As a participant in a YMCA sponsored program which includes accident and sickness insurance, this brochure outlines the basic provisions of coverage in force and available to you.

PERIOD OF COVERAGE

Coverage is in force throughout the official program, plus a short period, one day before arrival in the USA and one day after the ending date on the DS2019 form.

NATURE OF COVERAGE

A. ACCIDENTAL DEATH AND DISMEMBERMENT. If injury to an Insured shall result in any of the losses listed below within one hundred and eighty (180) days from the date of accident, the Company will pay the benefit shown for that loss, but only one payment will be made for all such losses which shall be the largest applicable.

for Loss Of:

Life	**$5,000.00**
Both Hands or Both Feet	**$5,000.00**
Entire Sight of Both Eyes	**$5,000.00**
One Hand and One Foot	**$5,000.00**
One Hand and the Entire Sight of One Eye	**$5,000.00**
One Foot and the Entire Sight of One Eye	**$5,000.00**
One Hand or One Foot	**$2,500.00**
Entire Sight of One Eye	**$1,750.00**
Thumb and Index Finger of Either Hand	**$1,250.00**

"Loss" as above stated shall mean with reference to hand or foot, actual severance through or above the wrist or ankle joint. Loss of sight of either eye shall mean the entire and irrecoverable loss of sight thereof. Loss of a thumb and index finger shall mean actual severance through or above metacarpo-phalangeal joints.

B. ACCIDENT MEDICAL EXPENSE INDEMNITY — $100,000.00 MAXIMUM LIMIT. If "injury" shall, within sixty (60) days after the date of accident, require treatment by a licensed medical practitioner or surgeon, hospital confinement, employment of a registered nurse, ambulance service, X-ray examinations, laboratory tests, use of operating room, anesthetist (private or hospital), surgical dressings or medications, plaster casts, crutches or use of a wheel chair, the Company will pay the Usual, Reasonable and Customary (UCR) expense actually incurred for such treatment, services, or supplies received by the Insured Person within fifty-two (52) consecutive weeks after the date of the accident up to an amount not exceeding $100,000.00, as the result of any one accident with respect to such Insured Person. A $100.00 deductible shall apply to each accident.

C. SICKNESS MEDICAL EXPENSE INDEMNITY — $100,000.00 MAXIMUM LIMIT. If "sickness" shall, within sixty (60) days of inception, require treatment by a licensed medical practitioner or surgeon, hospital confinement, employment of a registered nurse, ambulance service, X-ray examinations, laboratory tests, use of operating room, anesthetist (private or hospital), surgical dressings or medications, plaster cast, crutches or use of a wheel chair, or use of a respirator in cases of Poliomyelitis, the Company will pay the UCR expense actually incurred for such treatment, services or supplies received by the Insured Person within fifty-two (52) consecutive weeks after the first treatment for such sickness up to an amount not exceeding $100,000.00, as a result of any one sickness with respect to such Insured Person. A $100.00 deductible shall apply to each sickness.

D. MATERNITY EXPENSE BENEFIT — $2,500.00 MAXIMUM LIMIT. The Company, subject to all other provisions of the Policy applicable to Sickness, will pay the charges for Covered Expenses incurred as a result of pregnancy, including resulting childbirth, abortion or miscarriage.
Benefits are payable for charges made by:

a) a physician for the performance of an obstetrical procedure and examination;

b) a Hospital for medical care and treatment, including room and board and floor nursing care;

c) an anesthetist or by a Hospital for the cost and administration of anesthetics;

d) a professional ambulance service;

but in no event will the benefits payable exceed the maximum amount of $2,500.00. Pregnancy must commence after you become a participant in the YMCA Program and while the coverage is in force.

E. PSYCHIATRIC CARE BENEFIT. Expenses incurred for psychiatric care on an in-patient basis will be reimbursed up to a maximum of $5,000.00 per sickness. Expenses incurred for psychiatric care on an out-patient basis will be reimbursed up to a maximum of $1,000.00 per sickness (the maximum amount payable for any one visit shall not exceed $100.00). The combined maximum aggregate per sickness for in-patient and out-patient care is $5,000.00.

F. REPATRIATION OF REMAINS — $7,500.00 MAXIMUM LIMIT. In the event of the death of the Insured occurring within the term of the Policy, the Company will pay the reasonable Covered Expenses incurred to return the Insured's body to their former home (in accordance with applicable international requirements), but not to exceed a maximum amount payable of $7,500.00. Covered Expenses with respect to this benefit include but are not limited to expenses for embalming, cremation, coffins and transportation.

