



**Global 360**

**Individual Critical Illness Insurance  
Policy**



Welcome to the Global Benefits Group (GBG) family! We understand you have a choice in insurance providers, and thank you for placing your trust in GBG.

The Welcome Kit you received with your Global 360 Insurance policy contains an Acknowledgment of Receipt and an Authorization Form which require your signature. Please sign these documents and return to GBG immediately. You may keep the originals.

We invite you to visit our Member Services Portal at [www.gbg.com](http://www.gbg.com), and register as a New Member. The Member Services Portal allows you to conveniently access our Provider Directory, download Forms, submit Claims, and utilize other valuable tools and services.

We look forward to providing you with this valuable insurance protection and outstanding service throughout the year.

Sincerely,



Bob Dubrish  
Chief Executive Officer  
Global Benefits Group

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## Schedule of Benefits

The Policy Face Page details the deductible amount, coinsurance percentage, maximum out-of-pocket amount, and benefit plan maximums applicable to this Policy.

This Schedule of Benefits and Policy Face Page forms part of the Global 360 Plan Critical Illness insurance Policy and is a summary outline of the benefits payable under the Policy. All benefits described are subject to the definitions, limitations, exclusions, and provisions of the Policy and the Schedule of Benefits.

<b>Covered Illnesses and Events</b>	
Coverage is limited to, and benefits payable for the following illnesses and events in the event of first occurrence and definite medical diagnosis more than 90 days after commencement of the Policy. The 90 day period does not apply to Polytrauma.	
<b>Cancer</b>	A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes leukemia, but the following cancers are excluded: <ul style="list-style-type: none"> <li>• Non-invasive cancer in situ</li> <li>• All forms of Lymphoma in the presence of any Human Immunodeficiency Virus (HIV)</li> <li>• Kaposi's Sarcoma in the presence of any Human Immunodeficiency Virus(HIV)</li> <li>• Any skin cancer other than Invasive Malignant Melanoma</li> <li>• Tumors which are histologically described as pre-malignant, showing early malignant change, or having malignant potential.</li> <li>• Stage 1 Hodgkin's disease</li> </ul>
<b>Coronary Artery By-Pass Surgery</b>	The actual undergoing of open heart surgery on the advice of a Consultant or Specialist Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts but excluding balloon angioplasty, laser or any other procedures.
<b>Heart Attack</b>	The death of a portion of the heart muscle as a result of inadequate blood supply as evidenced by episode of chest heart pain; new electro-cardiographic changes and by elevation of cardiac enzymes.
<b>Kidney Failure</b>	End stage renal failure presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis or renal transplant is initiated.
<b>Major Organ Transplant</b>	The actual undergoing of a transplant as the receiver of a heart, liver, lung, pancreas or bone marrow.
<b>Polytrauma</b>	Association of multiple, severe traumatic injuries to different organs and tissues caused by the same Accident and are life threatening.
<b>Stroke</b>	A cerebrovascular incident resulting in permanent neurological damage. Transient Ischemic Attacks are specifically excluded.
<b>Pre-Existing Conditions Limitation</b>	
This Policy will not pay benefits for pre-existing medical conditions defined as any illness or injury, physical or mental condition, for which the Policyholder has received any diagnosis, medical advice, consultation, or treatment, or had taken any prescribed drug, or where distinct symptoms were evident at any time previous to the commencement date of the Policy or before the end of the Elimination Period. No benefit is payable on diagnosis of any of the named illnesses if it was caused by, resulted from, or secondary to any Pre-Existing Condition.	
<b>Elimination Period</b>	
The Elimination Period is 90 days after the commencement of the Policy. If the first diagnosis occurs during the Elimination Period, the policy will be void, the claim denied, and all premium will be refunded. The Elimination Period does not apply to Polytrauma.	

<b>Provider Access and Benefit Reimbursement</b>	
<b>Provider Access:</b> There are no provider limitations, with the exception of the United States. The Insurer maintains a Preferred Provider Network in the U.S. and In-Network Providers must be used. <u>No benefits are payable if an Out-of-Network Provider is used.</u>	
<b>Benefit Reimbursement:</b> The Insurer reimbursement as shown below is subject to the Insured's satisfaction of the Policy Year Deductible.	
<b>ALL BENEFITS DESCRIBED BELOW APPLY ONLY FOR THE COVERED ILLNESSES AND EVENTS SPECIFIED IN THIS POLICY</b>	
<b>Hospitalization and Inpatient Benefits</b>	
Private/Semi-private room	100% of UCR
Intensive Care (medically necessary)	100% of UCR
Medical treatment, medicines, laboratory and diagnostic tests (including cancer treatment, chemotherapy/radiotherapy)	100% of UCR
Inpatient Consultation by a Physician or Specialist	100% of UCR
Inpatient Surgery	100% of UCR
Inpatient Surgeon	100% of UCR
Extended Care / Inpatient Rehabilitation (Must be confined to facility immediately following a Hospital stay)	100% of UCR
Private Duty Nursing	100% of UCR-Requires Pre-authorization Maximum 100 days per policy period
<b>Emergency Ambulance</b>	
Ground Ambulance	100% of UCR
Air Ambulance (see Policy for details)	100% of UCR-Requires Pre-Authorization
<b>Outpatient Benefits</b>	
Emergency Room	100% of UCR
Emergency Medical Services	100% of UCR
Outpatient Physician Visit • Limited to 90 Days following a covered illness/event	100% of UCR
Consultation by Specialist • Limited to 90 Days following a covered illness/event	100% of UCR
Echocardiography, Ultrasound	100% of UCR
CAT Scan, PET Scan or MRI	100% of UCR
Endoscopy (e.g., gastroscopy, colonoscopy, cystoscopy)	100% of UCR
X-Rays and Laboratory	100% of UCR
Cancer Treatment (chemotherapy/radiotherapy)	100% of UCR
Outpatient or Ambulatory Surgery	100% of UCR
Outpatient Surgeon	100% of UCR
Outpatient Dialysis	100% of UCR
Therapeutic Services including Alternative Medicine: Physical Therapy, Occupational Therapy, Vocational Speech Therapy, Homeopathy and Acupuncture	100% of UCR Maximum 80 visits combined per policy period
Home Health Benefits; Private Duty Nursing, Skilled Nursing, Visiting Nurse, Home Health Nursing	100% of UCR (Pre-Authorization required after 4 visits) Maximum 100 days per policy period

Other Benefits	
Human Organ, Bone Marrow, Stem Cell Transplants, and other similar procedures. Note: Expenses for Donor are covered In the US must use Institutes of Excellence	100% of UCR
Hospice Care	100% of UCR, maximum of 240 days per policy year
Durable Medical Equipment: Rental Up to Purchase Price (as described in the policy)	100% of UCR
Special Treatments (prosthesis, implants, appliances, and orthotic devices, durable medical equipment, radiation therapy, chemotherapy, and highly specialized drugs	100% of UCR, Pre-authorization required
Prescription Drugs	
Use of Insurer's US Pharmacy Network is preferred for Prescription Drugs obtained in the US. <b>The deductible applies to this benefit.</b>	
Upon diagnosis, or following hospitalization or out-patient surgery	100%, For a maximum of 90 days following such event
Other Services	
Repatriation of Remains	\$20,000 Maximum Benefit
GBG Personal Medical Advisor (Medical Second Opinion)	Included
Pre-Authorization Requirements	
Pre-Authorization is required when a covered illness is <u>diagnosed or event occurs and prior to treatment being incurred</u> . The insured must obtain pre-authorization in writing from the insurance company. <b>Failure to Pre-Authorize will result in a 40% penalty for the entire episode of care.</b> Please refer to the "Pre-Authorization" section of the Policy for a complete description. When in doubt, the Insured is encouraged to consult with GBG Assist. Medical emergency authorizations should be received by the Insurer within 48 hours of the event.	

## General Provisions

**Name of Policyholder**, the covered person whose name is indicated in the Policy Face Page as "Policyholder", hereinafter shall be referred to as the "Policyholder".

**Insurer**; the Second party, GBG Insurance Limited, hereinafter shall be referred to, sometimes collectively, as the "Insurer", "We" "Us", or "Company".

The declarations of the Policyholder and eligible dependents in the application serve as the basis for the policy. If any information is incorrect or incomplete, or if any information has been omitted, the policy may be rescinded, cancelled or modified. Any references in this Policy to the Policyholder, the insured and his dependents that are expressed in the masculine gender shall be interpreted as including the feminine gender whenever appropriate.

