 8 day max per period of coverage	Up to an additional $850 max per day, 8 day max per period of coverage
Outpatient Surgical /Hospital Facility	Up to $2,000 max per surgical session Up to $750 max per surgical session *(facility)*	Up to $3,300 max per surgical session Up to $900 max per surgical session *(facility)*	Up to $5,500 max per surgical session Up to $1,000 max per surgical session *(facility)*
Laboratory **Radiology/X-ray**	Up to $400 max per period of coverage *($200 per procedure)*	Up to $450 max per period of coverage *($250 per procedure)*	Up to $500 max per period of coverage *($500 per procedure)*
Chemotherapy/Radiation Therapy	$550 max per visit	$1,100 max per visit	$1,350 max per visit
Pre-Admission Testing	Up to $750 max per period of coverage	Up to $1,100 max per period of coverage	Up to $1,100 max per period of coverage
Surgery	Up to $2,000 max per surgical session	Up to $3,300 max per surgical session	Up to $5,500 max per surgical session
Assistant Surgeon *20% of the primary surgeon's eligible fee*	Up to $450 max per surgical session	Up to $825 max per surgical session	Up to $1,375 max per surgical session
Anesthesia	Up to $450 max per surgical session	Up to $825 max per surgical session	Up to $1,375 max per surgical session

All coverage and benefits in the plan are in United States (U.S.) dollars. Benefits are subject to the exclusions and limitations and are payable only at Usual, Reasonable and Customary (URC) charges. This is a summary of a selection of plan benefits offered only as an illustration and does not supersede in anyway the Certificate of Insurance and governing policy documents (together the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.

**Acute onset benefits are subject to limitations that can be found in the Insurance Contract.*

SUMMARY OF BENEFITS

Durable Medical Equipment	$550 max per period of coverage	$1,000 max per period of coverage	$1,300 max per period of coverage
Physical Therapy *Medical order or treatment plan required*	Up to $40 max per visit per day, 12 max visits per period of coverage	Up to $40 max per visit per day, 12 max visits per period of coverage	Up to $40 max per visit per day, 12 max visits per period of coverage
Extended Care Facility *Upon direct transfer from an acute care hospital*	Covered under Hospital Room & Board	Covered under Hospital Room & Board	Covered under Hospital Room & Board
Home Nursing Care *Provided by a home healthcare agency upon direct transfer from an acute care hospital*	$550 max per period of coverage	$550 max per period of coverage	$550 max per period of coverage
Prescriptions *Dispensing limit: 90 days*	Up to $250 max per period of coverage	Up to $250 max per period of coverage	Up to $250 max per period of coverage
Emergency Local Ambulance	Up to $250 max per period of coverage	Up to $450 max per period of coverage	Up to $475 max per period of coverage
Emergency Medical Evacuation	Up to $25,000 max	Up to $50,000 max	Up to $50,000 max
Return of Mortal Remains	$25,000 max with $5,000 max for Cremation/Burial	$25,000 max with $5,000 max for Cremation/Burial	$25,000 max with $5,000 max for Cremation/Burial
Common Carrier Accidental Death	$25,000 max per period of coverage	$25,000 max per period of coverage	$25,000 max per period of coverage
Dental Injury	Up to $550 max per period of coverage	Up to $550 max per period of coverage	Up to $550 max per period of coverage
Incidental Trip *Maximum days: 14* *Insured person's country of residence is not the United States*	14 day maximum	14 day maximum	14 day maximum

All coverage and benefits in the plan are in United States (U.S.) dollars. Benefits are subject to the exclusions and limitations and are payable only at Usual, Reasonable and Customary (URC) charges. This is a summary of a selection of plan benefits offered only as an illustration and does not supersede in anyway the Certificate of Insurance and governing policy documents (together the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.


WORRY LESS.
Experience more.

INNOVATIVE TECHNOLOGY & **MEMBER** SERVICES

Self-Service Member Portal

My*IMG*℠ provides service at your fingertips, giving you the information and tools to manage your IMG plans anytime, anywhere, through award-winning, easy-to-use technology. You'll have immediate access to these important resources online, including our 24/7/365 service centers, plan document access, claims management tools, Explanations of Benefits, and much more.