G. MEDICAL EVACUATION — $10,000.00 MAXIMUM LIMIT. Benefits will be paid up to a maximum of $10,000.00 for expenses incurred to return an Insured to his/her permanent residence when in the opinion of a legally qualified medical authority, expenses incurred due to a covered illness or injury under this insurance plan are expected to exceed the policy maximum of $100,000.00 for the Basic Accident and Sickness Medical Expense Benefit. The method of transportation chosen shall be based on the consideration and recommendation of a legally qualified physician and shall be by the most direct and economical route.

AMERICAN INTERNATIONAL COMPANIES

YMCA CLAIM FORM — ICCP TRAINEE / INTERNATIONAL CAREER ADVANCEMENT PROGRAM

POLICY # GLB 9019705

Name of insured ..... Social Security #.....
(if applicable)

Permanent Address - Home .....

Parent or guardian if claimant is under 21 .....

Name of camp or organization.....

Address, if other than above - U.S.A. .....

Date of illness or accident.....Name of illness or injury .....

If illness, have you had it before? ..... When?—Dates of last medical treatment .....

If accident, how did it happen? .....

If accident, is it job related? Yes ..... No .....If yes, is coverage available under your employer's Worker's Compensation insurance?

If no, your employer must enclose a letter of denial from his Worker's Compensation insurance company so that we may process the claim.

Check should be sent to: ☐ Doctor ☐ Hospital ☐Claimant ☐ Other

Name and address of physician:.....

If payment is to other than provider (Doctor or Hospital) attach proof of payment.

PHYSICIAN, SURGEON OR HOSPITAL AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended me or examined me, to furnish to American International Companies or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date ..... Signature .....

2006

Claim Form & Insurance Information

for

YMCA'S

ICCP Trainee Program

or

International Career Advancement Program

All claims are to be mailed to:

American International Companies
Accident and Health Claims Division
PO Box 15701
Wilmington, DE 19850-5701
1-800-551-0824 (Inside the USA & Canada)
1-302-661-4176 (Collect from anywhere else)
8:00am - 6:00pm Eastern time Monday-Friday

EXCLUSIONS FROM COVERAGE

This policy does not cover the following:

1. Eye glasses or prescription therefor, or equipment for corrective treatment of sight.
2. Special appliances, except as noted in section B and C above.
3. Transportation costs, except ambulance service.
4. Suicide, or the attempt thereat, while sane or insane.
5. Injury occurring in a plane other than while riding as a passenger in a licensed passenger aircraft operated by a licensed commercial pilot, or hang-gliding apparatus, or parachuting.
6. Dental treatment, dental X-rays, dentures, except for accidents to sound, natural teeth.
7. Health treatments where no injury or sickness is involved.
8. Expenses covered by other insurance.
9. Loss caused by war or any act of war.
10. Any Injury or Sickness which originated prior to the effective date of the insured person's coverage and which has been under treatment during a period of less than thirty-one (31) days immediately preceding that date.

TERRITORIAL LIMITATIONS

This policy covers only injury and sickness while the Insured Person is engaged in a trip away from his place of domicile.

NOTICE OF CLAIMS

All claims must be processed through **American International Companies.** Duplicate copies of the claim forms (provided by YMCA or obtainable by writing to American International Companies) should be submitted, together with particulars fully substantiating each claim, immediately after the date of the accident or commencement of illness, and in any case, before departure, if possible. If available, bills for initial expenses should be sent to American International Companies with the claim forms. All subsequent bills should likewise be sent to American International Companies. All charges must be substantiated with statements submitted by doctors, hospitals, pharmacies, etc. before payment on a claim can be made.

Please refer to the instructions for completion on the back of each claim form.

A detailed explanation of the coverage provided by National Union Fire Insurance Company Inc., of Pittsburg, PA, the underwriting company and a member company of American International Group is contained in the master policy (Policy #GLB 9019705) filed at offices of the YMCA Headquarters and is available during office hours.

INSTRUCTIONS FOR FILLING OUT A CLAIM FORM

1. The first five lines are self-explanatory.
2. Be sure to fill in the name and address of the physician, even though you may not be submitting his bill at this time.
3. Be sure to sign the claim form and fill in the date when you mail to the Company.
4. Enclose all bills and duplicates which you have pertaining to the illness or injury.
5. Mail the claim form and all bills to:

   American International Companies
   Accident & Health Claims Division
   P.O. Box 15701
   Wilmington, Delaware 19850-5701
   Telephone # 1-800-551-0824; 302-661-4176

6. It is best to submit all bills for an illness or injury at the same time. However, if there is a delay in your receiving a bill or if your case will require extended or repeated treatment, file a claim as soon as possible after treatment, and send the bills along as you receive them. In this case, please indicate below that additional bills are to follow, giving details if possible.

IN NO CASE SHOULD YOU DELAY BEYOND 10 DAYS AFTER THE TERMINATION OF YOUR PROGRAM BEFORE SUBMITTING A CLAIM.

Remarks: