TIECARE INTERNATIONAL

GLOBAL STUDENT ADVANTAGE

Accident and Sickness
Limited and Short Duration Benefit Plan

TieCare International is the educational division of

GLOBAL BENEFITS GROUP
Insurance Without Borders®

Thank you for selecting Global Student Advantage Health Insurance.

Welcome to the Global Benefits Group (GBG) family!

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

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 how to use your coverage. Please review the Policy Face Page which shows the deductible you selected and any exclusions or amendments to your coverage.

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

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

Sincerely,

Ed Zutler
President, GBG Insurance Limited

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Schedule of Benefits

After the Deductible has been satisfied, benefits will be paid as listed for the Provider selected based on Usual, Reasonable, and Customary Charges. Or the negotiated rates.

GLOBAL STUDENT ADVANTAGE PREMIER PLAN created for the KOREAN STUDENT AND SCHOLAR ASSOCIATION STUDENT HEALTH INSURANCE			
General Features/Plan Specifications[1]			
Annual Maximum Per Injury or Sickness (Per policy year) [2]	**Unlimited / $1,000,000**		
Lifetime Maximum Per Covered Person	**Unlimited**		
Area of Coverage	**Worldwide**		
Outside of the United States including Home Country Coverage	**$500**		
	Outside U.S.	**U.S. In-Network**	**U.S. Out-of-Network**
Annual Individual Deductible (Per policy year)[3] • Family Deductible is 2 times Individual	**$0 / $250**	**$0 / $250**	**$0 / $500**
Member Coinsurance (after the deductible)	**20%**	**20%**	**40%**
Individual Out-of-Pocket Maximum (Coinsurance Maximum) [4] • Family Out-of-Pocket is 2 times Individual	**$6,350**	**$6,350**	**Unlimited**
Office Visit Co-payment, including Student Health Center • Doctor Non-Surgical Treatment/Examination • Consultation visits when referred by the attending Doctor	**$25** **$50**	**$25** **$50**	**$50**
Prescription Drug Benefits	**Plan Coinsurance80%**		
Preventive Care	**Included**		
Routine Dental	**Not Covered**		
Routine Vision	**Not Covered**		
Pre-Existing Conditions	**Waived for all polices of 120 days or more** **Pre-Existing conditions are not covered for short term policies of 30, 60, and 90 days**		
Covered Services and Benefit Levels: Subject to Deductible, Coinsurance, Co-payments, and Benefit Maximum.	**PLAN REIMBURSEMENT** Once the Annual Out-of-Pocket Maximum (Coinsurance Maximum) is met, the Plan reimbursement is 100%		
Hospitalization and Inpatient Benefits: ***Pre-Authorization Required***			
• Semi-private room • Intensive Care (medically necessary) • Medical treatment, medicines, laboratory and diagnostic tests • Inpatient Consultation by a Physician or Specialist • Inpatient Surgery • Inpatient Surgeon • Inpatient Ancillary Services	**80%**	**80%**	**60%**

[1] Benefits will be paid on a reasonable and customary basis, subject to all Policy exclusions, limitations and conditions for charges listed if they are incurred as a result of sickness or accidental bodily injury and the benefits must also be medically necessary and given or ordered by a physician.

[2] All references to Annual refer to a Policy Year, not a calendar year.

[3] The Deductible for "Outside U.S." and "U.S. In-Network" is combined. The Deductible for "U.S. Out-of-Network" is separate.

[4] The Annual Out-of-Pocket Maximum for "Outside U.S." and "U.S. In-Network" is combined. The Annual Out-of-Pocket Maximum for "U.S. Out-of-Network" is separate.