### Entire Policy and Changes

This Policy, Policy Face Page, Schedule of Benefits, the Policyholder application, and any amendments or endorsements (if any) comprise the entire Contract between the parties.

No change may be made to this Policy unless it is approved by an Officer of the Insurer. A change will be valid only if made by a Policy Endorsement signed by an Officer of the Insurer, or an amendment of the Policy in its entirety issued by the Insurer. No agent or other person may change this Policy or waiver any of its provisions.

### Right to Examine

The Policyholder can cancel this Policy within 14 days of receiving it. If no claims have been made under the Policy, the Insurer will refund any premiums paid.

### Administrative Agent

Global Benefits Group  
27422 Portola Parkway, Suite 110  
Foothill Ranch, CA 92610 USA

### Policy Disclaimer

This GBG Insurance Limited Policy is an international health insurance policy. As such, this Policy is subject to the laws of Guernsey, Channel Islands, and the insured should be aware that the laws governing the terms, conditions, benefits and limitations in health insurance policies issued and delivered in other countries including the United States are not applicable to this Policy, if any dispute arises as to the interpretation of this document, the English version shall be deemed to be conclusive and taking precedence over any other language version of this document..

**Deductible Options: Please refer to the Policy Face Page to determine the deductible amount that applies to your Policy.**

Option 1: \$1,000  
Option 2: \$5,000  
Option 3: \$10,000

## Administration

### Eligibility and Conditions of Coverage

#### Eligibility

- You must reside in Latin America or the Caribbean.
- Have not attained age 60 at the time of enrollment.
- Coverage terminates at the end of the Policy Period following attainment of age 75.
- Termination of the insurance of the primary member shall also cancel all coverage for dependents, except in the case of death.
- You may renew your policy if you reside outside of Latin America. The premium will be calculated at the rates applicable to the specific country where you reside.

#### Insured Dependents

Coverage under this Policy can be extended to the following family members. Insured Dependents may include:

- The spouse or domestic partner,
- Dependent children up to age 19 if single, or up to age 24 if single and a full-time student at an accredited college at the time the policy is issued and renewed. Dependents that are full-time students up to age 24 are charged the Child/Children rate.
- Dependents, which were covered under a prior policy with the insurer and are otherwise eligible for cover under their own separate policy, will be approved without underwriting for the same product with equal or higher deductible and with the same conditions and restrictions in effect under the prior policy. The health insurance application of the former dependent must be received before the end of the grace period for the policy which previously afforded coverage for the dependent.

Dependent children include the Policyholder's natural children, legally adopted children, and step children. Insured Dependents are covered from the date that the Insurer accepts them and the corresponding premiums are paid. Note that children over age 18 who have a child will need to apply for their own policy at the end of the Policy Period after they have attained the age of 18. Note that children age 19 or older who are not full time students should submit an application separate from their parent(s).

**Addition of a Newborn Baby or Legally Adopted Child During the Policy Year:** A newborn baby or adopted child may be covered providing the following applies.

- Application for the newborn baby must be made within 31 days of the date of birth, or
- The adopted child must be less than 19 years old, and
- The Insured will provide written notification to the Insurer (an official copy of the legal adoption papers or birth certificate is required with the notification), and
- A health application must be submitted detailing the medical history of the child.
- Coverage will be contingent upon the terms and conditions of the Policy
  - Coverage is not guaranteed and subject to underwriting approval. If approved, coverage will become effective as of the date of application.
  - Pre-existing conditions will not be covered.
  - The Elimination Period applies.



### **Pre-Existing Conditions and Eligibility**

Pre-Existing Conditions must be disclosed on the Application. Pre-existing conditions disclosed on the Application are only covered if named on the Policy Face Page accepting the condition as included and non-disclosed pre-existing conditions are never covered. See Definition for Pre-existing conditions. See the Policy Face Page for the terms and conditions regarding the issuance of this Policy.

### **Residency**

The permanent residence of the primary insured and all dependents is assumed to be in a country within Latin America or the Caribbean. If the insured or dependents change their residence to a different country, the Company must be notified in writing of their full-time residence immediately. GBG retains the right to modify the premium.

"Country of Residence" is defined as:

1. Where the Insured resides the majority of any calendar or policy year; or
2. Where the Insured has resided more than 180 days during any 12-month period while the policy is in effect.

## **Terms and Conditions**

### **Premium Payment**

All coverage under this Policy is subject to the timely payment of Premium, which must be made payable to the Insurer. Payment must be in the currency approved by the Insurer. Any other forms of currency shall not be accepted and will be considered as nonpayment of Premium unless otherwise agreed by the insurer. The policy and rates shall be guaranteed for one year and are continually subject to the terms in force at the time of each renewal date. All premiums are payable before coverage under this policy is provided.

### **Grace Period**

A grace period of 30 days, without interest charge, will be allowed for payment of any premium due after the first premium. During the grace period, Insurer will suspend coverage for 30 days if Premium is not received by the Premium Payment Date. If Premium is received within 30 days from the Premium Payment Date, coverage will resume without interruption in coverage.

If the Premium due is not paid within the grace period, Insurer will cancel the Policy as of the Premium Payment Date for which the grace period was in effect. All unpaid Premium through the date of termination is the obligation of the Policyholder.

If the Insurer receives written notice by the Policyholder of its intent to cancel the Policy, the Insurer will cancel the Policy on the later of:

- The date requested by the Policyholder but no greater than 30 days from the date notice was received by the Insurer; or
- The date the Insurer receives the notice.

All unpaid Premium through the date of cancellation is the obligation of the Policyholder and any other premium adjustments assessed as a result of cancellation.

There will be a service fee for any checks returned for insufficient funds, closed accounts, or for stop payments on checks. Returned checks will be treated as non-payment of Premiums.

### **Policy and Rate Modifications**

The Policy term begins on the Effective Date of the Policy as in the policy Face Page and ends at midnight 365 days later.

The Insurer has the right to modify premium, or rate basis, applying such changes to an entire class of insureds not any one individual on any Anniversary Date, unless there is a change in the number of Insureds or change in residence location of the Insureds. The Insurer must notify the Policyholder of the change at least 30 days before the Insurer makes the change.

### **Other Premium Changes**

Premium changes due to the following will occur automatically and will be charged from the date the change occurs:

- Addition of a new Insured; or
- Termination of an Insured;

Any such change will be prorated to the Premium payment period of the Policyholder and reflected on the Policyholder's next billing statement. Changes in an Insured Person's age are considered changes in the demographics of the Policyholder. Resulting premium changes will occur and are assessed upon renewal date.

### **Duration of Coverage**

Benefits are paid to the extent that an Insured Person receives any of the treatments covered under the Schedule of Benefits following the effective date, including any additional waiting periods and up to the date such individual no longer meets the definition of Insured Person.

### **Alterations**

The Insurer may modify this policy and rates on a class basis for this policy at renewal date. A copy of the current policy terms will be available to the Insured at such time.

### **Compliance with the Policy Terms**

Our liability under this policy will be conditional upon each Insured Person complying with its terms and conditions.

**Change of Risk** The policyholder must inform the Company as soon as reasonably possible, of any changes related to Insured Persons (such as change of address, occupation or marital status) or of any other material changes that affect information given in connection with the application for coverage under this policy. The Company reserves the right to alter the policy terms or cancel coverage for an Insured Person following a change of risk.

### **Cancellation**

The Company reserves the right to cancel any policy as described below:

- This policy will be canceled automatically upon nonpayment of the premium, although the Company may at their discretion reinstate the coverage if the premium is subsequently paid.
- If any premium due from the policyholder remains unpaid, the Company may in addition defer or cancel payment of all or any claims for expenditures incurred during the period it remains unpaid.
- While the Company shall not cancel this policy because of eligible claims made by any Insured Person, it may at any time terminate an individual /or any of their eligible dependents or subject his/her coverage to different terms if she/he or the policyholder has at any time:
  - Misled the Company by misstatement or concealment;
  - Knowingly claimed benefits for any purpose other than are provided for under this policy;
  - Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the Insurer detriment;
  - Failed to observe the terms and conditions of this policy, or failed to act with utmost good faith.
- The insurer retains the right to cancel, non-renew or modify a policy on a class basis as defined in this policy, and the insurer will offer the closest equivalent coverage possible to the insured. No individual insured shall be independently penalized by cancellation or modification of the policy due solely to a poor claim record.
- If the Company does cancel this policy, they shall give 30 days' notice. The Company will refund the unearned portion of the premium minus administrative charges and policy fees

If the Policyholder cancels the Policy after it has been issued, reinstated or renewed, the Insurer will not refund the unearned portion of the Premium.

