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

This Policy outlines the terms and conditions of the benefits covered by this plan. It also contains other important information about how to contact us and use your coverage. Please review the Policy Face Page which shows the deductible you selected and any exclusions or amendments to your coverage.

An Acknowledgment of Receipt and an Authorization Form are also included which require your signature. Please sign these documents and return a copy to GBG immediately. You may keep the originals.

We invite you to visit our Member Services Portal at latam.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
THANK YOU FOR SELECTING GLOBAL BENEFITS GROUP HEALTH INSURANCE
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1. SCHEDULE OF BENEFITS

The following benefits are per person per Policy Period and subject to the Insured’s Policy Period Deductible. Benefits will be paid on a Usual, Customary, and Reasonable basis, subject to Policy exclusions, limitations and conditions, for the charges listed, if they are:

- Incurred as a result of sickness or accidental bodily injury, under the care of a physician, and
- Medically Necessary; and
- Ordered by a physician; and
- Delivered in an appropriate medical setting

All the benefits in 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. Optional benefits that have been purchased and any other limitations established will be listed on the Policy Face Page. Please note that for some of the services listed below, the Pre-authorization is required, and the lack thereof will result in a 30% penalty for covered services.

### MAXIMUM BENEFIT

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No Annual or Lifetime Maximum</td>
<td></td>
</tr>
</tbody>
</table>

### PROVIDER NETWORK

- **Worldwide excluding USA:** The insured may use any licensed Provider.
- **USA:** The Insurer maintains a Preferred Provider Network. In-network benefits are paid at 100%. Out-of-network benefits are paid at 80% UCR.

### HOSPITALIZATION BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private/Semi-private room</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Intensive care unit</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Medical treatment, medicines, laboratory an diagnostic tests (including cancer treatment, chemotherapy/radiotherapy)</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Inpatient consultation by a physician or specialist</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Medical fees for Inpatient surgery</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Companion of hospitalized Insured</td>
<td>$300 per day; maximum of 10 days per Policy Period</td>
</tr>
<tr>
<td>Extended Care / Inpatient Rehabilitation (must be confined to facility immediately following a Hospital stay)</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Private duty nursing</td>
<td>100% UCR; maximum 100 days per Policy Period</td>
</tr>
<tr>
<td>Inpatient psychiatric hospitalization</td>
<td>100% UCR</td>
</tr>
</tbody>
</table>

### OUTPATIENT BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Specialist visit</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Mental health Outpatient</td>
<td>100% UCR; maximum 50 visits per Policy Period</td>
</tr>
<tr>
<td>Diagnostic exams including laboratory and imaging tests</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Outpatient surgery medical fees</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Therapeutic services: Physical Therapy, Chiropractic, Occupational Therapy, Vocational Speech Therapy, Homeopathy and Acupuncture</td>
<td>100% UCR; maximum 80 combined visits per Policy Period</td>
</tr>
<tr>
<td>Prescription Drugs following hospitalization or Outpatient surgery</td>
<td>100% UCR for a maximum of 6 months; $3,000 thereafter per Policy Period</td>
</tr>
<tr>
<td>Prescription Drugs after consultation</td>
<td>100% UCR; maximum of $2,500 per Policy Period</td>
</tr>
</tbody>
</table>

### EMERGENCIES

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Accident hospitalization (24 hours or more)</td>
<td>100% UCR; Deductible waived for period of first hospitalization only</td>
</tr>
<tr>
<td>Ground ambulance</td>
<td>100% UCR</td>
</tr>
<tr>
<td><strong>Air Ambulance</strong></td>
<td>100% UCR; Deductible waived</td>
</tr>
</tbody>
</table>
EMERGENCIES (Cont.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room and Emergency medical services</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Emergency dental Care - limited to accidental injury</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Travel Reimbursement Benefit</td>
<td>Up to $5,000 per Policy Period</td>
</tr>
</tbody>
</table>

SPECIALIZED TREATMENTS

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prophylactic surgery (only for gynecological cancer)</td>
<td>100% UCR; up to $5,000 Lifetime Maximum</td>
</tr>
<tr>
<td>Bariatric surgery (A 24-month Waiting Period applies)</td>
<td>100% UCR; up to $10,000 Lifetime Maximum</td>
</tr>
<tr>
<td>Congenital and Hereditary Conditions</td>
<td>Covered according to the limits of this Policy</td>
</tr>
<tr>
<td>Transplants procedures (In the U.S., must use the Institutes of Excellence approved by GBG)</td>
<td>100% UCR, $750,000 Lifetime Maximum per diagnosis, includes donor expenses</td>
</tr>
</tbody>
</table>

PREVENTIVE CARE/ CHECK UP - Deductible Waived

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children up to 6 months of age (including immunizations, exams and consultation)</td>
<td>100% UCR; Maximum 5 visits</td>
</tr>
<tr>
<td>Children 6 months or older and adults</td>
<td>100% UCR; maximum $600 per person, per Policy Period</td>
</tr>
</tbody>
</table>

OTHER BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncologic treatment</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Dialysis</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC). A 24 month Waiting Period applies. Benefit is not covered if condition was diagnosed as Pre-existing Condition.</td>
<td>100% UCR</td>
</tr>
<tr>
<td>GBG Personal Medical Advisor – Medical Second Opinion service</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Home Health Benefits/ Home Care</td>
<td>100% UCR; maximum 100 days per Policy Period</td>
</tr>
<tr>
<td>Special treatments (prosthesis, implants, appliances, and orthotic devices, and highly specialized drugs)</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100% UCR; maximum 240 days per Policy Period</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Prosthetic limbs</td>
<td>$40,000 Policy Period maximum; $150,000 Lifetime Maximum</td>
</tr>
<tr>
<td>Repatriation of mortal remains</td>
<td>$20,000</td>
</tr>
<tr>
<td>War and Terrorism benefit</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Additional payment for covered Critical Illness</td>
<td>$2,500; Lifetime Maximum per person</td>
</tr>
<tr>
<td>ATMSafe benefit</td>
<td>$300 per Policy Period</td>
</tr>
</tbody>
</table>

MATERNITY BENEFITS (Covered on Plans 3 and 4 only)

- The Deductible is waived for this benefit only on Plan 3 ($2,000 Deductible) unless stated otherwise
- The Deductible applies for this benefit on Plan 4 ($5,000 Deductible)
- A 10-month Waiting Period applies; no maternity related treatment for the mother or the newborn is covered during this period

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard benefit:</td>
<td></td>
</tr>
<tr>
<td>If only the mother is covered in the Policy (normal delivery or c-section)</td>
<td>$10,000 benefit maximum per pregnancy</td>
</tr>
<tr>
<td>Increased benefit:</td>
<td></td>
</tr>
<tr>
<td>If both the mother and the father are covered in the Policy (normal delivery or c-section)</td>
<td>$15,000 benefit maximum per pregnancy</td>
</tr>
<tr>
<td>Complications of Maternity and Perinatal (provided the child was born from a Covered Pregnancy).</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Provisional coverage for newborn (for a maximum of 90 days); Covered Pregnancies only</td>
<td>$5,000 benefit maximum per pregnancy</td>
</tr>
<tr>
<td><strong>Optional Rider</strong> for Complications of Maternity and Perinatal (Plans 5 and 6). Coverage for Policyholder or spouse only.</td>
<td>$500,000 Lifetime Maximum, all pregnancies combined; Deductible applies</td>
</tr>
</tbody>
</table>
2. GENERAL PROVISIONS

In this Policy it shall be considered:

**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”, “Our” 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.

2.1 Entire Policy

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.

2.2 Policy Changes

No change may be made to this Policy unless it is approved by the Insurer. A change will be valid only if made by a Policy endorsement/ Rider signed by the Insurer.