Outpatient Benefits			
• Emergency Room • Emergency Medical Services • Outpatient Physician Visit • Consultation by Specialist • Echocardiography, Ultrasound, • CAT Scan, PET Scan, MRI • Endoscopy (e.g. gastroscopy, colonoscopy, cystoscopy) • X-Rays • Laboratory • Outpatient or Ambulatory Surgery • Outpatient Surgeon	**80%**	**80%**	**60%**
Covered Services and Benefit Levels: Subject to Deductible, Coinsurance, Co-payments, and Benefit Maximum.	**PLAN REIMBURSEMENT** Once the Annual Out-of-Pocket Maximum (Coinsurance Maximum) is met, the Plan reimbursement is 100%		
	Outside U.S.	**U.S. In-Network**	**U.S. Out-of-Network**
Emergency Room			
• Deductible $300, waived if admitted	**100%**	**100%**	**100%**
Maternity –			
• 10 month waiting period, conception must occur while this coverage is in effect. • Normal delivery including prenatal care, postnatal care and complications of pregnancy. • Dependent Daughters are not covered. • Fertility/infertility services, tests, treatments, drugs and/or procedures, complications of that pregnancy, delivery and postpartum care are excluded from coverage.	**80%**	**80%**	**60%**
Therapeutic Services (Outpatient)			
Physical Therapy, Chiropractic, Occupational Therapy, Vocational Speech Therapy			
$70 per visit, maximum 30 days per occurrence	**80%**	**80%**	**60%**
Homeopathic and Acupuncture			
• Treatment for a covered illness ****Annual Maximum Benefit: $500**	**80%**	**80%**	**60%**
Extended Care / Inpatient Rehabilitation: *Pre-Authorization Required*			
• Must be confined to facility immediately following a Hospital stay • Acute or Sub-Acute Care only for Extended Care Episode ****Annual Maximum Benefit: 45 days**	**80%**	**80%**	**60%**
Hospice			
• Refer to Policy regarding qualifications for care **** Inpatient Lifetime Benefit Maximum: 45 Days** ****Outpatient Lifetime Benefit Maximum: $5,000**	**80%**	**80%**	**60%**
Emergency Ambulance			
• Ground Ambulance • Air Ambulance: Pre-Authorization Required • Refer to Policy for more specific details	**100%**		
Durable Medical Equipment: *Pre-Authorization Required*			

• Reimbursement of rental up to purchase price • See Policy for more specific details ****Annual Benefit Maximum: $10,000ar**	**80%**	**80%**	**60%**
Private Duty Nursing, Skilled Nursing, Visiting Nurse, Home Health Nursing: *Pre-Authorization Required*			
• Refer to Policy for specific details ****Annual Benefit Maximum: 100 Days Per Year**	**80%**	**80%**	**60%**
Covered Services and Benefit Levels: Subject to Deductible, Coinsurance, Co-payment, and Benefit Maximum.	**PLAN REIMBURSEMENT** Once the Annual Out-of-Pocket Maximum (Coinsurance Maximum) is met, the Plan reimbursement is 100%		
	Outside U.S.	**U.S. In-Network**	**U.S. Out-of-Network**
Diabetic Supplies: *Pre-Authorization Required*			
• Includes Insulin Pumps and associated supplies ****Annual Maximum Benefit: $7.500**	**80%**	**80%**	**60%**
Mental Health			
****Inpatient: Annual Benefit Maximum: 30 days;** ****Outpatient: Annual Benefit Maximum: 40 visits**	**80%**	**80%**	**60%**
Alcohol and Drug Abuse: Out-patient & In-patient; *Pre-Authorization Required*			
****Inpatient: Annual Benefit Maximum: 30 days;** ****Outpatient: Annual Benefit Maximum: 40 visits**	**80%**	**80%**	**60%**
HIV, AIDS, ARC and Sexually Transmitted Diseases			
Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions • Treatment available if condition is not pre-existing	**80%**	**80%**	**60%**
Emergency Dental Care			
• Limited to accidental injury of sound natural teeth sustained while covered under the policy • Palliative Care covered up to $600 per Policy Period • Covered under the medical benefit **** Benefit Maximum: $300 per tooth**	**100%****	**100%****	**80%****
Preventive Care			
Child Wellness			
• Includes child immunizations and routine medical exams • Up to 12 months of age – maximum 9 visits • Up to 18 years – Annual visit	**100%****	**100%****	**80%****
Adult Female and Male Examinations, Mammograms and Immunizations Covered on an Annual Exam Basis			
Other Benefits			
Medical Evacuation or Repatriation to Home Country	**$50,000 Maximum Benefit**		
Repatriation of Remains	**$20,000 Maximum Benefit**		
War and Terrorism	**Included**		

Accidental Death and Dismemberment	**$15,000 Maximum Benefit**

NOTES:

- We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance, Deductible or Co-pay amount.
- **Eligible Expenses** will be paid under the Inpatient benefits for Surgery and under the Outpatient benefits for Surgery, but not both for the same or related procedure.