### **Fraudulent/Unfounded Claims**

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

### **Jurisdiction**

This policy is governed by, and shall be construed in accordance with the laws of Guernsey, Channel Islands and shall be subject to the exclusive jurisdiction of its courts.

### **Privacy**

The confidentiality of information is of paramount concern to the GBG companies. GBG complies with Data Protection Legislation and Medical Confidentiality Guidelines. Information submitted to GBG over our website is normally unprotected until it reaches us. We do share information, but only as it pertains to the administration of your health care benefits.

### **Settlement of Claims**

All paid claims will be settled in the same currency as the premium currency. If the insured paid for treatment, or receives a bill for covered services in a currency other than premium currency, including bills sent directly to the Company or its Claims Administrator, such payments and bills shall be converted to premium currency at the exchange rate in effect at the time such service was rendered. The exchange rate will be determined by the Insurer acting reasonably.

### **Waiver**

Waiver by the Company of any term or condition of this policy will not prevent us from relying on such term or condition thereafter.

### **Transfer**

If the primary insured dies, this policy will automatically be transferred to the oldest Insured Person over the age of 18 years who shall, upon the death of the primary insured, become the primary insured for all the purposes of this policy and be responsible for paying the premium.

### **Denial of Liability**

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

## Claims

All claims worldwide are subject to Usual, Customary and Reasonable charges as determined by Insurer and are processed in the order in which they are received. In order for claims payment to be made, claims must be submitted in a form acceptable to Insurer. Claim forms can be obtained from our website at [www.gbg.com](http://www.gbg.com).

### Claims submitted by the provider:

The claims may be submitted to Insurer directly by the institution or provider. Bills coming from Providers within the United States should be submitted on HCFA 1500 or UB92 formats.

### Claims submitted by the Insured:

If the insured has already paid the institution or provider, The Insured must submit the claim with the itemized invoices, the original paid receipts, and claim form directly to Insurer. The original paid receipts must accompany such claims. Photocopies will not be accepted unless the claim is submitted electronically. Insurer will reimburse the Insured in accordance with the terms of this Policy. Refer to the Section entitled, How to File a Claim.

### Claim Payment Information:

All paid claims will be available to view on the [www.gbg.com](http://www.gbg.com) website. You must log in and then you will have access to claim status and claim payment or explanation of benefit information. All communication with regard to Explanation of Benefits will be electronic. Claim payments are subject to copayments, coinsurance, deductible and charges in excess of Usual, Customary and Reasonable.

### Releasing Necessary Information

The Insured agrees on behalf of him/herself and his Insured Dependent(s), to let any Physician, Hospital, Pharmacy or Provider give Insurer all medical information determined by Insurer to be necessary, including a complete medical history and/or diagnosis. Insurer will keep this information confidential. In addition, by applying for coverage, the Insured authorizes Insurer to furnish any and all records respecting such Insured Person including complete diagnosis and medical information to an appropriate medical review board, utilization review board or organization and/or to any administrator or other insurance carrier for purposes of administration of this Policy. There may also be additional health information requests from the Insured.

### Request for Reproduction of Records

Insurer reserves the right to charge a fee for reproductions of claims records requested by the Insured or his/her representative.

### Time Limits

Requests for payment of benefits must be received in Insurer's claims administrator office no later than **180 days** following the date on which the Insured received the service. Claims received after this date will be excluded from coverage.

Inquiries regarding past claims must be received within 12 months of the date of service to be considered for review.

### Coordination of Benefits

When an Insured Person has coverage under another insurance contract, including but not limited to health insurance, travel insurance, Medicare, Medicaid, worker's compensation insurance, automobile insurance (whether direct or third party), and occupational disease coverage, and a service received is covered by such contracts, benefits will be reduced under this Policy to avoid duplication of benefits available under the other contract including benefits that would have been payable had the Insured Person claimed for them.

In no event will more than 100% of the Allowable Charge and/or maximum benefit for the covered services be paid or reimbursed. It is the duty of the Insured to inform Insurer of all other coverage. United States citizens who are eligible for USA Medicare benefits must apply for coverage under those benefits for medical and prescription services obtained within the USA. The insurer has full right of subrogation. To determine the Primary Policy, the following guidelines will be used:

- If two Plans cover the claimant as an individual, the Plan that has covered him/her for the longer period of time is the Primary Plan.

### Subrogation/Indemnity

The insurer has a right of subrogation or reimbursement from or on behalf of an insured to whom it has paid any claims, if such insured has recovered all or part of such payments from a third party. Furthermore, the insurer has the right to proceed at its own expense in the name of the insured, against third parties who may be responsible for causing a claim under this policy or who may be responsible for providing indemnity of benefits for any claim under the policy.

## Plan Deductibles and Lifetime Maximums

### Deductible

Deductible is the first dollar amount paid by each of the Insured Persons of the allowable charges for eligible medical treatment expenses during each policy year before the Policy benefits are applied. The deductible accumulates on a combined basis for all countries. The deductibles is shown on the medical Identification Card and the Policy Face Page.

### Application of Deductible

When claims are presented to Insurer, the allowable charges will be applied towards the Deductible, and if applicable will then be calculated and reimbursed at the percentage listed on the Schedule of Benefits. Once the Deductible has been satisfied, all allowable expenses will be paid at a percentage of UCR up to the listed maximum amounts outlined in the Schedule of Benefits.

### Lifetime Maximum

Certain payment of Benefits are subject to a lifetime aggregate maximum per individual Insured Person as indicated in the Schedule of Benefits, as long as the Policy remains in force. The Lifetime Maximum includes all Benefit Maximums specified in this Policy, including those specified in the Schedule of Benefits, Policy Face Page and in any Policy Endorsements or Riders. Note that when an Insured Person reaches the age of 60, the Lifetime Maximum benefit is reduced. This amount is reflected on the Policy Face Page.

## Pre-Authorization Requirements and Procedures

Pre-Authorization is a process by which an Insured Person notifies the Insurer when a covered illness is diagnosed or covered event occurs. The Insurer will inform the Insured of the necessary process to obtain approval for non-emergency, medical procedures or treatments prior to the commencement of the proposed medical treatment, as well as assist with finding contracted providers. The Insured Person will be asked to submit a completed Pre-Authorization Request form to GBG Assist **a minimum of 5 business days prior** to the scheduled procedure or treatment date. GBG Assist will review the matter and respond to the Insured Person. To assure full reimbursement for covered services, written approval from GBG Assist must be received by the Insured Person prior to the commencement of the proposed medical treatment.

**Certain designated services require Pre-Authorization, and Insureds are required to follow the procedures outlined below. In certain geographic areas, or in accordance with specific policy features, Insureds may also be required to utilize the Insurer's Preferred Provider Organization (PPO) or Preferred Provider Network, (PPN).**

**The Insured Person must obtain a letter of authorization, prior to the performance of the services** for both Pre-authorization requests and Network information. Customer Service representatives are available 24 hours a day, every day. Network facilities can also be found at [www.gbg.com](http://www.gbg.com).

**Please note:** some treatment requests may require longer than 5 days for the review process to be completed.

**Medical Emergency Authorizations** must be received within 48 hours of the admission or procedure. In instances of medical emergency, the Insured should go to the nearest Hospital or provider for assistance even if that Hospital or provider is not part of the Network.

**Failure to obtain pre-authorization will result in a 40% reduction in payment of covered expenses. Any such penalty will apply to the entire episode of care. If treatment would not have been approved by the pre-authorization process, all related claims will be denied.**

Notwithstanding the requirement to pre-authorize:

- Pre-Authorization approval does not guarantee payment of a claim in full, as deductibles, charges in excess of Usual, Customary and Reasonable and out of pocket charges may apply.
- Benefits payable under the Policy are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Policy.

## Preferred Provider Network

For your convenience the Company maintains a Preferred Provider Network both inside and outside the United States. Please visit [www.gbg.com](http://www.gbg.com) for a complete list of providers.

**Outside the United States:** The insured may utilize any licensed provider.

**In the United States:** The insured must utilize an In-Network Preferred Provider. If an Out-of-Network provider is utilized, no benefits are payable.

For information on the providers and facilities within the Preferred Provider Network, consult GBG Assist at the number on the medical I.D. card or [www.gbg.com](http://www.gbg.com).

## Health Care Coverage and Benefits

### Scope of Coverage

The Policy covers the Insured Persons for Allowable Charges for covered medical services only for the illnesses and events specified in this Policy, provided in the areas of coverage selected in the Policy Face Page, including hospitalization, surgery, out-patient services, medical treatment and medical supplies incurred while such Insured Person is enrolled under the Policy. Such services must be recommended or approved by a licensed medical professional. They must also be essential and Medically Necessary, in the Insurer's judgment, for the treatment of an Insured Person's injury or sickness for which insurance is provided under the Policy.

**Areas of Coverage** – The Policy area of coverage is Worldwide.

### Schedule of Benefits and Policy Face Page

All benefits of this Policy are payable in accordance with the Schedule of Benefits and the Policy Face Page in effect at the time the services are rendered. The Schedule of Benefits and the Policy Face Page contains payment levels, benefit limitations, benefit maximums and other applicable information. Receipt of the current Schedule of Benefits and the Policy Face Page by the Policyholder shall constitute delivery to the Insured. Payment of Benefits as set forth in the Schedule of Benefits is subject to the Policy Year Deductible, Co-payments and any other limitations set forth in the policy, unless otherwise noted.

## Inpatient Hospital Benefits

### Inpatient Services

Hospitalization services include, but are not limited to, private and semi-private room and board (as listed in the Schedule of Benefits), general nursing care and the following additional facilities; services and supplies as Medically Necessary and approved and covered by the Policy, meals and special diets (only for the patient), use of operating room and related facilities, use of intensive care and cardiac units, and related services to include X-ray, laboratory and other diagnostic tests, drugs, medications, biological anesthesia and oxygen services, radiation therapy, inhalation therapy, chemotherapy and administration of blood products.

Benefits are provided per the Schedule of Benefits for medically necessary inpatient Hospital care.

- Accommodations: All charges in excess of the allowable private and semi-private rate are the responsibility of the Insured.
- Intensive Care Units: Benefits will be provided based on the Allowable Charge for medically necessary Intensive Care services.

### Inpatient Ancillary Hospital Services

If medically necessary for the diagnosis and treatment of the illness or injury for which an Insured Person is hospitalized, the following services are also covered:

- Use of operation room and recovery room;
- All medicines listed in the U.S. Pharmacopoeia or National Formulary;
- Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services
- Surgical dressings;
- Laboratory testing;
- Durable medical equipment;
- Diagnostic X-ray examinations;
- Radiation therapy rendered by a radiologist for proven malignancy or neoplastic diseases;
- Respiratory therapy rendered by a Physician or registered respiratory therapist;
- Chemotherapy rendered by a Physician or Nurse under the direction of a Physician;
- Physical and Occupational therapy (if covered) must be rendered by a Physician or registered physical or occupational therapist and relate specifically to the physician's written treatment plan.
- Therapy must:
  - Produce significant improvement in the Insured's condition in a reasonable and predictable period of time, and
  - Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist, or
  - Be necessary to the establishment of an effective maintenance program. Maintenance itself is not covered.

## Surgical and Medical Benefits

### Surgical Services

Insurer will provide benefits for covered surgical services received in a Hospital, a Physician's office or other approved facility. Surgical services include operative and cutting-procedures, treatment of fractures and dislocations and obstetrical delivery. When medically necessary, assistant surgical fees will be paid.

### Anesthesia Services

Benefits are provided for the service of an anesthesiologist, other than the operating surgeon or his/her assistant, who administers anesthesia for a covered surgical or obstetrical procedure.

### Inpatient Medical Services

Insurer will reimburse one Physician visit per day while the Insured is a patient in a Hospital or approved Extended Care Facility. Visits that are part of normal preoperative and postoperative care are covered under the surgical fee and Insurer will not pay separate charges for such care. If medically necessary, Insurer may elect to pay more than one visit of different physicians on the same day if the physicians are of different specialties. When lengthy, prolonged or repeated inpatient visits by the Physician are necessary because of a Critical Condition, payment for such intensive medical services is based on each individual case. Insurer will require submission of records and other documentation of the medical necessity for the intensive services. Inpatient Medical Services are payable in accordance with the current Schedule of Benefits.

### Inpatient Care Duration/ Inpatient Extended Care

Inpatient hospital confinements, where an overnight accommodation, ward, or bed fee is charged, will only be covered for as long as the patient meets the following criteria:

- The patient's medical status continues to require either acute or sub-acute levels of curative medical treatment, skilled nursing, physical therapy, or rehabilitation services. .

Inpatient hospital confinements primarily for purposes of receiving non-acute, long term custodial care, chronic maintenance care, or assistance with Activities of Daily Living (ADL), or where the procedure could have been done in an outpatient setting are not eligible expenses.

### Extended Care Facility Services, Skilled Nursing and Inpatient Rehabilitation

Inpatient confinement and services provided in an approved extended care facility following or in lieu of, an admission to a Hospital as a result of a covered illness, disability or injury. Care provided must be at a skilled level and is payable in accordance with the current Schedule of Benefits. Intermediate, custodial, rest and homelike care services will not be considered skilled and are not covered.

Coverage for confinement is subject to Insurer approval. Covered services include:

- Skilled nursing and related services on an inpatient basis for patients who require medical or nursing care for a covered illness.
- Rehabilitation for patients who require such care because of a covered illness, disability or injury.
- Therapy must:
  - Produce significant improvement in the Insured's condition in a reasonable and predictable period of time, and
  - Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist, or
  - Be necessary to the establishment of an effective maintenance program. Maintenance itself is not covered.

Pre-authorization by GBG Assist is mandatory if more than 4 visits are required. Insurer has the right to review a confinement, as it deems necessary, to determine if the stay is medically appropriate. A confinement includes all approved extended care facility admissions not separated by at least 180 days.

## Outpatient Services

### Outpatient Physician Visits

Insurer provides benefits for medical visits to a Physician/Specialist in the physician's office if medically necessary and as follow-up care to a covered hospitalization. Benefits are limited to one visit per day per insured person. Services for routine physicals including related diagnostic services are not covered. All outpatient visits are payable in accordance with the Schedule of Benefits.

## Other Benefits

### Transplant Procedures (Human Organ, Bone Marrow, Blood and Stem Cell)

This coverage applies only when the transplant recipient is an Insured Person under this Policy. In the United States, GBG offers the use of the Institutes of Excellence for Transplants (Preferred Providers Network). This transplant benefit begins once the need for transplantation has been determined by a physician and has been certified by a second surgical or medical opinion, and includes:

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



- Pre-surgical workup including all laboratory and X-ray exams, CT scans, Magnetic Resonance Imaging(MRI's), ultrasounds, biopsies, scans, medications and supplies is included.
- The costs of organ, cell or tissue procurement, transportation and harvesting including bone marrow and stem cell storage or banking are covered up to a maximum as listed in the Schedule of Benefits which are included as part of the maximum transplant benefit. The donor workup, including testing of potential donors for a match is included in this benefit.
- The hospitalization, surgeries, physician and surgeon's fees, anesthesia, medication and any other treatment necessary during the transplant procedure is included.
- Post –transplant care including but not limited to any medically necessary follow-up treatment resulting from the transplant and any complications that arise after the transplant procedure, whether a direct or indirect consequence of the transplant is included.
- Medication or therapeutic measures used to ensure the viability and permanence of the transplanted organ, cell or tissue is included.
- Home healthcare, nursing care (e.g. wound care, infusion, assessment, etc.), emergency transportation, medical attention, clinic or office visits, transfusions, supplies, or medication related to the transplant is included.

### Hospice Program

Hospice is a program approved by the Insurer to provide a centrally administered program of palliative and supportive services to terminally ill persons and their families. Terminally ill means the patient has a prognosis of 240 days or less. Services are provided by a medically supervised interdisciplinary team of professionals and volunteers.

Covered services are available in home, outpatient (following an Inpatient Hospitalization) and inpatient settings up to the amount listed on the Schedule of Benefits. Admission to a hospice program is made on the basis of patient and family need.

The Hospice care:

- Must relate to a covered medical condition that has been the subject of a prior valid claim with the Insurer, with a diagnosis of terminal illness from medical doctor;
- Benefits are provided as outlined in the Schedule of Benefits as an outpatient, per insured;
- Benefit is payable only in relation to care received by a recognized hospice.

### Home Health Care Including Private Duty Nursing, Skilled Nursing, Visiting Nurse

An initial period of 30 days will be covered if preapproved. An advanced treatment plan signed by the treating Physician is required for the proper treatment of the illness or injury and used in place of in-patient treatment. Home health care includes the services of a skilled licensed professional (nurse or therapist) outside the hospital and does not include custodial care.

These services need to meet specified medical and circumstantial criteria to be covered. Thorough case manager review is required.

1. The Insurer considers home nursing care medically necessary when recommended by the member's primary care and/or treating physician and **both** of the following circumstances are met:
  - Member has skilled needs; **and**
  - Placement of the nurse in the home is done to meet the skilled needs of the member only; not for the convenience of the family caregiver.
  - Therapy must:
    - Produce significant improvement in the Insured's condition in a reasonable and predictable period of time, and
    - Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist, or
    - Be necessary to the establishment of an effective maintenance program. Maintenance itself is not covered.

Ongoing skilled home nursing care is not considered medically necessary for Insured's who are on bolus nasogastric (NG) or gastrostomy tube (GT) feeds and do not have other skilled needs. Home nursing care may be considered medically necessary for these Insured's only as a transition from an inpatient setting to the home.

### Prescription Drugs

Prescription drugs are medications which are prescribed by a physician and which would not be available without such prescription. Certain treatments and medications, such as vitamins, herbs, aspirin, and cold remedies, medicines, experimental or Investigative drugs, or supplies, even when recommended by a physician, do not qualify as prescription drugs. Any drug that is not scientifically or medically recognized for a specific diagnosis or that is considered as off label use, experimental, or not generally accepted for use will not be covered, even if a Physician prescribes it. Highly specialized drugs are not part of this benefit.

This benefit is subject to the deductible. Refer to Schedule of Benefits for details.

### Special Treatments and Highly Specialized Drugs

- Prosthesis, appliances, orthotic durable medical equipment, and implants will be covered, but must be pre-authorized in advance by GBG Assist.

- Highly specialized drugs for specific uses will be covered but must be pre-authorized and coordinated in advance by GBG Assist. These drugs are; Interferon beta-1-a, PEGylated Interferon Alfa 2a, Alfa, Interferon beta-1-b, Etanercept, adalimumab, Bevacizumab, Cyclosporine A, Azathioprine, and Rituximad.

### **Durable Medical Equipment**

Insurer provides benefits for prosthetic devices (artificial devices replacing body parts), orthopedic braces and durable medical equipment (including wheelchairs and hospital beds). The contract will pay the Reasonable and Customary Charges for Artificial Devices listed, provided such durable medical equipment (DME) is:

1. Prescribed by a Physician, and
2. Customarily and generally useful to a person only during an illness injury, and
3. Determined by Insurer to be medically necessary and appropriate.

Insurer will allow for two breast prosthesis for cancer patients who have a Mastectomy while covered under this Policy. Bras will be a covered expense.

Allowable rental fee of the Durable Medical Equipment must not exceed the Purchase price. Benefits are payable in accordance with the current Schedule of Benefits.

Charges for repairs or replacement of artificial devices or other Durable Medical Equipment originally obtained under this Policy will be paid at 50% of the allowable reasonable and customary amount.

Durable Medical Equipment **does not** include: motor driven wheelchairs or bed; more wheels; comfort items such as telephone arms and over bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies; exercycles, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment; and similar items or the cost of instructions for the use and care of any durable medical devices. The customizing of any vehicle, bathroom facility, or residential facility is also excluded.

### **Prosthetic Limbs**

Includes artificial arms, hands, legs, and feet and are covered up to the maximum benefit shown in the Schedule of Benefits. The benefit includes all the costs associated with the procedure, including any therapy related to the usage of the new limb. Prosthetic limbs will be covered when the individual does not have a significant cardiovascular, neuromuscular, or musculoskeletal condition which would be expected to adversely affect or be affected by the use of the prosthetic device.

Repair of the prosthetic limb is covered only when anatomical or functional change or reasonable wear and tear renders the item nonfunctional and the repair will make the equipment usable.

Replacement of the prosthetic limb is covered only when anatomical or functional change or reasonable wear and tear renders the item non-functional and non-reparable. Initial coverage, repair, and/or replacement of prosthetic limbs must be pre-authorized by GBG Assist

Special high performance prosthetics for sports or improvement of sports performance will not be covered by this benefit.

### **Emergency Ambulance Services / Medical Evacuation**

#### **Emergency Ground Ambulance Services**

Benefits are provided for medically necessary emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care and are payable in accordance with the current Schedule of Benefits. The use of ambulance services for the convenience of the insured, which are not medically necessary, will not be considered a covered service.

#### **Air Ambulance and Medical Evacuation**

Utilization of the medical evacuation provision requires the prior approval of GBG Assist. In the event of an emergency that may require medical evacuation, contact GBG Assist in advance in order to approve and arrange such Emergency Medical Air Transportation. If the Insured fails to follow these conditions, he or she will be liable for the full costs of any transportation. GBG Assist, on behalf of the insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. GBG Assist contact information can be located on the insured's I.D. card. The cost of a person accompanying an Insured Person is covered under this policy

- Emergency evacuation is only covered if related to a covered condition for which treatment cannot be provided locally, and transportation by any other method would result in loss of life or limb. GBG Assist, on behalf of the insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. Emergency transportation must be provided by a licensed and authorized transportation company to the nearest medical facility. The vehicle or aircraft used must be staffed by medically trained personnel and must be equipped to handle a medical emergency.
- **Approved medical evacuations will be to the nearest medical facility capable of providing the necessary medical treatment.** GBG Assist contact information can be found on the medical I.D. card.



- The insured agrees to hold the Insurer and any company affiliated with the insurer by way of similar ownership or management, harmless from negligence resulting from such services, or negligence regulating from delays or restrictions on flights caused by the pilot, mechanical problems, or governmental restrictions, or due to operational conditions.
- Within ninety days of the medical evacuation, the return flight for the covered person and an accompanying person will be reimbursed up to the cost of an airplane ticket in economy class only to the covered person's Country of Residence – Maximum \$2000 per person.

#### Repatriation of Mortal Remains

The necessary clearances for the return of an Insured Person's mortal remains by air transport to the Country of Residence will be coordinated by Insurer's GBG Assist department.

A benefit for either repatriation of mortal remains or local burial is included under this policy. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar personal burial preferences.

Refer to Schedule of Benefits for details.

## Exclusions and Limitations

All services and benefits described below are excluded from coverage or limited under your policy of Insurance.

1. Charges in excess of Usual, Reasonable and Customary allowable charges for any covered procedure.
2. Charges for illnesses or events not specifically covered under this Policy.
3. Pre-existing medical conditions defined as any illness or injury, physical or mental condition, for which the Policyholder has received any diagnosis, medical advice, consultation or treatment, or had taken any prescribed drug, or where distinct symptoms were evident at any time previous to the effective date of the Policy or before the end of the Elimination Period.
4. Charges incurred in the United States when an out-of-network provider is used.
5. Claims and costs for medical treatment, occurring before the effective date of coverage (including waiting periods) or after the expiration date of the policy. Claims and costs for medical services with dates of service after the policy termination date that are related to accidents, sicknesses, or maternity originating during the policy year, unless the policy has been renewed. This includes any portion of a covered prescription to be used after the expiration of the current policy year.
6. Services, supplies, or treatment including drugs and/or emergency services that are provided by or payment is available from; (a) Workers' Compensation law, Occupational Disease law or similar law concerning job related conditions of any country, (b) the Insured Person, a family member or any enterprise owned partially or completely by the aforementioned persons, (c) another insurance company or government, (d) under the direction of public authorities related to epidemics.
7. Services, supplies or treatments, including drugs, that are not scientifically or medically recognized for a specific diagnosis, or that is considered as off label use, experimental or not approved for general use are considered experimental or investigational and therefore not eligible services..
8. Any services, supplies, treatments including drugs and/or emergency air services; (a) not ordered by a Physician, (b) not medically necessary, not recommended or approved by a physician, (c) not rendered under the scope of the Physician's licensing, (d) medical and dental services that do not meet professionally recognized standards or are determined by Insurer to be unnecessary for proper treatment.
9. Telephonic consultations, missed appointments, or "after hours" expenses.
10. Personal comfort and convenience items including but not limited to television, housekeeping services, telephone charges, take home supplies, ambulance services (other than those provided by this Policy), and all other services and supplies that are not medically necessary including expenses related to travel and hotel costs incurred for medical or dental care.
11. Rest cures, custodial care, home-like care, assistance with activities of daily living (ADL), milieu therapy for rest and/or observation; whether or not prescribed by a Physician. Any admission to a nursing home, home for the aged, long term care or rehabilitation facility, sanatorium, spa, hydro clinic or similar facilities that do not meet the policy definition of a hospital. Any admission, arranged wholly or partly for domestic reasons, where the hospital effectively becomes or could be treated as the Insured's home or permanent abode.
12. Treatment of any illness arising directly or indirectly from alcohol or drug abuse or addiction. This includes but is not limited to treatment for any injuries caused by, contributed to or resulting from the Insured's use of alcohol, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purposed prescribed by the Insured's Doctor.
13. Treatment for any conditions as a result of self-inflicted illnesses or injuries, suicide or attempted suicide, while sane or insane, or emergency air services for the same.
14. Injuries and/or illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law by an Insured Person.
15. Durable Medical Equipment consisting of the following: motor driven wheelchairs or bed; additional wheels; comfort items such as telephone arms and over bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies; exercycles, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment; and similar items or the cost of instructions for the use and care of any durable medical devices. The customizing of any vehicle, bathroom facility, or residential facility is also excluded.
16. Health care services associated with conditions as a result of travel, following the receipt of advice against travel because of health reasons from any health care provider.
17. Any expense for the treatment of a mother or newborn child related to a maternity, maternity complications, or birth complications.
18. Hearing Aids, Hearing Devices and Bone Anchored Hearing Aids.