Pharmacy Discount Savings

Universal Rx is a discount savings program that allows you to purchase prescriptions from one of 35,000 participating pharmacies in the U.S. and receive the lower of **1)** Universal Rx contract price or **2)** the pharmacy regular retail price. This network offers a simplified claims process with minimal paperwork for the member if they visit an in-network provider.

This program is not insurance coverage; it is purely a discount program.

First Health Network

For travelers in the U.S., the First Health network is a wide-ranging national PPO network that gives you more access to more doctors and services, including:

- 5,000 hospitals
- 90,000 ancillary facilities
- 1 million healthcare professional service locations

UNDERSTANDING YOUR NEEDS.
EXCEEDING YOUR EXPECTATIONS.

HOW TO GET COVERED

1 **Step 1:**
Contact your producer directly to obtain an application or to apply online.

2 **Step 2:**
Complete your application: If applying as a family, you may include yourself, your spouse, and dependents on one application. For dependents 18 and over, please complete a separate application.

3 **Step 3:**
Receive a fulfillment kit that includes an identification card, declaration of insurance, and a Certificate of Insurance outlining the details of the plan. Welcome to the IMG family!

HOW TO EXTEND YOUR COVERAGE

To meet the needs of our customers, Visitors Care plans can be purchased for up to a 12-month period. They can be extended up to 24 continuous months. Renewals are available in daily increments and may be completed online. For each renewal, you will be charged an additional $5 processing fee. Each insured person must only satisfy one deductible and coinsurance within each 12-month coverage period.

Please note that renewal rates may differ from initial rates. Eligibility to purchase, extend, or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including the Patient Protection and Affordable Care Act (PPACA).

CONDITIONS OF COVERAGE

1. Coverage and benefits are subject to the applicable deductible and scheduled limits and sub-limits, and all other terms, conditions, and exclusions of the Visitors Care plan as described in the complete Certificate of Insurance.
2. Coverage under the plan is secondary to any other available coverage or benefits.
3. Coverage and benefits are for medically necessary, and usual, reasonable, and customary charges only.
4. Treatment must be administered or ordered by a physician.
5. Charges must be incurred during the period of coverage.
6. Claims must be presented to IMG for payment within 180 days from the date the claim was incurred.






IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA): *This insurance is not subject to and does not provide benefits required by PPACA. Since January 1, 2014, PPACA requires U.S. citizens, U.S. nationals and certain U.S. residents to obtain PPACA-compliant insurance coverage unless they are exempt from PPACA. Penalties may be imposed on persons who are required to maintain PPACA-compliant coverage but do not do so. Eligibility to purchase, extend or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is an insured person's sole and exclusive responsibility to determine the insurance requirements applicable to them, and the Company and IMG shall have no liability whatsoever, including for any penalties a person may incur, for failure to obtain coverage required by any applicable law including, without limitation, PPACA. For information on whether PPACA applies to you or whether you are eligible to purchase Patriot Travel Medical Insurance, please see IMG's Frequently Asked Questions at www.imglobal.com/faq.*

VISITORS CARE®

Producer Contact Information

This invitation to inquire allows eligible applicants an opportunity to seek information about the insurance offered, and is limited to a brief description of any loss for which benefits may be payable. Benefits are offered as described in the insurance contract. Benefits are subject to all deductibles, coinsurance, provisions, terms, conditions, limitations and exclusions in the insurance contract. Certain contracts do contain a pre-existing condition exclusion and do not cover losses or expenses related to a pre-existing condition.