Accidental Death and Dismemberment

Class 1 - Principal Sum for Policy Holder	$15,000
Class 2 Principal Sum for Spouse and/or Dependents	$ 7.500

Time Period for Loss	**90 days**
Loss of:	**Benefit: Percentage of**
Loss of Life	**Principal Sum**
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	100%
Loss of One Foot	50%
Loss of Sight of One Eye	50%

Description of Accident and Dismemberment Benefits

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Severance means the complete separation and dismemberment of the part from the body.

The covered Person must receive initial medical treatment within 30 days of the date of Accident. The insurance does not cover injuries received while making a parachute jump (unless to save a life).

The maximum amount payable for this benefit is $25,000. If the Insured incurs a covered loss listed above, we will pay the percentage of the Principal Sum opposite the loss in the table above. If the covered person sustains more than one such loss as the result of one accident, the Insurer will only pay

one amount, the largest to what the insured is entitled. The loss must result within 90 days of the accident. Your coverage under the policy must be inforce.

General Provisions

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

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

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

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

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

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

Administrative Agent
Global Benefits Group
26000 Towne Centre Dr. Suite 100
Foothill Ranch, CA 92610 USA

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

Administration

Eligibility and Conditions of Coverage

Application
Acceptance is guaranteed. Pre-Existing conditions will be waived for Policies over 120 days.
Consult the Policy Face Page for the terms and conditions regarding the issuance of this Policy.
This policy is a 364 day non-renewable term policy.

Eligibility

- Minimum age 18 to Maximum age of 40,
- Must not be a US Citizen**.**
- International students with F-1 visas who are enrolled in a full-time associate, bachelor, master or Ph.D. degree program, or formal ESL program at a university, who are currently registered with no less than 6 credit hours (unless such school's full-time status requires less credited hours), and International Visiting Scholars with J-1 visas are eligible to enroll in this insurance plan. The six credit hours requirement is waived for summer, if the applicant was enrolled in this plan as a full-time student in the immediately preceding spring term.
  applicant was enrolled in this plan as a full-time student in the immediately preceding spring term.

- Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence and online courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy eligibility requirements have been met. If the Company discovers that the policy eligibility requirements have not been met, its only obligation is to refund premium.
- Termination of the insurance of the primary member shall also cancel all coverage for dependents.

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Insured Dependents

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

- The spouse or domestic partner,
- Dependent children up to age 19 if single, or up to age 24 if single and a full-time student at an accredited college or at the time the policy is issued and renewed. Dependents that are full-time students up to age 24 are charged the Child/Children rate.
- A US citizen may not be a spouse or dependent.

Dependent children include the Policyholder's natural children, legally adopted children, and step children. Insured Dependents are covered from the date that the Insurer accepts them and the corresponding premiums are paid.

Addition of a Newborn Baby or Legally Adopted Child:

Babies Born under a Pregnancy Covered by the Maternity Benefit

- Provide written notification to the Insurer within 30 days of the date of birth.
- The newborn child 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.
- Any request received beyond the 30-day notification period shall result in coverage only being effective from the date of notification (except for the first 30 days, which are covered regardless of notification).

Legally Adopted Child, Child born of a Surrogate Mother.

- 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

Newborn Child born when the Maternity Benefit is Not Covered under the Policy will be accepted under the Parent's policy without medical underwriting. 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 ten consecutive calendar months. To be added a copy of the birth certificate including the newborn's full name, gender and date of birth must be submitted within thirty calendar days of birth.

Pre-Existing Conditions and Eligibility

- Pre-Existing Conditions are waived for all covered persons insured under a policy period of 120 days or more.
- Pre-Existing Conditions will not be covered under a policy period of 30, 60, or 90 days..
- Refer to explanation of Pre-Existing in Definitions

Residency

The permanent residence of the primary insured and all dependents is assumed to be international and not in the United States. If the insured or dependents change their residence to a different country, the Company must be notified in writing. If the insured or dependents change permanent residency to the U.S., GBG retains the right to modify the benefits or premium until the end of the current benefit period.

"Country of Residence" is defined as:

Where the Insured has been issued a passport from. In the event of dual citizenship with the US, the Insured will be considered a US Citizen.

Terms and Conditions

Premium Payment

All coverage under this Policy is subject to the timely payment of Premium, which must be made payable to the Insurer. Payment must be in the currency approved by the Insurer. Any other forms of currency shall not be accepted and will be considered as nonpayment of Premium unless otherwise agreed by the insurer. The policy and rates shall be guaranteed for 364 days. The policy is non-renewable.

Grace Period

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

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

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

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

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

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

Policy and Rate Modifications
The Policy term begins on the Effective Date of the Policy as in the policy Face Page and ends at midnight 364 days later.

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

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

- An increase or decrease in benefits provided under the Policy; or
- Addition of a new Insured; or
- Termination of an Insured;

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

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

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

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

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

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

- This policy will be canceled automatically upon nonpayment of the premium, although the Company may at their discretion reinstate the coverage if the premium is subsequently paid.
- If any premium due from the policyholder remains unpaid, the Company may in addition defer or cancel payment of all or any claims for expenditures incurred during the period it remains unpaid.
- While the Company shall not cancel this policy because of eligible claims made by any Insured Person, it may at any time terminate an individual /or any of their eligible dependents or subject his/her coverage to different terms if she/he or the policyholder has at any time:
    - Misled the Company by misstatement or concealment;
    - Knowingly claimed benefits for any purpose other than are provided for under this policy;
    - Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the Insurer detriment;
    - Failed to observe the terms and conditions of this policy, or failed to act with utmost good faith.
- If the Company does cancel this policy, they shall give 30 days' notice. The Company will refund the unearned portion of the premium minus administrative charges and policy fees

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

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

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

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

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

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

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

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

Claims

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

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

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

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

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

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

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

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

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

If the insured has another policy in his/her country of residence:

- All claims incurred in the country of residence must be submitted in the first instance against the other policy. This policy shall only provide benefits when such benefits payable under the other policy have been paid out and the policy limits of such policy have been exhausted. The following documentation is required to coordinate benefits: Explanation of Benefits and copy of bills covered by the local insurance company containing information about the diagnosis, date of service, type of service, and covered amount.

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.

In no event will more than 100% of the Allowable Charge and/or maximum benefit for the covered services be paid or reimbursed. It is the duty of the Insured to inform Insurer of all other coverage. The insurer has full right of subrogation. Where allowed. To determine the Primary Policy, the following guidelines will be used:

- The Plan is Primary if it covers the claimant as an active individual.
- If two Plans cover the claimant as an individual, the Plan that has covered him/her for the longer period of time is the Primary Plan.
- If an Insured is covered as an active individual under the Plan and as a retired or laid off individual under another Plan, the Plan that covers him as an active individual is the Primary Plan. The Plan that covers him/her as a retired or laid off individual is the Secondary Plan.

Excess Benefit Provision

- No benefit of this policy is payable for any expense incurred for Injury or Sickness which is paid or payable by: 1) other valid and collectible Insurance or, 2) under an automobile insurance policy.
- This Excess Provision will not be applied to the first $5000 of medical expenses incurred.
- Covered Medical Expenses excludes amounts not covered by the Primary Carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

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

Plan Deductibles and Lifetime Maximums

Deductible
Deductible is the first dollar amount paid by each of the Insured Persons of the allowable charges for eligible medical treatment expenses during each policy year before the Policy benefits are applied. Deductibles for In-network and out of country accumulate on a combined basis. Deductibles are shown on the medical Identification Card and the Policy Face Page.

Application of Deductible
When claims are presented to Insurer, the allowable charges will be applied towards the Deductible, and if applicable will then be calculated and reimbursed at the percentage listed on the Schedule of Benefits. Once the Deductible has been satisfied, all allowable expenses will be paid at 100% of UCR up to the listed maximum amounts outlined in the Schedule of Benefits.

Lifetime Maximum
Certain payment of Benefits are subject to a lifetime aggregate maximum per individual Insured Person as indicated in the Schedule of Benefits, as long as the Policy remains in force. The Lifetime Maximum includes all Benefit Maximums specified in this Policy, including those specified in the Schedule of Benefits, Policy Face Page and in any Policy Endorsements or Riders.

Preferred Provider Network

The Company maintains a Preferred Provider Network. For information on the providers and facilities within the Preferred Provider Network, consult GBG Assist at the number on the medical I.D. card or www.gbg.com. **Please refer to Pre-Authorization Requirements and Procedures**.

U.S only:

- **Preferred Provider In-Network:** This tier consists of all providers as well as other preferred providers designated by the Company and listed on the website. In-Network providers have agreed to accept a negotiated discount for services. The ID card contains the logo for the network. Present it to the physician or hospital.
- **Out-Of-Network:** Utilizing providers that are Out-of-Network is a more costly financial option for the Insured. The Insurer reimburses such providers up to a Usual, Reasonable, and Customary as determined by the Insurer. The provider may bill the Insured the difference between the amounts reimbursed by the Insurer and the providers billed charge. Additionally, the Insured will pay a coinsurance amount that is higher than if an In-Network provider was used.

All other Countries: The Insured may utilize any licensed provider. However, we suggest the insured contact GBG Assist to locate a provider with a direct billing arrangement with the Insurer.

The Company retains the right to limit or prohibit the use of Providers, which significantly exceed usual, reasonable and customary charges.

Pre-Authorization Requirements and Procedures

Certain designated services require Pre-Authorization, and Insureds are required to follow the procedures outlined below.
In certain geographic areas, or in accordance with specific policy features,

Pre-Authorization is a process by which an Insured Person obtains approval for certain non-emergency, medical procedures or treatments prior to the commencement of the proposed medical treatment. This requires that the Insured Person submit a completed Pre-Authorization Request form to GBG Assist **a minimum of 5 business days prior** to the scheduled procedure or treatment date. GBG Assist will review the matter and respond to the Insured Person. To assure full reimbursement for covered services, written approval from GBG Assist must be received by the Insured Person prior to the commencement of the proposed medical treatment.

The following services require Pre-Authorization:

- Hospitalization
- Outpatient Surgery
- All Cancer Treatment in excess of $10,000 (Including Chemotherapy and Radiation)
- Home Health Benefits including Private Duty Nursing, Skilled Nursing, and Visiting Nurse
- Air Ambulance – Air ambulance service will be coordinated by Insurer's air ambulance provider
- Specialty Treatments and Highly Specialized drugs
- Physical Therapy and Rehabilitation Services
- Any condition, including cancer treatment or any chronic condition, or outpatient services which do not meet the above criteria, but are expected to accumulate over $5,000 of medical treatment per policy year.

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

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

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

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

Notwithstanding the requirement to pre-authorize:

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

Health Care Coverage and Benefits

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

Areas of Coverage - The Policy is written on a Worldwide basis.

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

Inpatient Hospital Benefits

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

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

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

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

Inpatient Mental Health Benefits
Benefits are provided for psychotherapeutic treatment and psychiatric counseling and treatment for an approved psychiatric diagnosis and are payable as follows and in accordance with the current Schedule of Benefits.

As set forth in the Schedule of Benefits:

1. Benefits are for inpatient mental health treatment only in a Hospital or approved facility. A Physician or a psychiatrist must provide all mental health care services.
2. Services include treatment for Bulimia; Anorexia; Schizophrenia, Major Depressive Disorder; Bipolar Disorders; and Paranoia and other serious mental illnesses.

Surgical and Medical Benefits

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

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

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

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

- The patient's medical status continues to require either acute or sub-acute levels of curative medical treatment, skilled nursing, physical therapy, or rehabilitation services. GBG Assist is responsible for this determination of the patient's medical status.

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

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

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

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

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

Outpatient Services

When an Insured Person 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 for the following:

- Treatment of accidental injury within 48 hours of the accident;
- Minor surgical procedures;
- Medically necessary covered emergency services, as defined herein.

Outpatient Physician Visits
Insurer provides benefits for medical visits to a Physician, in the Physician's office, if medically necessary. Services for routine physical examinations, including related diagnostic services and routine foot care are not covered, except as specifically provided for in this Policy. All outpatient physicians visits are payable in accordance with the current Schedule of Benefits.

Diabetic Medical Supplies -
Insurer provides benefits for certain diabetic supplies including Insulin Pumps and associated supplies.