19. Exceptional Risks; (a) treatment as a consequence of injury sustained while participating in a hazardous activity or training for professional sports; (b) treatment as a consequence of injury sustained while participating in, or training for, war (declared or not), acts of terrorism, acts of foreign enemy hostilities, civil war, rebellion, revolution or insurrection; (c) chemical contamination; (d) contamination by radioactivity from any nuclear material or from the combustion of nuclear fuel (e) treatment for any loss or expense of nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily injury, except in an endeavor to save human life.
20. Treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the HIV Virus.
21. This Policy will not cover any services or accidents or injuries received by any parties or in any countries where otherwise prohibited by the US/UN/EU economic or trade sanctions.
22. Transient Ischemic Attack (TIA).
23. Cancer limited to the following:
  - Non-Invasive carcinoma-in-situ,
  - All forms of Lymphoma in the presence of any Human Immunodeficiency Virus (HIV),
  - Kaposi's Sarcoma in the presence of any Human Immunodeficiency Virus (HIV),
  - Any skin cancer other than invasive malignant Melanoma,
  - Tumors which are historically described as pre-malignant, showing early malignant change or having malignant potential,
  - Stage 1 Hodgkin's disease

## How to File a Claim

Claims Forms are downloadable from [www.gbg.com](http://www.gbg.com). International Claims Services (ICS) can also send Claims Forms by e-mail, upon request. International Claims Services must receive completed forms within **180 days** of treatment to be eligible for reimbursement of covered expenses.

The claim form is to be used only when a provider does not bill the Company directly, and when you have out-of-pocket expenses to submit for reimbursement. All claims forms must have itemized bills and receipts attached, and should include the following information: name of patient; printed invoice number; name and entity of medical practitioner or institution; description of services rendered. Prescriptions must accompany all pharmacy bills.

### Mail the Claim Form and documentation to:

INTERNATIONAL CLAIMS SERVICES  
7600 Corporate Center Drive, Suite 500  
Miami, FL 33126 USA

### Submission of claims by Scan or Online

- Scan claims to: [eclaims360@gbg.com](mailto:eclaims360@gbg.com)
- Log-on to [www.gbg.com](http://www.gbg.com)

Upon the first medical diagnosis of an insured Critical Illness condition, the Insurer shall be notified within 30 days. In addition, the following initial documents will be submitted to the Insurer:

1. A detailed medical report on the diagnosis, onset and course of the insured Critical Illness;
2. All medical history records initially to be obtained from the attending physician. Additional medical records may need to be requested from other sources to substantiate the claim for benefits.

### Status of claims

Insured's wishing to request the status of a claim or have a question about a reimbursement received, please submit the status request form via our website at [www.gbg.com](http://www.gbg.com) or e-mail customer service at [claims@gbg.com](mailto:claims@gbg.com). Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review. Claim Payment Information including status and payment (EOB)'s will be available electronically for your review.

### Claims Appeal

#### International Claims Services

Attention: Appeals Department  
27422 Portola Parkway, Suite 110  
Foothill Ranch, CA 92610 USA

Appeals should be submitted within 60 days of receiving your processed claim. Upon appeal, the member will pay any fees associated with the request of medical records. The ICS appeals committee will review your information and provide a response within 30 business days of receipt. For more detailed information regarding the appeals process, please visit the website.

## GBG Assist

GBG Assist must be contacted for the following services:

- Notification of a critical illness or covered event and Pre-Authorization of medical services
- Emergency Services / Medical Evacuation
- Locating preferred providers
- Case management

The Company has selected GBG Assist to provide these services. Insureds may be required to receive approval from GBG Assist prior to receiving certain treatment. (See also *Pre-authorization Section*.) Through this process, GBG Assist will:

- Verify coverage of Insured's.
- Determine whether the services or supplies are covered.
- Ensure treatment is medically necessary
- Minimize out-of-pocket costs to the member.

The Company retains the right to refer certain large claims to GBG Assist, which will then be responsible for establishing and monitoring the scope and nature of the care provided. When the Company elects to refer a claim to GBG Assist, in order for treatment to continue to be eligible for reimbursement under the policy, the member will be required to follow the procedures indicated by GBG Assist.

GBG Assist will guide you to appropriate facilities and will evaluate the medical necessity of the recommended treatment. The intention of this process is not to substitute for the medical judgment of your physician, as the ultimate decision for treatment is up to the patient. Regardless of the decisions taken by the patient, coverage under this policy is subject to all stated limitations and exclusions as well as a consideration of the medical necessity of the proposed treatment and the effective management of health care costs. Treatment is approved and monitored by GBG Assist, which will be the sole determinant of the nature and scope of treatment.

### **For Treatment in All Countries except for Brazil: GBG ASSIST (24 hours)**

- Inside USA/Canada Toll Free: +1.866.914.5333
- Worldwide Collect: +1.905.669.4920
- Email: [GBGAssist@gbg.com](mailto:GBGAssist@gbg.com)

### **For Treatment in Brazil: WORLD ASSIST (24 hours)**

- Worldwide Collect + 55.213231.6307
- Fax + 55.212224.7364
- E-mail [assistant@worldassist.us](mailto:assistant@worldassist.us) and [callcenter@worldassist.com.br](mailto:callcenter@worldassist.com.br)

## Definitions

Certain words and phrases used in this Policy are defined below. Other words and phrases may be defined where they are used.

**Accident** – Any sudden and unforeseen event occurring during the policy year period, resulting in bodily injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control.

**Active Service/Actively at work** – An individual will be considered in active service on any day if he/she is then performing in the customary manner all the regular duties of his/her employment as performed or were capable of being performed on the last regularly scheduled work day.

**Activities of Daily Living (ADL)** – Activities of daily living are those activities normally associated with the day-to-day fundamentals of personal self-care, including but not limited to: walking, personal hygiene, sleeping, toilet/continence, dressing, cooking/feeding, medication and transferring (getting in and out of bed).

**Acute Care** – Medically necessary, short-term care for an illness or injury characterized by rapid onset, severe symptoms, and brief duration, including any intense symptoms, such as severe pain.

**Admission** means the period from the time that an Insured Person enters a Hospital, Extended Care Facility or other approved health care facility as an inpatient until discharge.

**Air Ambulance** means an aircraft specially equipped with the necessary medical personnel, supplies and Hospital equipment to treat life-threatening illnesses and/or injuries for persons whose conditions cannot be treated locally and must be transported by air to the nearest medical center that can adequately treat their conditions. This service requires pre-authorization. A commercial passenger airplane does not qualify as an air ambulance.

**Allowable Charge** means the fee or price Insurer determines to be the Usual, Reasonable and Customary Charge for health care services provided to Insured Persons that are covered under the Policy. The Insured Person is responsible for the payment of any balance over the Allowable Charge (except in the U.S. when a Preferred Provider has delivered coverage, then there is no balance due). All services must be medically necessary. Once an allowable charge is established then the deductible, co-payments and any excess charges must be paid by the Insured.

**Ambulatory Surgical Center** means a facility which: (a) has as its primary purpose to provide elective surgical care; and (b) admits and discharges a patient within the same working day; and (c) is not part of a Hospital. "Ambulatory Surgical Center" does not include: (1) any facility whose primary purpose is the termination of pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained by a Dentist for the practice of Dentistry.