The Policyholder understands and agrees that the Policy purchased is written on an annual basis and Premium is due for the Policy Period, regardless of the Premium payment mode agreed to by the Insurer as shown on the Policy Face Page.

The Company reserves the right to change this Policy and rates based on Class on the renewal date. A copy of the updated Policy terms will be sent to Policyholder at that time.

**THE FOLLOWING SERVICES REQUIRE PRE-AUTHORIZATION**

Failure to pre-authorize a procedure that requires Pre-authorization will result in a 30% penalty.

- Hospitalization
- Exams or Outpatient Procedures that requires more than local anesthesia
- Oncologic Treatment in excess of $10,000
- Home Health Benefits/ Home Care
- Organ, bone marrow, stem cell transplants, and other similar procedures
- Air Ambulance – Air Ambulance service will be coordinated by Insurer’s Air Ambulance Provider
- Specialty treatments and Highly specialized drugs
- Any condition that is expected to accumulate over $10,000 of medical treatment per Policy Period

### POLICY PERIOD DEDUCTIBLES

<table>
<thead>
<tr>
<th>Plan</th>
<th>In Country of Residence</th>
<th>Out of Country of Residence</th>
<th>Plan</th>
<th>In Country of Residence</th>
<th>Out of Country of Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 1</td>
<td>N/A</td>
<td>N/A</td>
<td>Plan 4</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Plan 2</td>
<td>N/A</td>
<td>N/A</td>
<td>Plan 5</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Plan 3</td>
<td>$2,000</td>
<td>$2,000</td>
<td>Plan 6</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

Family Maximum Deductible: 2 x Individual Deductible

**PLEASE SEE YOUR POLICY FACE PAGE TO DETERMINE THE DEDUCTIBLE AMOUNTS THAT APPLY TO YOUR COVERAGE**
2.3 Change of Product or Deductible plan
The Policyholder may only request to change to another product or Deductible plan at the anniversary date of the Policy. The new product/Deductible plan chosen must be available in the current Country of Residence. The request for change must be submitted in writing and received before the anniversary date. Some requests will be subject to underwriting – for those cases a Health Application will be requested and approval is not guaranteed.
During the first thirty (30) days from the effective date of the change, benefits payable for any Illness or injury not caused by Accident or infectious disease, will be limited to the lesser of benefits provided by the new product or the prior product, and the higher Deductible plan will apply. During the first ten (10) months after the effective date of the change, benefits for maternity, newborn, and congenital will be limited to the lesser benefit provided by either the new product/Deductible plan or prior product/Deductible plan. During the first six (6) months after the effective date of the change, transplant benefits will be limited to the lesser benefit provided by either the new product or prior product.

2.4 Right to Examine
When the Policy is initially approved, the Policyholder will be allowed to cancel this Policy within 14 days after the payment is received by the Company. If no claims have been made under the Policy, the Insurer will refund any Premium paid.

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

2.6 Policy Disclaimer
This GBG Insurance Limited Policy is an international health insurance Policy. GBG Insurance Limited is an insurance company incorporated in Guernsey with registration number 42729 and licensed by the Guernsey Financial Services Commission to conduct insurance business under the Insurance Business (Bailiwick of Guernsey) Law, 2002 as amended. This Policy shall be governed by and construed in accordance with the laws of England and Wales and each party agrees to submit to the exclusive jurisdiction of the courts of England and Wales. The Insured should be aware that 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. 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.

2.7 Premium Payment
This Policy is written on an annual basis and all Premiums are payable before coverage under this Policy is provided. The Insurer may allow for Premium to be paid on an approved payment cycle, as reflected on the Policy Face Page. All coverage under this Policy is subject to the timely payment of Premium and is due upon receipt of the invoice sent by the Insurer. Payment must be in the currency approved and any other forms of currency shall not be accepted and will be considered as non-payment of Premium.
The Insurer has the right to change any Premium, or rate basis, only on the Policy's anniversary date, when:

- There is a change of age band
- There is a change in the rate base of a product
- Change of product and / or Deductible
- Change of Country of Residence
- The Insurer will provide the Policy renewal letter at least 30 days prior to the date the change is made. Premium changes will automatically occur and will be charged as of the date the following 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’s age are considered changes in the demographics of the Policyholder. Resulting premium changes will occur and are assessed upon renewal date.

2.8 Late Payment Provision
A period of 30 days will be allowed for payment of any Premium, after the Premium payment due date. The Insurer will suspend coverage during this period if Premium is not received. If Premium is received during the 30-day period, the coverage will resume without any interruption. If the Premium due is not paid, the Insurer will cancel the Policy as of the date through which Premiums are paid.
All unpaid Premium through the date of cancellation and any other Premium adjustments assessed as a result of cancellation are the obligation of the Policyholder. 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.

2.9 Cancellation
The Company reserves the right to cancel the Policy as described below:

- Lack of payment
- False statement or omission of information
- When the Policyholder or any dependent have agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to Our detriment
- Failure to observe the terms and conditions of this Policy, or failure to act with utmost good faith

The Insurer retains the right to cancel, non-renew or modify a Policy on a Class basis, 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 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 reinstated or renewed, the Insurer will not refund the unearned portion of the Premium. In case of death of any insured covered in this Policy, the Company will refund the unearned premium minus the administration fees.

2.10 Change of Risk
The Policyholder must inform the Company within 30 days of any changes regarding Country of Residency or marital status related to Insureds. The Company reserves the right to alter the Policy terms, Premiums or cancel coverage for an Insured following a change of residence if it is not possible to maintain GBG’s coverage in the new Country of Residence.

2.11 False/Unfounded Claims
If any claim under this Policy is in any respect false or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and, if appropriate, recoverable by the Company.

2.12 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 is normally unprotected until it reaches us. We do share information, but only as it pertains to the administration of your health care benefits.

2.13 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 market conditions.

2.14 Ex Gratia Payment
If the Company decides to waive any term or condition of this Policy and/or make an ex-gratia payment, the Company is not obligated to waive any future terms or conditions and make future payments for similar, identical or any benefits that are not covered by the Policy.

2.15 Transfer
If the primary Insured dies, this Policy will automatically be transferred to the oldest Insured over the age of 18 years who shall, become the primary Insured for all the purposes of this Policy and be responsible for paying the Premium.

If the Insured older than 18 years of age is considered a dependent child before the death of the primary Insured, his/her Premium will be based on an adult rate from the moment he/she becomes the primary Insured.

In the case all other Insureds on the Policy are under the age of 18, a guardian shall be appointed who in no way will be considered as an Insured and thereafter shall be responsible for the Policyholder’s obligations.
2.16 Denial of Liability
The Insurer is not 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 based on an act of omission or error of a Hospital, physician or other Provider of care or service.

3. ELIGIBILITY

3.1 Policy Terms and Pre-Existing Conditions Limitation
The Policy terms begin on the Policy Effective Date, as shown on the Face Page, and end 365 days later. All applications are subject to underwriting by the Insurer. Acceptance is not guaranteed. The Insurer will advise in writing if your application has been approved along with the terms and conditions of the approval. Pre-existing conditions not disclosed on the Application are never covered. Consult the Policy Face Page for the terms and conditions regarding the issuance of this Policy.

3.2 Eligibility
- You must reside in Latin America or the Caribbean at the time the Policy is issued,
- Have not attained age 75 at the time of enrollment.
- There is no maximum renewal age for person’s already covered under this Policy.
- Termination of the insurance of the primary member shall also cancel all coverage for dependents, except in the case of death or unless otherwise agreed with the Company.

3.3 Insured Dependents
Coverage under this Policy can be extended to the following family members:
- The spouse or domestic partner.
- Dependent children up to age 19 if single, or up to age 24 if single and student at an accredited institution or at the time the Policy is issued. Dependents that are students up to age 24 are charged the Child/Children rate.

Dependents, which were covered under a 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 Policy. The request of Policy of the former dependent must be received before the end of the Policy Period coverage. 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.

3.4 Addition of a Newborn or Newborn Adopted Child:
3.4.1 Babies Born under a Pregnancy Covered by the Maternity Benefit
- Provide written notification to the Insurer within 90 days of the date of birth.
- The newborn shall be accepted from the date of birth, for full coverage according to the terms of the Policy, regardless of health status.
- The newborn baby will be enrolled for the same coverage as the Insured only if the Company is notified within the first 90 days.
- After the first 90 days, the coverage is not guaranteed and will be subject to the submission of a health application and medical underwriting.

3.4.2 Legally Adopted Child, Child born of a Surrogate Mother or as a result of Fertility treatment.
- The 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 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. If approved, coverage will become effective as of a date established by the Insurer, which will be after the application date.
- For a period of 12 months from the effective date of coverage, Pre-existing Conditions will not be covered.

3.4.3 Newborn Child born when the Maternity Benefit is Not Covered under the Policy
For the purpose of adding a newborn child to the parent’s Policy without underwriting, the parent’s Policy must have been in effect for at least 10 consecutive calendar months and the child is not a result of fertility/infertility treatment or any assisted medical treatment or procedures. To be added a copy of the birth certificate including the newborn’s full name, gender and date of birth must be submitted
within 90 calendar days of birth along with the Maternity Questionnaire fully completed and signed by the attending physician. If the birth certificate is not received within 90 calendar days of birth, an individual health application is required for the addition and will be subject to underwriting and coverage is not guaranteed.

3.5 Waiting Period
This Policy contains a 30-day Waiting period, during which only Illnesses or injuries caused by an Accident occurring within this period, or diseases of infectious origin that first manifest themselves within this period, will be covered.

The Insurer may waive the Waiting Period only if:
- Other medical expense insurance coverage was in effect with another company for at least one consecutive year, and
- The effective date of this Policy begins within 30 days of the expiration of the previous coverage, and
- The prior coverage is disclosed in the health application, and
- The prior Policy and a copy of the receipt for the last year’s Premium payment are submitted with the health application.

*Failure to notify the Insurer at the time of application may result in a denial of the requested waiver of the 30 days Waiting Period.*

If the Waiting Period is waived, benefits payable for any condition manifested during the first 30 days of coverage are limited, while the Policy is in effect, to the lesser benefit provided by either this Policy or the prior Policy. See Policy Face Page to determine if this Waiting Period applies to your Policy.

3.6 Residency
Upon issuance of the Policy, the primary Insured and all dependents (if any) must have their permanent residence in Latin America or the Caribbean. If the Insured or his/her dependents change their residence to a different country, the Company must be notified in writing of their full-time residence immediately.

“Country of Residence” is defined as:
1. Where the Insured resides the majority of any calendar or Policy Period; or
2. Where the Insured has resided more than 180 days during any 12-month period while the Policy is in effect.

If the Insured or dependents change permanent residency to another country, GBG retains the right to modify the Premium.

4. CLAIMS ADJUDICATION AND PRE-AUTHORIZATION PROCEDURES

4.1 Claims
All claims are subject to Usual, Customary and Reasonable (UCR) 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. Claims will be considered for processing only when the services rendered incurred within the effective period and have been eligible under the terms of this Policy. The claim form can be obtained from our website at latam.gbg.com.

Claims must be received by the Insurer no later than 180 days after the date on which the Insured has received the service. Requests received after this period will be excluded from the coverage. Inquiries regarding past requests must be received within 12 months from the service date to be considered for review.

All claims must be submitted in the official currency where the service was rendered.

4.1.1 Claims submitted by the Insured
If the Insured has already paid the institution or Provider, the Insured must submit the following digital documents:
- Claim form, completed and signed;
- Itemized bills of the service performed;
- Proof of payment;
- Copy of medication prescription (if applicable);
- Medical reports (if applicable);
- EOB emitted by the other Insurer (if applicable);
- Maternity questionnaire in case of pregnancy related claim.

The Company may request the original receipt(s) at any time. The Company will pay the Insured according to the terms of this Policy. Please see section 13 of this Policy (How to File a claim) for more information.
In case of the death of the claimant Insured, any outstanding medical claims reimbursements will be paid accordingly.

<table>
<thead>
<tr>
<th>Insured</th>
<th>Beneficiary</th>
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<tbody>
<tr>
<td>Death of an insured dependent spouse or child</td>
<td>Medical claims reimbursement will be paid to the Policyholder</td>
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</table>
| Death of the Policyholder, when dependents are insured | Medical claims reimbursement are payable as follows:  
  - Dependent spouse, or  
  - If no dependent spouse, then payment will be paid to the oldest Insured dependent child. |
| Death of a Policyholder, when no dependents are insured | Medical claims reimbursement are payable to the Policyholder estate. |

4.2 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 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. The Insurer may also request additional health information from the Insured.

4.3 Coordination of Benefits
Within the Country of Residence: When an Insured has another insurance Policy:
1. All benefits paid by the local plan that are considered payable by this Policy will be applied to this Policy Deductible.
2. In case the benefits paid by the local plan exceed this Policy Deductible, this Policy will not pay benefits in duplicity.
3. Benefits not covered by the local plan that are considered covered by this Policy, will be processed and, if applicable, the exceeded amount above the Deductible will be reimbursed according to this Policy conditions up to the UCR limit.

Outside the Country of Residence: GBG will function as the primary Insurer and retains the right to collect any payment from local or other Insurers. If a travel insurance policy exists, such Policy will function as primary. For Insureds with two (2) or more international policies, the policy that has been in force the longest will be considered primary.

Special Note for U.S. Citizens: United States citizens who are eligible for U.S. Medicare benefits must apply for coverage under those benefits for medical and prescription services obtained within the U.S.

4.4 Subrogation/Indemnity
The right of the Insurer to undertake, on its own behalf and on behalf of the Insured, a third party and also the Insurer’s right to request from the Insured the return of amounts to the Insurer if the insurer has paid for expenses already reimbursed to the Insured by third parties.

4.5 Deductible
Deductible is the first amount paid by each of the Insureds of the allowable charges for eligible medical treatment expenses during each Policy Period before the Policy benefits are paid. Deductibles for In and Out of Residence Country accumulate on a combined basis. Deductibles are shown on the medical identification card and the Policy Face Page. If the individual/family Deductible was not met in a given Policy Period, any incurred eligible charges during the last three months of that Policy Period will be carried over to be applied towards the Deductible for the following Policy Period, unless the family Deductible was met. The amount of allowable charges applied towards the Deductible also reduces the applicable benefit maximum by the same amount.

4.6 Family Deductible
There is only one Deductible per person, per Policy Period. For families we apply a maximum equivalent of the sum of two individual Deductibles on your Policy, per Policy Period. The amount of reimbursement applied to the Deductible outside the country of residence will also be applied to the inside country of residence Deductible and vice versa.
4.7 Pre-Authorization Requirements and Procedures
The Pre-Authorization Request shall be sent to the Company within a minimum of five business days prior to the scheduled procedure or treatment date, along with the attending physician request that must include:

- Diagnosis;
- Recommended Treatment;
- Place where treatment will be performed (institution name);
- Service date and medical fees.

The following procedures and medical services must be pre-authorized. Failure to obtain Pre-Authorization will result in a 30% reduction in payment of covered expenses:

- Hospitalization
- Exams or Outpatient procedures that requires more than local anesthesia
- Oncologic treatment in excess of $10,000
- Home Health Benefits/ Home Care
- Organ, bone marrow, stem cell transplants, and other similar procedures
- Air Ambulance – Air Ambulance service will be coordinated by Insurer’s Air Ambulance Provider
- Specialty treatments and Highly Specialized drugs
- Any condition, which do not meet the above criteria, but are expected to accumulate over $10,000 of medical treatment per Policy Period, such as, but not limited to:
  - Chronic illness
  - Dialysis
  - Ambulatory services Admission

Medical Emergency Authorizations must be received within 72 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.

If treatment would not have been approved by the Pre-authorization process, all related claims will be denied.

5. PREFERRED PROVIDER NETWORK
The Company maintains a Preferred Provider Network. For information on the Providers and facilities within the Preferred Provider Network, consult GBG at the number on the medical I.D. card or latam.gbg.com.

U.S. Only
- Preferred Provider: Providers who agree to receive direct payment made by the Company.
- Non-Preferred Provider: Payment to non-preferred Providers will be made through reimbursement up to the UCR, as these Providers may not accept payment made by the Company. The Provider may bill the Insured the difference between the amounts reimbursed by the Insured and the Provider’s billed charges.

In the U.S., in case of the use of a Non-Preferred Provider, the Company will only reimburse 80% of UCR and the remaining balance will be the Insured’s responsibility.

The Preferred Provider Network may change at any time. For a complete and updated list, please consult the Company’s website.

6. HOSPITALIZATION BENEFITS
Medically Necessary services redeemed in a Hospital unit lasting at least 24 hours. Benefits are provided as per the Schedule of Benefits and Policy conditions. All services will be evaluated according to medical necessity.

Accommodations will be paid within the allowed amounts for private and semi-private room rates. All charges in excess are the responsibility of the Insured.

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. Insurer will require submission of records and other documentation of the medical necessity for the Inpatient services. Inpatient Rehabilitation services are covered and subjected to the Policy conditions.

Inpatient Hospital confinements 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 and will not be covered.

6.1 Inpatient Psychiatric Hospitalization
Benefits are provided for psychiatric hospitalization and psychiatric treatment for an approved diagnosis and are payable as follows:

1. Benefits are for Inpatient mental health treatment only in a Hospital or approved facility. Mental health care must be provided by a psychiatrist only.
2. Services include, but are not limited to treatment for bulimia; anorexia; schizophrenia, major depressive disorder; bipolar disorders, and paranoia and other serious mental Illnesses.

6.2 Companion of a Hospitalized Insured
Charges included for overnight Hospital accommodations for the companion of a hospitalized Insured will be payable up to a daily maximum. The cost of meals for the companion are not covered. See your Schedule of Benefits for specific benefit maximum.

7. OUTPATIENT SERVICES
When an Insured is treated as an Outpatient of a Hospital or other approved facility, benefits will be paid for facility charges and ancillary services according to the current Schedule of Benefits.

7.1 Outpatient Mental Health Visits
Services include treatment for Bereavement, attention deficit Disorder (ADD), attention deficit hyperactivity disorder (ADHD); bulimia; anorexia; schizophrenia, major depressive disorder; bipolar disorders, autism and other serious mental Illnesses covered by this Policy. All Outpatient mental health services must be provided by a psychiatrist. Outpatient services provided by a psychologist will be covered if requested by a psychiatrist for mental conditions covered by this Policy.

7.2 Therapeutic Services
Insurer will provide benefits for Medically Necessary therapeutic services treatment rendered to an Insured as an Outpatient of a Hospital, Provider’s office, or approved facility. Benefits are payable in accordance with the current Schedule of Benefits. Services must be in accordance with the treatment plan prescribed by the physician and must:

• Produce significant improvement in the Insured’s condition in a reasonable and predictable period of time; and
• Be consistent with the given diagnosis. Acupuncture must be performed by a physician or licensed physical therapist.

7.3 Diabetic Medical Supplies
Insurer provides benefits for certain diabetic supplies including insulin pumps and associated supplies.

7.4 Prescription Drugs
Prescription drugs are medications which are prescribed by a physician and which would not be available without such prescription. This benefit is subject to the Deductible. Refer to Schedule of Benefits for details.

8. EMERGENCY SERVICES / MEDICAL EVACUATION

8.1 Serious Accident Hospitalization
An unforeseen trauma occurring without the Insured’s intention, which implies a sudden external cause and violent impact on the body, resulting in demonstrable bodily injury that requires immediate Inpatient hospitalization for 24 hours or more within the next few hours after the occurrence of the severe injury to avoid loss of life or physical integrity. Severe injury shall be determined to exist upon agreement by both the treating physician and the Insurer’s medical consultant, after review of the triage notes, emergency room and Hospital Admission medical records.
8.2 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 Schedule of Benefits. The use of ambulance services for the convenience of the Insured, which is not Medically Necessary, will not be considered a covered service.

8.3 Air Ambulance and Medical Evacuation
This benefit requires the prior approval and coordination by GBG.
- The 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.
- The Insurer retains the right to decide the medical facility to which the Insured shall be transported.
- 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 or weather conditions.
- Emergency medical evacuation by Air Ambulance will only be performed from the hospital where the insured is admitted to the Hospital where he/she will continue the treatment.
- Within 90 days of the medical evacuation, the return flight for the Insured and an accompanying person will be reimbursed up to the cost of an airplane ticket in economy class only to the Insured’s Country of Residence – Maximum $2,000 per person.

8.4 Emergency Dental
Emergency dental treatment and restoration; required as a result of an Accident covered by the Policy is included.

8.5 Travel Reimbursement Benefit
The Company will reimburse up to a maximum of $5,000 per Policy Period for unexpected, sudden Emergency medical Accidents or Illnesses that arise while travelling outside of the Insured’s country of residence. This benefit only applies to medical services in a Hospital Emergency room, urgent care center, or acute care center as a result of an Emergency, as defined in this Policy, on a reimbursement basis.

The below conditions apply:
- Emergencies related to chronic medical conditions only qualify for this benefit if the Insured has been Stable and unchanged in the treatment of the condition in question for at least the last six (6) months prior to the Emergency. For cardiovascular related conditions, the Insured's condition must have been Stable and unchanged for twelve (12) months prior to the Emergency.
- To be eligible for this benefit, the Insured must be travelling outside of his country of residence for no more than 21 days from the departure date until the return date to his country of residence.
- The Insured must present proof of travel (copy of the payment of airfare, copy of the passport with an entry stamp and exit stamp and tourist visa, if applicable).
- All Policy exclusions and Insured underwriting exclusions apply.
- Medical conditions with an additional underwriting Deductible are not eligible for this benefit.
- Insured must pay for services and then submit the claim form and supporting documentation for reimbursement of this benefit.
- The Policy Waiting Period of 30 days applies unless otherwise stated on the Policy Face Page.

9. SPECIALIZED TREATMENTS

9.1 Prophylactic Surgery
Prophylactic surgery for gynecological cancer only (consisting on Mastectomy and/or oophorectomy) and/or BRCA testing, will be covered when Medically Necessary accordingly with company guidelines and based on American Cancer Association protocol.

9.2 Bariatric Surgery
This Policy will cover Bariatric Surgery only, up to the limit stated on the Schedule of Benefits. This benefit will be available for adults aged 18 years or older, with the presence of persistent severe obesity, documented in contemporaneous clinical records, in accordance with company's guidelines and based on American Society for Metabolic and Bariatric Surgery protocol.

9.3 Congenital and Hereditary Conditions
Congenital and/or Hereditary conditions are covered under the terms and conditions of this Policy according to the Schedule of Benefits and not under the benefit of maternity complications or optional attachment for maternity complications.
9.4 Transplant Procedures
Coverage for human organ, bone marrow, blood and stem cell transplant. This coverage applies only when the transplant recipient is an Insured under this Policy. In the United States, the use of the Institutes of Excellence for transplants approved by GBG is mandatory. 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.
- Pre-surgical workup including all exams, medications and supplies.
- 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.
- 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.
- Medication or therapeutic measures used to ensure the viability and permanence of the transplanted organ, cell or tissue.
- Home Healthcare, nursing care, Emergency transportation, medical attention, clinic or office visits, transfusions.

10. OTHER BENEFITS

10.1 Nose and Nasal Septum Deformity
When nose or nasal septum deformity is the result of trauma caused by a covered Accident, surgical and physician treatment will only be covered if the evidence of trauma in the form of fracture must be confirmed radiographically (X-rays, CT Scan, etc.) prior to the procedure. Any other condition not aroused of a trauma, will have its medical necessity assessed by the Insurer.

10.2 Therapeutic Services
Insurer will provide benefits for Medically Necessary therapeutic services treatment rendered to an Insured as an Outpatient of a Hospital, Provider’s office, or approved facility. Benefits are payable in accordance with the current Schedule of Benefits.

Services must be in accordance with the treatment plan prescribed by the physician and must:

- Produce significant improvement in the Insured’s condition in a reasonable and predictable period of time; and
- Be consistent with the given diagnosis

10.3 HIV, AIDS and ARC
Benefits are available only if caused by an Accident or blood transfusion, provided the condition(s) are not considered Pre-existing Conditions. A 24-month Waiting Period applies. Sexually transmitted diseases and all related conditions are not covered.

10.4 Sports and Hazardous Activity
This Policy provides coverage for a wide range of activities and sports, excluding professional sports. Listed below are examples of activities and sports not covered:

- Mountain Climbing, mountaineering, alpinism;
- Aviation Sports (aerobatics, parachuting, paragliding, parasailing, sky diving and wingsuit flying);
- Bungee Jumping
- Off piste skiing
- Scuba Diving below 60 feet
- Water Rafting above class 4
- Cliff Diving
- Off track or on track motor vehicle racing

GBG is available to provide clarification if a specific sport or activity would be covered under the Policy. GBG should be contacted prior to engagement in such sport or activity. Please contact your GBG Elite Team for clarifications.
10.5 Home Health Benefit/Home Care
Home Health care includes the services of a skilled licensed professional (nurse or therapist) outside the Hospital and does not include Custodial Care. An initial period of 30 days will be covered if pre-authorized. 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 Inpatient treatment.

These services must to meet specified medical criteria to be covered. Thorough Insurer review is required.

The Insurer considers home nursing care Medically Necessary when recommended by the member’s treating physician and both of the following circumstances are met:

- Insured has skilled needs; and
- Placement of the nurse in the home is done to meet the skilled needs of the Insured only, not for the convenience of the family caregiver.

10.6 Highly Specialized Drugs
Highly specialized drugs for specific uses will be covered, but must be Pre-authorized and coordinated in advance by GBG. Highly specialized drugs are subject to the limit shown on the Schedule of Benefits. These drugs include, but are not limited to the following: Interferon beta-1-a, PEGylated Interferon alfa 2a, Alfa, Interferon beta-1-b, Etanercept, Adalimumab, Bevacizumab, Cyclosporine A, Azathioprine, and Rituximad. When necessary, and if possible, the Insurer will coordinate the delivery of such medications. Experimental drugs and drugs not approved by the FDA, are not covered.

10.7 Hospice Care
Hospice is a program approved 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. Admission to a Hospice program is made on the basis of patient and family medical need.

The Hospice care must:

- Be relate to a covered medical condition, with a diagnosis of terminal illness from the attending physician;
- Be performed by a recognized Provider.

10.8 Durable Medical Equipment
The Policy will pay the Usual, Customary and Reasonable Charges for artificial devices listed, provided such Durable Medical Equipment (DME) is:

1. Prescribed by a physician, and
2. Determined by Insurer to be Medically Necessary and appropriate.

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.

The Insurer suggests a pre-notification for this benefit in order to evaluate costs and the possibility of direct payment.

10.9 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 Insured 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.
Special high performance prosthetics for sports or improvement of sports performance will not be covered by this benefit. Insurer will allow for two breast prosthesis for cancer patients who have a mastectomy while covered under this Policy. Post surgical bra will be a covered expense.

10.10 Repatriation of Mortal Remains
In the event that an Insured dies outside his/her country of residence from a covered condition under the terms of this Policy, the Insurer shall pay the costs of remains repatriation to the Insured's country of residence or burial at the place of death. The coverage is limited to the services and materials needed to prepare the body and transport it to the Insured's country of residence. Preparations should be coordinated with the Insurer. In the case of burial at the place of death, only the preparation of the body and burial shall be covered.

10.11 War and Terrorism
This Policy covers bodily injury directly or indirectly caused by certain acts of War and Terrorism. This benefit is subject to all Policy exclusions, limitations and conditions, including any applicable Deductibles and co-payments. Notwithstanding any provision to the contrary within this Policy, or any Rider attached thereto, it is agreed that coverage under this Policy is extended to include bodily injury directly or indirectly caused by, resulting from, or in connection with any of the following:

1. War, hostilities or warlike operations (whether war be declared or not),
2. Invasion,
3. Act of an enemy foreign to the nationality of the Insured or the country in, or over, which the act occurs,
4. Civil war,
5. Riot,
6. Rebellion,
7. Insurrection,
8. Revolution,
9. Overthrow of the legally constituted government,
10. Civil commotion assuming the proportions of, or amounting to, an uprising,
11. Military or usurped power,
12. Explosions of war weapons,
13. Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Insured whether war be declared with that state or not,
14. Terrorist activity

Please refer to Schedule of Benefits for maximum benefit limitations.

War and Terrorism Exclusions: Benefits will not be available for the following:

- The Insured's active participation in any, or all, of items described above;
- When the circumstances of items (1) to (14) as described above are the result of the utilization of nuclear, chemical or biological weapons of mass destruction however these may be distributed or combined;
- Limited war exclusion: notwithstanding anything to the contrary herein, this Policy does not cover loss consequent on:
  - War, whether declared or not, between any of the following countries, namely, China, France, the United Kingdom, the Russian Federation and the United States of America, or
  - War in Europe, whether declared or not (other than civil war and any enforcement action by or on behalf of the United Nations), in which any of the said countries or any armed forces thereof are engaged.

10.12 Lump-sum Payment in case of Critical Illness
The following diagnosis/procedures qualify for this benefit:

- Cancer
- Coronary Artery By-Pass Surgery
- Heart Attack
- Kidney Failure
- Major Organ Transplant
- Polytrauma
- Stroke

This Benefit becomes effective only:

- If the event of first occurrence and definite medical diagnosis occur more than 90 days after the commencement of the Policy.
• If the Insured have survived for at least 30 days.
• If the above mentioned diagnosis are not considered pre-existent.
• Until the end of the Policy Period after the Insured has reached the age of 60.

Please see section 12 (Exclusions for more information on the limitations and requirements of this benefit).

10.13 ATM Safe Benefit
If an Insured is robbed within 10 minutes after withdrawing funds from an ATM and the stolen funds are not recovered within 48 hours of the Robbery, the Company will pay a benefit equal to the amount stolen up to the withdrawn amount not to exceed the maximum benefit amount as shown on the Schedule of Benefit.

11. MATERNITY AND NEWBORN BENEFITS

11.1 Maternity Waiting Period
A 10-month Waiting Period applies for any maternity related service, including pre-natal, delivery, post-natal, related condition of pregnancy incurred for the mother or the newborn.

For the increased normal pregnancy or c-section benefit to be paid under this Policy, both parents must have been covered under the same Policy and must have met the 10-month Maternity Waiting Period.

11.2 Obstetrical Services
Services are covered as set forth in the Schedule of Benefits and are limited to:

- Hospital services rendered in a Hospital or licensed birthing center (including anesthesia, delivery, pre-natal and post-natal care) for any condition related to pregnancy, including, but not limited to childbirth.
- Pre-natal vitamins are covered during the term of the pregnancy only, if prescribed by a physician.
- The Deductible is waived on Plan 3 (US$2,000 Deductible) only.
- For pregnancies resulting from fertility/infertility treatment or other related procedures, only the delivery will be covered. Birth coverage in this case does not qualify the pregnancy as a Covered Pregnancy. For the purpose of newborn addition in this Policy, babies born in this scope must submit an insurance application that will be subject to underwriting and it acceptance is not guaranteed.

Note: Maternity coverage for an Insured dependent daughter under the parent’s Policy terminates on the next Policy anniversary date after the Insured dependent daughter turns 18 years old and she can be automatically transferred to her individual Policy with equal coverage and Deductible.

11.3 Complications of Maternity and Perinatal
Maternity complications and/or newborn complications of birth (not related to Congenital or Hereditary disorders), such as miscarriage, prematurity, low birth weight, jaundice, hypoglycemia, respiratory distress, and birth trauma are covered as follows:

- This benefit shall only apply for Covered Pregnancies,
- This benefit does not apply to complications related to any condition excluded or not covered by this Policy,
- Complications caused by a condition that was diagnosed before the pregnancy, and/or any consequences thereof, will be covered in accordance with general Policy provisions and not under the maternity complications benefit,
- Complications that arise within the 10-month Waiting Period are not covered,
- This benefit applies to all eligible dependents.

This Deductible does not apply for plans 2 and 3 only.

11.4 Newborn Infant Care Services
Newborn infant’s coverage will be covered as part of the maternity maximum for Covered Pregnancies only. Charges for Hospital nursery services and professional services for the newborn infant are covered as part of the total maternity benefit and are not subjected to the satisfaction of the Policy Period Deductible.
11.5 Newborn Provisional Coverage
If born from a Covered Pregnancy, each newborn will automatically be covered for complications of birth and for any injury or illness during the first 90 days after birth up to a maximum as listed on the Policy Face Page. For this benefit, the Deductible does not apply on Plan 3. The Deductible applies on Plan 4 for this benefit. See requirements for addition of a newborn. This benefit will not be paid if the newborn is not added to this Policy.

11.6 Maternity and Perinatal Complications Rider
Available for Plans 5 & 6 and at the time of application or at renewal time only.
This rider offers a lifetime optional coverage per eligible insured for complications of the pregnancy, complications of the delivery, and perinatal complications not related to congenital or hereditary disorders, such as miscarriage, prematurity, low birth weight, jaundice, hypoglycemia, respiratory distress, and birth trauma. A 10-month Waiting Period applies after the Effective Date of the rider. Once issued, the rider will be renewed along with this Policy renewal as long as the additional Premium for the rider is paid. This optional rider only covers the primary Insured or dependent spouse and does not apply to depend daughter. The Deductible applies to this rider.

11.7 Special Notes regarding Dependent Maternity
The following conditions regarding pregnancy, maternity and birth apply to eligible dependent children and their children:

- On the anniversary date after the dependent turns 18 years old, he/she must obtain coverage for himself/ herself and his/her child under his/her own individual Policy if he/she wants to maintain coverage for the baby.
- The depend must submit written notification, which will be approved without underwriting for the same product with the same or higher Deductible, and with the same conditions and restrictions in effect under the prior Policy.

When a dependent daughter who is 18 years of age or older has a confirmed pregnancy, if she wants to maintain the coverage for her baby, she must:

- Submit a written notification before the actual date of delivery to be considered eligible for maternity coverage under her own Policy.

She will be approved without underwriting for an equal product with the same or higher Deductible. If there is no gap in coverage, the 10-month Waiting Period will be reduced by the time she was covered under her parent’s Policy.

12. EXCLUSIONS AND LIMITATIONS
All services and benefits described below are excluded from coverage or limited under this Policy of insurance.

1. Claims and costs for medical treatment, occurring before the effective date of coverage (including Waiting Periods) or after the expiration date of the Policy.
2. 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, 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.
3. Services, supplies or treatments, including drugs, that are not scientifically or medically recognized for a specific diagnosis, or that are considered as off label use, experimental or not approved for general use are considered Experimental or Investigational.
4. Any services, supplies, treatments including drugs and/or Emergency air services;
   a. Not ordered by a physician,
   b. Not Medically Necessary,
   c. Medical and dental services not performed in a medical facility.
5. Telephonic consultations, missed appointments, or “after hours” expenses.
6. 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.
7. Health check-ups, inoculations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.).
8. Immunizations, other than provided for under the Preventive Care/Check-up benefit as listed on the Schedule of Benefits.

9. Certain treatments and medications, such as vitamins, herbs, aspirin, and flu medicines. Over-the-counter (OTC) drugs, supplies or medical devices, which do not require a physician prescription, even if recommended/prescribed by a physician, including, but not limited to, smoking cessation drugs, appetite suppressant, hair regenerative drugs or products, anti-photo aging drugs, cosmetic and beauty aids, acne and rosacea drugs (including hormones and retin A) for cosmetic purposes, megavitamins, vitamins, (other than pre-natal as described under section 11 “Maternity”), sexual enhancement devices, supplements, herbs or drugs, for any reason.

10. Services and supplies related to visual therapy, Radial keratotomy procedures, Lasik, or eye surgery to correct refractive error or deficiencies, including myopia or presbyopia, unless stated on the Schedule of Benefits.

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, 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. Cosmetic surgery, procedures, treatments, technologies, drugs, devices, items and supplies that are not Medically Necessary treatment of a covered accidental injury or Illness or disease, and that may only be provided for the purpose of improving, altering, enhancing, or beautification unless required due to the treatment of an injury, deformity, or Illness that compromises functionality and that first occurred while the Insured was covered under this Policy. This also includes any surgical treatment for nasal or septal deformity that was not induced by trauma. Any medical complications arising directly or indirectly as a result of a non-authorized elective or cosmetic procedure. Cosmetic surgery is defined as surgery or therapy performed to improve or alter appearance for self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.

13. Sleep studies and other treatments relating to restless leg syndrome.

14. Exams and treatments related to snoring.

15. Weight related treatment; any expense, service or treatment for obesity, nutritionist consultation (related to any diagnosis, conditions and/or symptoms), weight control, or any form of food supplement. This includes expenses related to or associated with treatment of morbid or non-morbid obesity, including, but not limited to, gastric bypass, gastric balloons, gastric stapling, jejunal ileal bypass, and any other procedures or complications arising there from, unless stated on the Schedule of Benefits.

16. Any fertility/infertility services, tests, treatments and/or procedures of any kind, including, but not limited to, fertility/infertility drugs, including drugs to regulate the menstrual cycle/ovulation for family planning purposes, artificial inseminations, in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), surrogate mother and all other procedures and services related to fertility and infertility. Any pregnancy resulting from such treatments, complications of that pregnancy, and postpartum care are also excluded, unless stated on the Schedule of Benefits. The delivery will be covered up to the maximum on the Schedule of Benefits, but will not be considered a Covered Pregnancy for any other benefits.

17. Genetic counseling, screening, testing or treatment, unless stated on the Schedule of Benefits.

18. Elective abortions; any voluntarily induced termination of pregnancy, unless the mother's life is in imminent danger.

19. Conditions related to sex or gender issues and sexually transmitted diseases. Any expense for gender reassignment, sexual dysfunction including, but not limited to impotence, inadequacies, disorders related to sexually transmitted human papillomavirus (HPV) and any other sexually transmitted diseases.


21. Circumcisions, unless Medically Necessary and pre-authorized.

22. Treatment for alcoholism, solvent abuse, drug abuse or addictive conditions of any kind, and 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 purpose prescribed by the Insured's doctor.

23. Treatment for any conditions as a result of self-inflicted illnesses or injuries, suicide or attempted suicide, while sane or insane, or Emergency ambulance services for the same.

24. Injuries and/or Illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law by an Insured.

25. Eyeglasses; contact lenses; sunglasses.

26. Prosthesis and corrective devices which are not medically required intra-operatively or equivalent appliances; except Durable Medical Equipment used as an integral part of treatment prescribed by a physician, meeting the covered categories of Durable Medical Equipment and approved in advance by GBG.
27. Durable Medical Equipment does not include motor driven wheelchairs or beds, 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.

28. Routine podiatry or other foot treatment not resulting from an Illness or injury. Pedicures, special shoes, inserts of any kind or any other supportive devices for the feet such as, but not limited to, arch supports and orthotic devices or any other preventive services and supplies. Any treatments, services or devices for diagnosis of weak, unstable, flat feet or fallen arches; or any specified lesions of the feet such as corns, calluses, hyperkeratosis, toenails or bunions (hallux valgus).

29. Growth hormones, unless Medically Necessary and pre-authorized by GBG. This includes treatment by a bone growth stimulator, bone growth stimulation or treatment related to growth hormone, regardless of the reason for prescription.

30. Hearing aids, hearing devices and bone anchored hearing aids.

31. Exceptional risks;
   a. Treatment as a consequence of injury sustained while participating in an uncovered sports/hazardous activity or training for any professional sport or activity;
   b. Treatment as a consequence of injury sustained while participating in, or training for, or as a consequence of: war, hostilities or warlike operations (whether war be declared or not), invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of the legally constituted government, civil commotion assuming the proportions of, or amounting to, an uprising, military or usurped power, explosions of war weapons, act of an enemy foreign to the nationality of an individual, terrorist activity, utilization of nuclear, chemical or biological weapons, war (whether declared or not) between any of the following countries, namely, China, France, the United Kingdom, the Russian Federation and the United States of America, or war in Europe, whether declared or not (other than civil war and any enforcement action by or on behalf of the United Nations), in which any of the said countries or any armed forces thereof are engaged.
   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.

32. Dental and orthodontic care not resulting from accidental injury.

33. Treatment services or supplies as the result of prognathism, retrognathism, micrognathism, or any treatment, services, or supplies to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible. This includes treatment for Temporomandibular Malocclusion Joint Disorders (TMJD).

34. Any services received by any parties or in any countries where otherwise prohibited by the U.S./UN/EU law.

35. Treatment and services related to infectious diseases declared to be an outbreak, epidemic, or public Emergency by the World Health Organization (WHO), Center for Disease Control and Prevention (CDC), or any other Government or Government Agency or ruling body of the country where the outbreak or epidemic has occurred in. Additionally, such coverage is also excluded if there has been an official warning issued against travel to the area, by the State Department, Embassy, Airline or other Governmental Agency, prior to travel to the affected country. This exclusion will not apply if exposure occurs accidentally or unknowingly while travelling to or from areas not declared to be at risk, or if exposure occurs as a result of residing or working in the area prior to the outbreak.

36. Lump-sum Payment in case of Critical Illness Exclusions
   In addition to the Exclusions and Limitations shown above, the following exclusions also pertain to this benefit.
   a. 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.
   b. Transient Ischemic Attack (TIA).
   c. The following Cancer conditions:
      - 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 a pre-malignant, showing early malignant change or having malignant potential,
      - Stage 1 Hodgkin’s disease
13. HOW TO FILE A CLAIM

The claim form is downloadable from latam.gbg.com. The Company must receive completed forms within 180 days of the treatment's date of service to be eligible for reimbursement of covered expenses.

The claim form must 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.

13.1 Mail the Claim Form and documentation to:
Global Benefits Group
7600 Corporate Center Drive, Suite 500
Miami, FL 33126 USA

Submission of claims by scan or online:
• Scan claims to: eclaims360@gbg.com
• Log-on to latam.gbg.com

13.2 ATMSafe Claims
This benefit will be payable provided the robbery is reported to the police within 48 hours of its occurrence, and the following documentation is produced upon submission of a claim:
1. A copy of the police report;
2. A fully completed dated and signed (by the Insured) claim form;
3. A copy of the ATM transaction receipt, showing the amount withdrawn, time, date and location of the ATM; and;
4. Confirmation from the financial institution records that the transaction occurred at the time, date and said location.

The Robbery benefit is limited to two benefits, per Policy Period.

All claims must be submitted to the Insurer within 10 days from the date of the robbery.

13.3 Status of Claims
Insureds wishing to request the status of a claim or have a question about a reimbursement received, should contact the Company. 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.

13.4 Claims Appeal
13.4.1 Level One Appeal
If you are not satisfied with an administrative, eligibility, rescission of coverage, denial or reduction of benefit or if a health care determination for pre-service or current care coverage has been denied; you or your appointed representative has the right to file an appeal within 180 days.

Your appeal will be reviewed and the decision made by a member of the claims staff who was not included in the original decision. Appeals involving Medical Necessity, clinical appropriateness, or Experimental and Investigational treatments will be considered by a health care professional.

For level one appeals regarding required pre-service or concurrent care coverage decision, GBG will respond with a decision within 15 calendar days. We will respond within 30 calendar days for appeals regarding a post service coverage decision. If more time or information is needed to make the decision, GBG will notify you to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

13.4.2 Level Two Appeal
If you are dissatisfied with the level one appeal decision, you may request a level two appeal. To start, follow the same process required for a level one appeal.
Most requests for a second review will be conducted by the appeals committee, which consists of at least three people. Anyone involved in the prior decisions may not vote on the committee. For appeals involving Medical Necessity, clinical appropriateness, or being experimental or investigational, the committee will consult with at least one physician reviewer in the same or similar specialty as the care under consideration, as determined by Our medical review agent.

For level two appeals we will notify you that we have received your request and schedule a committee review. For required pre-service and concurrent care coverage determinations, the committee review will be completed within 15 calendar days. For post-service claims, the committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional time needed by the committee to complete the review. You will be notified in writing of the decision within five working days of the meeting, and within the committee review time frames.

13.4.3 Independent Review Procedure
If you are not satisfied with the final decision of the level two appeal review, you may request that your appeal be referred to an independent review organization. The independent review organization is composed of persons who are not employed by Us, Our administrator, or any of Our affiliates. A decision to use this external level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. The Company will abide by the decision of the independent review organization.

In order to request a referral to an independent review organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination or because it is considered to be Experimental or Investigational by Our medical review agent. Administrative, eligibility, or benefit coverage reductions or exclusions are not eligible for appeal under this process.

To request a review, you must notify the appeals coordinator within 180 days of your receipt of The Company's final adverse benefit determination. The Company will then forward the file to the independent review organization. The independent review organization will render an opinion within 30 days of request.

13.4.4 Expedited Appeals
You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health, ability to regain maximum function or, in the opinion of your physician, would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an Admission or continuing inpatient stay. GBG medical review agent in consultation with the treating physician will decide if an expedited review is necessary. When an appeal is expedited, GBG will respond within 72 hours, followed up in writing or electronically within five days.

13.4.5 Complaints Procedure
If you are not satisfied with the outcome of the Appeals process as described above, you may file a formal complaint. The complaints procedures are listed at GBG's website.

14. HOW TO CONTACT GBG

GBG must be contacted for the following services:
- All services that require Pre-authorization,
- Emergency Services / Medical Evacuation,
- Locating preferred Providers

GBG 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, which will be the sole determinant of the nature and scope of treatment.

**For Emergency medical assistance/Pre-authorization/benefit verification, please contact:**

- **Worldwide Collect:** +1.305.697.1778
- **Email:** preauthorizations@gbg.com
- **Mexico local number:** 55.1454.2772
- **Venezuela local number:** 212.720.7411
- **Colombia local number:** 1.508.5170
- **Brazil local number:** 11.4380.3493

**15. 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 Period, resulting in bodily injury, in which the cause is external and occurs beyond the victim’s control.

**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).

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

**Air Ambulance:** an aircraft specially equipped with the necessary medical personnel, supplies and Hospital equipment.

**ATM:** an automatic electronic device designed to permit the Insured to interface with a financial institution without teller assistance using a registered card.

**Bereavement Counseling:** counseling of a terminally ill or deceased member’s family by a psychiatrist or psychologist.

**Cancer:** a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

**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.

**Complementary Therapy:** treatments performed by a medical professional, prescribed by the attending physician, for the completion of a medical treatment.

**Complications of Maternity and Perinatal** means a condition;

a. Caused by pregnancy; and
b. Requiring medical treatment prior to, or subsequent to termination of pregnancy; and
c. The diagnosis/complication are distinct for pregnancy; and
d. Causes complications in the newborn unrelated to Congenital or Hereditary Conditions.

**Congenital Condition:** any inherited disorders or illnesses that exist prior to childbirth regardless of cause, whether or not they have manifested or been diagnosed during childbirth or years thereafter.
**Coronary Artery Bypass Surgery:** 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 non-surgical techniques such as balloon angioplasty, laser or any other procedures.

**Covered Pregnancy** is all that:

a. Whose delivery date is at least 10 months after the Effective Date of coverage for the Insured mother, and
b. Conception did not occur due to any fertility/infertility treatment or any assisted medical treatments or procedures, and
c. Maternity coverage is included under the Policy, and
d. The Insured meets the eligibility criteria for maternity related services.

Note: The acquisition of the Maternity and Perinatal Complications Rider does not qualify for a Covered Pregnancy.

**Custodial Care:** services provided that include, but are not limited to, personal assistance, which does not require professional qualification, for example: cleaning, feeding and dressing an individual.

**Deductible:** the amount of covered allowable charges payable by the Insured during each Policy Period before the Policy benefits are activated.

**Durable Medical Equipment:** equipment customarily and generally useful to a person only during an Illness or injury.

**Effective Date:** the date upon which an Insured's coverage will become effective under this Policy.

**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 and requires medical care within 24 hours from the time such symptoms first occur.

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

**Extended Care Facility:** 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.

**Face Page:** the Policy certificate of coverage, which includes information about Insureds, Deductible, Premium, exclusions or additional restrictions, product and coverage.

**Heart Attack:** 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-cardio graphic changes and by elevation of cardiac enzymes.

**Hereditary Condition:** Illness or disorder, which is genetically transmitted from parent to child or ancestors to descendants.

**Home Health Care Agency/ Home care:** an agency or organization, or subdivision thereof that is primarily engaged in providing skilled nursing services and other therapeutic services in the covered person's home.

**Home Health Care** is a program:

a. for the care and treatment of an Insured 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:** treatment provided to patients suffering from advanced, progressive and incurable diseases and who have a prognosis of less than 240 days of life and such treatment has as primary objective the relief of suffering and improvement of the quality of life.
**Hospital:** is a legally licensed institution for the provision of clinical and surgical services under the supervision of medical professionals. The term Hospital does not include nursing homes, rest home, health resorts, homes for the aged, infirmaries or establishments for domiciliary care.

**Illness:** abnormal condition of the body that are manifested by signs, symptoms or abnormal medical examination results that identify the condition as different from the normal state of the body and can be caused by internal or external factors.

**Inpatient:** Medically Necessary Admission in a Hospital or other health care facility for at least 24 hours.

**Kidney Failure:** 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.

**Lifetime Maximum:** maximum amount that the Insurer will pay for a benefit during the lifetime of the Insured or the Policy.

**Major Organ:** the actual undergoing of a transplant as the receiver of a heart, liver, lung, pancreas or bone marrow.

**Medically Necessary:** medical treatment, service or supply, determined as necessary and appropriate for the diagnosis and / or treatment of an Illness or injury approved by the Insurer. A treatment, service or supply will not be considered Medically Necessary if:

a. It is only a convenience to the Insured, the Insured's family or the service Provider; or
b. It is not considered appropriate for the diagnosis or treatment of the Insured; or
c. Exceeds the level of care required to allow diagnosis and appropriate treatment, or
d. Do not follow the standard of practice, as established by the professional councils of its field (medicine, physiotherapy, nursing, etc.)

The Company reserves the right to determine the medical necessity of a planned treatment.

**Outpatient:** any medical services/procedures (surgical or not) performed for less than 24 hours in a Hospital setting or not.

**Out-of-pocket:** expenses that are the responsibility of the Insured.

**Policy:** is the document issued by the Insurer that guarantees the Insured and Insurer the fulfillment of the agreement established through contractual rules.

**Policyholder:** the person that has applied for coverage and is named as the Policyholder on the Face Page of this Policy.

**Policy Limits:** the maximum payment for benefits that can be per Policy Period, per life or event and will always be subject to the UCR. The limits of the Policy can be observed in the Table of Benefits.

**Policy Period:** is the period of 365 days counting from the Effective Date of the Policy.

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

**Pre-Authorization:** the process by which an Insured obtains written approval for certain medical procedures or treatments, from GBG prior to the commencement of the proposed medical treatment.

**Pre-Existing Condition:** any Illness or injury, physical or mental condition and any consequences of such, for which an Insured received any diagnosis, medical advice, treatment, had taken any prescribed drug or where distinct symptoms were evident prior to the Policy’s Effective Date.

**Preferred Provider Organization (PPO):** a participating Provider, such as Hospital, clinic or physician that has entered into an agreement to provide health services to Insureds by the Insurer. The Company also maintains an international network of medical Providers and facilities with which it has arranged direct billing procedures.
Premium(s) is the consideration owed by the Policyholder to the Insurer in order to secure benefits under this Policy.

Prescription Drugs: medications which are prescribed by a physician and which would not be available without such prescription.

Preventive Care/ Check-Up: exams and consultation without the presence of symptoms or diagnosis.

Professional Sports: activities in which the participants receive payment for participation.

Prophylactic Surgery: surgery to remove an organ or gland that shows no signs of cancer, in an attempt to prevent development of cancer of that organ or gland within preset conditions approved by the Company.

Provider: the organization, facility or person performing or supplying treatment, services, supplies or drugs.

Robbery: the taking of cash withdrawn from any automated cash dispensing machine from any ATM, credit or debit card customer by inflicting or threatening imminent physical harm or bodily injury to the customer or by placing any such customer in fear of imminent physical harm or bodily injury while withdrawing funds from any automated cash dispensing machine, provided that the Robbery is not committed by an officer or employee of the Insured.

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.

Schedule of Benefits: 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.

Serious Accident: an Accident that requires immediate hospitalization for at least 24 hours. Medical necessity will be assessed by the Company.

Stable: Any medical condition or related condition, whether or not a diagnosis has been made, which in the 180 days before your Effective Date, there have been;
- No new/change in treatment; medical management; medication, and
- No new/more frequent/more severe symptoms or findings, and
- No new test results or test results showing a deterioration, and
- No investigations initiated or recommended for your symptoms, and
- No hospitalization or referral to a specialist.

Stroke: a cerebrovascular incident resulting in permanent neurological damage. Transient Ischemic Attacks are specifically excluded.

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 country 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 according to medical protocols approved for each condition.

**Waiting Period:** the period from the Insured Effective Date, during which benefits will be limited or no benefit will be available.
Global Benefits Group offers worldwide expertise, Products and services unbound by geographic constrains.

Any Country.
Any Nationality.