GLOBAL *peace of mind*®

Visitors Care®
Daily Rates

$25,000 MAXIMUM BENEFIT PER LIFE OF PLAN

PLAN A

Age	OPTION 1 $0 deductible *per period of coverage*	OPTION 2 $50 deductible *per period of coverage*	OPTION 3 $100 deductible *per period of coverage*
2 weeks - 29	$0.71	$0.59	$0.53
30 - 39	$0.80	$0.68	$0.59
40 - 49	$0.83	$0.71	$0.62
50 - 59	$1.17	$0.96	$0.90
60 - 69	$1.45	$1.20	$1.11
70 - 79	N/A	$1.88	$1.79
80+*	N/A	$3.76	$3.57
Dependent child	$0.79	$0.64	$0.61

**The maximum amount of coverage for applicants who are 80 years of age or older is $10,000.*

$50,000 MAXIMUM BENEFIT PER LIFE OF PLAN

PLAN B

Age	OPTION 4 $0 deductible *per period of coverage*	OPTION 5 $50 deductible *per period of coverage*	OPTION 6 $100 deductible *per period of coverage*
2 weeks - 29	$1.06	$0.90	$0.81
30 - 39	$1.25	$1.06	$0.97
40 - 49	$1.27	$1.09	$0.99
50 - 59	$1.77	$1.52	$1.37
60 - 69	$2.08	$1.73	$1.62
70 - 79	N/A	$2.83	$2.67
Dependent child	$1.17	$0.98	$0.87

$100,000 MAXIMUM BENEFIT PER LIFE OF PLAN

PLAN C

Age	OPTION 7 $0 deductible *per period of coverage*	OPTION 8 $50 deductible *per period of coverage*	OPTION 9 $100 deductible *per period of coverage*
2 weeks - 29	$1.48	$1.22	$1.13
30 - 39	$1.63	$1.37	$1.28
40 - 49	$1.66	$1.39	$1.31
50 - 59	$2.35	$1.93	$1.78
60 - 69	$2.74	$2.29	$2.24
70 - 79	N/A	$4.03	$3.91
Dependent child	$1.60	$1.35	$1.24

www.imglobal.com

New premium rates per Insured Person are effective for purchases beginning May 1, 2019 for eligible individuals whose applications are approved by IMG. IMG reserves the right to assess the most current rates at the time of the effective date in the event these rates expire, are modified or are replaced.

Visitors Care® **Application**

Please print legibly and complete ALL SECTIONS *(front and back)* of this application. Mail, fax, or email application to:
International Medical Group, 2960 North Meridian Street, Ste. 300, Indianapolis, IN 46208 USA Fax: +1.317.655.4505 Email: insurance@imglobal.com

1 PRIMARY APPLICANT INFORMATION:

First Name:	Last Name:	Middle:
Government Issued ID Number:		Sex: ☐ Male ☐ Female
Country of Residence: *(Must not be U.S.)*	Country of Citizenship:	Destination Country: *(Must be U.S.)*
Beneficiary for Applicant:	Relationship to Applicant:	

Please indicate beneficiaries for the common carrier accidental death benefits. Unless indicated otherwise, the applicant will be deemed the beneficiary for his/her spouse and children.

2 FULFILLMENT AND INFORMATION DELIVERY METHOD:

☐ **Communications should be sent via email to:**

☐ **For mail fulfillment kit purposes ONLY: Instead of receiving confirmation of coverage via email, I prefer to receive a paper copy of the coverage verification letter and insurance contract to the following address:**

Name:		Address:
City:	Postal Code:	Country:

If the address provided is in Florida, is the applicant currently located in Florida? *(Determines applicable surplus lines tax and will not affect coverage)* ☐ Yes ☐ No

☐ **I AGREE TO THE PROCESSING OF MY PERSONAL INFORMATION TO PROVIDE THE SERVICES I HAVE PURCHASED, INCLUDING TO ADMINISTER CLAIMS, AND TO RECEIVE MEMBER COMMUNICATIONS, IN ACCORDANCE WITH IMG'S PRIVACY POLICY, FOUND AT IMGLOBAL.COM/LEGAL/PRIVACY-POLICY.**

☐ **I AGREE TO RECEIVE RELEVANT INFORMATION AND OTHER COMMUNICATIONS FROM IMG ABOUT INSURANCE COVERAGES AND SERVICE OPTIONS. I UNDERSTAND THAT I CAN WITHDRAW MY CONSENT AT ANY TIME.**

3 PLAN OPTIONS:

Select the coverage plan option:

Plan A: ☐ Option 1 ☐ Option 2 ☐ Option 3 **Plan B:** ☐ Option 4 ☐ Option 5 ☐ Option 6 **Plan C:** ☐ Option 7 ☐ Option 8 ☐ Option 9

Requested Start Date: ___/___/____ *(MM/DD/YYYY)* **Requested End Date**: ___/___/____ *(MM/DD/YYYY)*

4 PREMIUM CALCULATION:

Names of persons to be insured: *Please attach additional sheet for more children*		Date of Birth *(MM/DD/YYYY)*	Sex	Daily Rate	# of Days	Total
Applicant		___/___/____		_____ x	_____ =	_____
Spouse		___/___/____		_____ x	_____ =	_____
Child 1		___/___/____		_____ x	_____ =	_____
Child 2		___/___/____		_____ x	_____ =	_____
Child 3		___/___/____		_____ x	_____ =	_____
					TOTAL	**(A)**

TOTAL PREMIUM	
(A) Premium total *(from above)*	_____
Optional express mail $20	+_____
TOTAL AMOUNT DUE	=_____

APPLICATION FORM CONTINUED ON BACK

Visitors Care® **Application**

Please print legibly and complete ALL SECTIONS (front and back) of this application.

5 APPLICATION TERMS

The undersigned, on behalf of the above individuals (Applicants), hereby apply and subscribe to the Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN, or its successor, for the insurance coverage requested above and as underwritten and offered by Sirius Specialty Insurance Corporation (publ) (the Company) on the date of receipt hereof and as administered by the Company's authorized representative and plan administrator, International Medical Group, Inc. (IMG). The Applicants understand and agree: (i) the insurance applied for is not an employee welfare benefit plan, accident & health product, health insurance, major medical, nor a health plan subject to or complying with U.S. laws, but is intended for use as travel coverage in the event of a sudden and unexpected illness or injury for which eligible coverage may be available, (ii) The Applicants must pay premiums for the entire period of coverage in advance, and no coverage will be effective until the required premium has been paid and this application has been accepted in writing by the Company, (iii) no modification or waiver relating to this application or the coverage applied for will be binding upon the Company or IMG unless approved in writing by an officer of the Company or IMG, and (iv) the Company relies on the accuracy, truthfulness, and completeness of the information provided herein and any misrepresentation or omission contained herein will void the insurance contract and any and all claims and benefits thereunder will be forfeited and waived, (v) by submission of this application and/or any future claim for benefits. The Applicants purposefully initiate and take advantage of the privilege of conducting business with the Company in Indiana, through IMG as its managing general underwriter and plan administrator, the contract of insurance represented by the Master Policy and evidenced by the Certificate of insurance will be deemed issued and made in Indianapolis, IN, and sole and exclusive jurisdiction and venue for any legal proceeding relating to the insurance will be in Marion County, Indiana, for which the Applicants hereby consent. The Applicants consent and agree that Indiana surplus lines law shall govern all rights and claims raised under the insurance contract. **ACKNOWLEDGMENT**. The Applicants understand and agree that: (i) the insurance producer/agent/broker soliciting, assigned to, or assisting with this application is the agent and representative of Applicants and IMG acts in fulfillment of its contractual duties to the Company and on behalf of the Company, (ii) the insurance does not provide benefits for any Injury, Illness, sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment that, with reasonable medical certainty, existed at the time of Application or at any time during the three (3) years prior to the Effective Date of this insurance, whether or not previously manifested, symptomatic or known, diagnosed, Treated, or disclosed to the Company prior to the Effective Date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom (a "pre-existing condition"), and that all charges and/or claims incurred for pre-existing conditions will be excluded from coverage as described in the Certificate of Insurance, which is incorporated by reference here and can be accessed at imglobal.com/sample-contracts, (iii) the subjects of insurance applied for are not intended or considered by the Applicants, the Company or IMG to be resident, located, or expressly to be performed in any particular jurisdiction, (iv) the Company, as carrier and underwriter of the insurance plan, is solely liable for the coverages and benefits to be provided under the insurance contract and IMG has no direct or independent liability under any insurance contract, and (v) that if at any time in the future, Applicant is deemed no longer eligible for the insurance applied for here, that they will lose coverage under the insurance. **AUTHORIZATION FOR RELEASE OF INFORMATION**. The Applicants authorize any health plan, health care provider, health care professional, MIB, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency, employer, benefit plan, or any other organization or person that has provided care, advice, diagnosis, payment, treatment, or services to them or on their behalf, has any records or knowledge of their health, has any information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of them, and any non-medical information about me, to disclose their entire medical record, file, history, medications, and any other information concerning them and to give any and all such information to their agent of record and authorized representatives of Company, IMG, and their affiliates, and subsidiaries. **CERTIFICATION**. The Applicants hereby certify, represent and warrant that : (i) they have read the foregoing statements and any marketing materials and sample insurance contract which were made available upon request and prior to the application or that they have been read to them, and the Applicants understand them, (ii) they are eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) they are currently in good health and have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing or other medical condition which the Applicants foresee may require treatment during the insurance or for which the Applicants intend to claim under the insurance, and (iv) each Applicant is not hospitalized, disabled, or HIV+. If signed as the legal representative of the Applicant, the signer warrants their authority and capacity to so act and to bind each Applicant. By acceptance of coverage and/or submission of any claim for benefits, each Applicant ratifies the authority of the signer to so act and bind the Applicants. **IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)**: This insurance is not subject to, and does not provide benefits required by, PPACA. PPACA requires U.S. citizens, U.S. nationals and resident-aliens to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so. Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is solely the Applicants' responsibility to determine the insurance requirements applicable to them and the Company and its Administrator shall have no liability whatsoever, including for any penalties that the Applicants may incur, for their failure to obtain coverage required by any applicable law including without limitation PPACA. **E-CONSENT**. The Applicants wish to receive information and communicate electronically, and prefer to use an e-mail address rather than regular mail. The Applicants agree IMG, its affiliates, and subsidiaries may provide each insured person with any communications in electronic format, and paper communications are not required, unless and until the Applicant withdraws this consent. The Applicants unambiguously give consent to the transfer of personal data to entities established in a country outside the EU Member States. This consent is freely given, specific for the administration of coverage and benefits, and an informed indication of the Applicants' wishes. The Applicants acknowledge and understand the transfer is necessary for the performance of a contract, taken in response to their request, and necessary for the conclusion or performance of a contract concluded in their interest. The Applicants also agree it is their responsibility to provide IMG with true, accurate and complete e-mail address, contact, and other information related to my coverage, and to maintain and promptly update any changes in this information. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Insured or Proxy *(Required)*	X _____
Date: ___/___/_____ *(MM/DD/YYYY)*	Phone:

6 PAYMENT METHOD

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ Wire ☐ Check (To IMG) ☐ Money Order (To IMG) ☐ *eCheck (ACH)* *(available upon request)*

By supplying my account information, I wish to pay the premium by credit card or the designated account for each Applicant requesting coverage. If the application is accepted, the credit card or designated account will be billed for the premium at the selected payment mode. By signing and submitting this form, Applicant represents and warrants that he/she has the card or account holder's authorization to use the account and, if not, will take full responsibility for the payment and any charges accruing to it. By submitting the signed application, I agree to pay via my credit card or applicable account the premium amount owed and have read and agree to all terms, conditions, and other statements in this application. I hereby authorize IMG to debit my payment type for the total amount due. In the event that I have chosen to pay premiums semi-annually, quarterly, or monthly, I hereby elect to pre-authorize future credit card payment installments for the balance of the policy period and for renewals, and hereby request and authorize IMG to charge my credit card periodically as payment installments become due for premiums and renewal premiums. This authorization will remain in effect until revoked by me in writing, and until IMG actually receives the notice of revocation. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. I understand that I will be given advance notice of the renewal premiums and that they may vary each year. ***This document should only be transmitted to IMG through secure means.***

Card #:	Expiration Date: ___/_____ *(MM/YY)*	Cardholder Name:
Signature: (Required)	Cardholder Daytime Phone:	Email:
Cardholder Billing Address:		
Payment must be made for the total number of days you want coverage. All payments must be made in U.S. dollars and drawn on U.S. banks.		

IMG PRODUCER USE ONLY		
Producer #:		
Name:		
Address:		
City:	State:	Zip:
Phone:		
Email:		