**Bereavement Counseling** – Counseling of a terminally ill or deceased member's family by a licensed counselor, psychiatrist, psychologist, or pastor. Benefits for Bereavement Counseling are eligible for coverage only under the Outpatient Mental Health benefit of this Policy.

**Cardiologist** is a physician who specializes in the diagnosis and treatment of disorders of the heart.

**Class.** The insureds of all policies of the same type, including but not limited to benefits, deductibles, age group, country, product, plan, year groups, or a combination of any of these.

**Consultant or Specialist** is a senior Physician who has completed all of their general medical training and who has chosen to take additional training in specific medical areas in order to advise hospitals, medical groups, physicians, or individuals in their specific area of medical expertise.

**Coronary Artery Diseases and Peripheral Vascular Disease.** Coronary Artery Disease is defined as a disease of the arteries that supply blood to the heart muscle, causing damage to or malfunction of the heart. Peripheral Vascular Disease is defined as narrowing of blood vessels in the legs, and sometimes in the arms, restricting blood flow and causing pain and other medical complications in the affected area.

**Confinement** means an inpatient stay at an approved extended care facility for necessary skilled treatment or rehabilitation in accordance with the contract.

**Country of Residence** means the country where; a) the insured resides the majority of any calendar or policy year, or b) where the insured has resided more than one hundred eighty continuous days during a calendar year.

**Covered Expenses** means the Reasonable and Customary charges incurred by an Insured Person, while covered under this Policy, for Medically necessary services, treatments or supplies described under the provisions titled Covered Medical Expenses and, if applicable, Covered Dental Expense and/or Covered Vision Expense.

**Critical Condition** – An immediate life threatening or perilous illness or conditions due to an accident or natural causes, which requires urgent specialized treatment without delay.

**Custodial Care** includes: (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and (3) rest cures, respite care and home care provided by family Insureds. Upon receipt and review of a claim, the Insurer or an independent medical review will determine if a service or treatment is Custodial Care.

**Dangerous or Hazardous Activities** means any activity that exposes the participant to any foreseeable danger or risk. Examples of dangerous or hazardous activities include, but are not limited to aviation sports, rafting or canoeing involving white water rapids in excess of grade 5, tests of velocity, scuba diving at a depth of more than thirty meters, bungee jumping, and participation in any extreme sport.

**Deductible**, whether the Individual Annual Deductible, the Family Annual Deductible, the Annual Dental Deductible or any other deductible as set forth in the Schedule of Benefits, means the amount of covered Allowable Charges payable by the Insured during each policy year before the Policy benefits are applied. Such amount will not be reimbursed under the Policy.

**Dependent** a member of the Insured's family who is enrolled under the policy with the Company after meeting all the eligibility and requirements and for whom premiums have been received by the Company (See Eligibility and Conditions of Coverage Section).

**Domestic Partner** is a person of the opposite sex or same sex with whom the Policyholder has established a domestic partnership

**Domestic Partnership** is a relationship between the Policyholder and one other person of the opposite or same sex. All the following requirements apply to both persons:

- They must not be currently married to or be a domestic partner of another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age
- They must be mentally competent to consent to contract.
- They must be financially interdependent and must have furnished documents to support at least 2 of the following conditions of such financial interdependence:
  - They must have a single dedicated relationship of at least 1 year;
  - They have joint ownership of a residence;
  - They have at least 2 of the following
    - A joint ownership of an automobile,
    - A joint checking, bank or investment account
    - A joint credit account
    - A lease for a residence identifying both partners as tenants
    - A will or life insurance policy which designates the other as primary beneficiary

**Durable Medical Equipment** means orthopedic braces, artificial devices replacing body parts and other equipment customarily and generally useful to a person only during an illness or injury and determined by Insurer to be medically necessary. See DME Section for more details and services that are not consider eligible DME benefits.

**Eligibility** means the requirements that an Insured, including the primary Insured person and/or his dependent's must meet at all times in order to be covered under the this Contract. (See *Eligibility and Conditions of Coverage Section*.)

**Elimination Period** means the number of days that must be satisfied after the Policy commencement date before a benefit will be paid.

**Emergency Medical Transportation** – In the event of a Life Threatening emergency, when appropriate treatment is not available locally, this policy provides Emergency Medical Transportation to the closest medical facility capable of providing the required care. Should treatment be available locally, but if the Insured Person chooses to be treated elsewhere, transportation expenses shall be the responsibility of the Insured Person.

In the event of such emergency, GBG Assist must be contacted in advance in order to approve and arrange such Emergency Medical Air Transportation. GBG Assist, on behalf of the insurer, retains the right to decide the medical facility to which the Insured Person shall be transported and the means of transportation. If the person chooses not to be treated at the facility and location arranged by GBG Assist, then transportation expenses shall be the responsibility of the Insured Person. All emergency medical transportation must be arranged, in advance, with GBG Assist at the telephone number located on the back of the Insureds I.D. card. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

**Enrollment Effective Date** means the date upon which an Insured Person's coverage will become effective under this Policy, as determined by the Policyholder or otherwise.

**Examinations** – The Company and the Claims Administrator shall have the right and opportunity, through their medical representatives, to examine any person whenever and as often as they may reasonably require within the duration of any claim. The Insured Person shall make available all medical reports and records, as well as requested health information questionnaires, and where required, shall sign all authorization forms necessary to give the Company

a full and complete medical history. The Company and the Claims Administrator shall have the right and the opportunity to require an autopsy in the case of death, unless forbidden by law or religious beliefs.

**Experimental and/or Investigational** means any treatment, procedure, technology, facility, equipment, drug, drug usage, device, or supplies not recognized as accepted medical practice in the United States or by Insurer.

**Extended Care Facility** means a nursing and/or rehabilitation center approved by Insurer that provides skilled and rehabilitation services to patients who are discharged from a Hospital or who are admitted in lieu of a Hospital stay. The term Extended Care Facility does not include nursing homes, rest home, health resorts, homes for the aged, infirmaries or establishments for domiciliary care, custodial care, care of drug addicts or alcoholics, or similar institutions.

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

**Highly Specialized Drugs** mean drugs with a high unit cost that have a significant role in maintaining patients in an out-patient setting, prescribed and supervised by a specialist to treat conditions that are uncommon, severe, or resistant to first line treatment.

**Home Health Care Agency** means an agency or organization, or subdivision thereof, that; a) is primarily engaged in providing skilled nursing services and other therapeutic services in the Covered Person's home; b) is duly licensed, if required, by the appropriate licensing facility; c) has policies established by a professional group associated with the agency or organization, including at least one Physician and one registered graduate nurse (R.N.), to govern the services provided; d) provides for full-time supervision of such services by a Physician or by a Registered Nurse (R.N.); e) maintains a complete medical record on each patient; and f) has a full-time administrator.

**Home Health Care Plan** means a program: a) for the care and treatment of an Insured Person in his home; b) established and approved in writing by his attending Physician; and c) Certified, by the attending Physician, as required for the proper treatment of the injury or illness, in place of inpatient treatment in a Hospital or in an Extended care Facility.

**Hospice** means an agency which provides a coordinated plan of home and inpatient care to a terminally ill person and which meets all of the following tests: a) has obtained any required state or governmental license or Certificate of Need; b) provides service 24-hours-a-day, 7 days a week; c) is under the direct supervision of a Physician; d) has a nurse coordinator who is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.); e) has a duly licensed social service coordinator; f) has as its primary purpose the provision of Hospice services; g) has a full-time administrator; and h) maintains written records of services provided to the patient.

**Hospital** means and includes only acute care facilities licensed or approved by the appropriate regulatory agency as a hospital, and whose services are under the supervision of, or rendered by a staff of physicians who are duly licensed to practice medicine, and which continuously provides twenty-four (24) hour a day nursing service under the direction or supervision of registered professional nurses. The term Hospital does not include nursing homes, rest home, health resorts, and homes for the aged, infirmaries or establishments for domiciliary care, custodial care, care of drug addicts or alcoholics, or similar institutions.

**Identification Card (I.D. card)** – The card provided to each Insured and his Insured Dependents, which outlines the policy benefits, name of the policyholder, Insured Persons, and endorsements, if any. On this card, insureds will find benefit information, as well as contact information for submitting claims and emergency medical treatment. Insureds may in certain circumstances have two identification cards.

**Inpatient** means a person admitted to an approved Hospital or other health care facility for a medically necessary overnight stay.

**Insured Dependent** means a Dependent of an Insured who is enrolled for and is entitled for coverage under this Policy and for whom the required Premium has been paid.

**Insured Person** means an Insured or his Insured Dependents enrolled for and entitled to coverage under this Policy and for who the required Premium has been paid.

**Invasive Malignant Melanoma** is an aggressive cancerous tumor of the pigmented cells of the skin that is spreading and cutting through the deeper tissue such as lymph nodes.

**Kaposi's sarcoma** is a multifocal malignant neoplasm of primitive vasoformative tissue, occurring in the skin and sometimes in the lymph nodes or viscera, consisting of spindle cells and irregular small vascular spaces frequently infiltrated by hemosiderin-pigmented macrophages and extravasated red blood cells. Clinically manifested by cutaneous lesions consisting of reddish-purple to dark-blue macules, plaques, or nodules; seen most commonly in men older than 60 years of age and in AIDS patients, as an opportunistic disease associated with human herpes virus-8 infection.

**Life Threatening Emergency**- An injury or illness that is acute, with sudden onset of symptoms and poses an immediate risk to a person's life or long term health. The following signs and symptoms include but is not limited to such emergencies; respiratory distress or cessation of breathing, severe chest pains, shock, uncontrolled bleeding, choking, poisoning, prolonged unconsciousness, severe burns, any complaint or observation which indicates head or spinal cord injury.



**Lifetime Maximum** means the payment specified in the Schedule of Benefits, which is the maximum amount payable by Insurer over the course of Insured Person's lifetime, regardless of changes in coverage of benefit plan.

**Lymphoma** is a type of cancer that begins in immune system cells called lymphocytes. Like other cancers, Lymphoma occurs in a state of uncontrollable cell growth and multiplication.

**Maximum Benefit** means the payment specified in the Schedule of Benefits, for specific services, which is the maximum amount payable by Insurer per person, per policy year (unless otherwise noted) regardless of the actual or allowable charge. This is after the insured has met his obligations of deductible, co-payments and any other applicable costs.

**Medical Emergency Services** mean services provided in connection with an "Emergency", defined as a sudden or unexpected onset of a condition requiring medical or surgical care which the Insured Person secures after the onset of such condition (or as soon thereafter as care can be made available, but in any case not any later than twenty-four (24) hours after the onset) and in the absence of which care an Insured would be expected to suffer serious bodily injury or death.

**Medical Exclusion** means specific provision excluding coverage for conditions or illnesses for the life of this Policy. Exclusions are imposed when the Policy is issued as a condition for the issuance of coverage. Medical Exclusion or Exclusions, if issued as a condition for the issue of coverage, form a part of this Policy through an endorsement or rider or as listed in the Exclusions and Limitations section of the policy.

**Medically Necessary** means those services or supplies which are provided by Hospital, Physician or other approved medical providers that are required to identify or treat an illness or injury and which, as determined by Insurer, are:

1. Consistent with the symptom, or diagnosis and treatment of condition, disease or injury; and
2. Appropriate with regard to standards of accepted professional practice; and
3. Not solely for the Insured Person's convenience, the Physician's convenience or any other provider's convenience, and
4. The most appropriate supply or level of service, which can be provided. When applied to an inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an outpatient; and
5. Is not a part of or associated with the scholastic education or vocational training of the patient; and
6. Is not Experimental or Investigative.

**Neurologist** is a physician specializing in the non-surgical diseases of the brain and nervous system.

**Nurse** means a person licensed as a Registered Nurse, (R.N.) or Licensed Practical Nurse, (L.P.N.) by the appropriate licensing authority in the areas which he or she practices nursing.

**Outpatient** means services, supplies or equipment received while not an inpatient in a hospital, or other health care facility, or overnight stay. Outpatient Surgery is inclusive of all invasive procedures including colonoscopy and endoscopy procedures.

**Physician** means any person who is duly licensed and meets all of the laws, regulations, and requirements of the jurisdiction in which he practices medicine, osteopathy or podiatry and who is acting within the scope of that license. This term does not include; (1) an intern; or (2) a person in training.

**Policy** means the agreement between Insurer and the Policyholder. The Policy includes this document, the Policy Declarations, the applicable Schedule of Benefits, any application forms, any medical questionnaires; the last issued identification card, and any amendments or endorsement modification made in accordance with the Policy. This also includes any riders or endorsements purchased by the Policyholder.

**Policy Effective Date** means the date that this Policy first takes effect, without regard to renewals thereafter.

**Policyholder** means a person that has applied for coverage and is named as the Policyholder on the Declarations Page of this Policy.

**Polytrauma** means an association of multiple, severe traumatic injuries to different organs and tissues caused by the same Accident and are life threatening.

**Pre-Existing Condition** means any illness or injury, physical or mental condition, for which an Insured Person received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident prior to the effective date. (The Terms and Conditions related to this plan's Pre-existing Conditions are described in the Schedule of Benefits.

**Preferred Provider Organization (PPO)** – a participating provider, such as Hospital, clinic or Physician that has entered into an agreement to provide health services to persons insured by the Insurer. The Company also maintains an international network of medical providers and facilities with which it has arranged direct billing procedures. Please refer to your Identification card to locate Preferred Providers, or access a list of providers at [www.gbg.com](http://www.gbg.com).

**Premium(s)** means the consideration owed by the Policyholder to the Insurer in order to secure benefits for its Eligible s under this Policy.

**Premium Payment Date** means the recurring date specified in the Policy Declarations upon which the Premium for this Policy is due.

**Prescription Drugs** – Prescription drugs are medications which are prescribed by a physician and which would not be available without such prescription. Certain treatments and medications, such as vitamins, herbs, aspirin, cold remedies, medicines, experimental or Investigative drugs, or medical supplies even when recommended by a physician, do not qualify as prescription drugs. Specialized drugs are not part of this benefit.

**Professional Sports** – Activities in which the participants receive payment for participation.

**Provider** means the organization or person performing or supplying treatment, services, supplies or drugs.

**Rehabilitation** – Therapeutic services designed to improve a patient's medical condition within a predetermined time period through establishing a maintenance program designed to maintain the patient's current condition, prevent it from deteriorating and assist in recovery. Inpatient rehabilitation is only covered during the acute and sub-acute recovery phase of treatment and only when authorized by the GBG Assist Department.

**Repatriation or Local Burial** – This is the expense of preparation and the air transportation of the mortal remains of the Insured Person from the place of death to their home country, or the preparation and local burial of the mortal remains of an Insured Person who dies outside his/her home country. This benefit is excluded where death occurs in their home country.

**Schedule of Benefits** means the summary description of the available benefits, payment levels and maximum benefits, provided under this Policy. The Schedule of Benefits is included with and is part of this Contract.

**Sub-Acute Care** – Medical care that is somewhat acute, falling between acute and chronic care, but with some acute features.

**Subrogation** – The term subrogation refers to the substitution of one person in the place of another relative to a lawful claim or right. In a health plan this type of provision allows the plan to be substituted for the covered person in a case where the covered person takes legal action. Theoretically, a subrogation provision permits the health plan to take direct legal action against a responsible third party and, therefore, the health plan could force the covered person to pursue legal remedies, although he may not have intended to do so.

**Terrorism** – Terrorist activity means an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization (s) or government (s).

**Transient Ischemic Attack** is like a stroke, producing similar symptoms, but usually lasting only a few minutes and causing no permanent damage. Often called a mini stroke, a transient ischemic attack may be a warning.

**Usual, Customary and Reasonable Charge** means the lower of: a) the provider's usual charge for furnishing the treatment, service or supply; or b) the charge determined by the Insurer to be the general rate charged by the others who render or furnish such treatments, services or supplies to persons: (1) who reside in the same country; and (2) whose Injury or Illness is comparable in nature and severity.

The Reasonable and Customary Charge for a treatment, service or supply that is unusual, or not often provided in the area, or that is provided by only a small number of providers in the area, will be determined by the Insurer. The Insurer will consider such factors as: (1) complexity; (2) degree of skill needed; (3) type of specialist required; (4) range of services or supplies provided by a facility; and (5) the prevailing charge in other areas. The term "area" means a city, a county or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment.

**Utilization Review Measures** – The Company retains the right to determine the medical necessity of a planned treatment. The appropriateness of care and the treatment plan will be reviewed in consultation with the attending physician and alternative care options may be recommended.

**Waiting Period** - means the period of time beginning with the Insured's Effective Date, during which limited or no benefits are available for particular services. After satisfaction of the Waiting Period, benefits for those services become available in accordance with this plan.



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