Maternity and Newborn Benefits –
Maternity Related Services – Maternity Services and Newborn Infant Care Services are included
Maternity Waiting Period:
Costs associated with normal pregnancy or C-Section, and childbirth and any related condition of pregnancy incurred where the actual date of delivery is at least 10 months from the effective date of the respective insured parent / dependent daughter will be considered a Covered Pregnancy. ***No maternity related treatment for the mother or the newborn is covered during this period.*** Conception must occur after the effective date of the Policy.

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

- Hospital services rendered in a licensed Hospital or approved birthing center (including anesthesia, delivery, pre-natal and post-natal care) for any condition related to pregnancy, including but not limited to childbirth and miscarriage.
- Obstetrical services (including prenatal, delivery and post-natal care) and anesthesia services by physicians.
- Pre-natal vitamins are covered during the term of the pregnancy only, if prescribed by a physician;
- The deductible is waived.

Complications of Pregnancy
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Maternity complications and/or newborn complications of birth (not related to congenital or hereditary disorders), such as prematurity, low birth weight, jaundice, hypoglycemia, respiratory distress, and birth trauma are covered as follows:

- This benefit shall only apply if all the stipulations under Maternity Related Services have been met.
- This benefit does not apply to complications related to any condition excluded or not covered by this Policy, including but not limited to maternity and newborn complications of birth in a pregnancy that is the result of any type of fertility treatment or any type of assisted fertility procedure, or non-covered pregnancies.
- Complications caused by a condition that was diagnosed before the pregnancy, and/or any consequences thereof, will be covered in accordance with Policy provisions.
- Complications that arise within the ten month waiting period are not covered.
- This benefit applies to all eligible female dependents.

Newborn Infant Care Services
Newborn infant's coverage will be covered as part of the Maternity under a Covered Pregnancy 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 subject to the satisfaction of the Policy Year Deductible

Infant Examinations
Immunizations and routine visits up to six months for Infants born from Covered Pregnancies only – See Schedule of Benefits for Maximum Benefit and number of visits. The deductible is waived for this benefit.

Other Benefits

Nose and Nasal Septum Deformity
When nose or nasal septum deformity is the result of trauma during 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.

Congenital Conditions

- Congenital Condition means any hereditary condition, birth defect, physical anomaly and/or any other deviation from normal development present at birth, which may or may not be apparent at that time. Congenital and Hereditary Conditions which first manifest themselves or are diagnosed before the Insured reaches 18 years of age are limited to the amount shown on the Schedule of Benefits.
- Congenital or Hereditary Conditions which first manifest themselves or are diagnosed after the date the Insured reaches 18 years will be covered up to the amount shown on the Schedule of Benefits.

- Newborn Diseases and/or Conditions that are related to Congenital, Hereditary Condition, are covered under the benefit of Congenital and Hereditary Conditions, and not under complications of maternity.

HIV, AIDS and ARC

- Benefits are available for medically necessary, non-experimental services, supplies and drugs for the treatment of Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), only if caused by an accident or blood transfusion, provided the condition(s) are not considered pre-existing conditions. Sexually transmitted diseases and all related conditions are not covered.

Hospice Program

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

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

The Hospice care:

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

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

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

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

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

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

Prescription Drugs

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

.Refer to Schedule of Benefits for details.

- Highly specialized drugs for specific uses will be covered but must be pre-authorized and coordinated in advance by GBG Assist. 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.

Durable Medical Equipment

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

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

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

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

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

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

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

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

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

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

Emergency Ambulance Services / Medical Evacuation

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

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

- Emergency evacuation is only covered if related to a covered condition for which treatment cannot be provided locally, and transportation by any other method would result in loss of life or limb. GBG Assist, on behalf of the insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. Emergency transportation must be provided by a licensed and authorized transportation company to the nearest medical facility. The vehicle or aircraft used must be staffed by medically trained personnel and must be equipped to handle a medical emergency.
- **Approved medical evacuations will be to the nearest medical facility capable of providing the necessary medical treatment.** GBG Assist contact information can be found on the medical I.D. card.
- The insured agrees to hold the Insurer and any company affiliated with the insurer by way of similar ownership or management, harmless from negligence resulting from such services, or negligence regulating from delays or restrictions on flights caused by the pilot, mechanical problems, or governmental restrictions, or due to operational conditions.
- Within ninety days of the medical evacuation, the return flight for the covered person and an accompanying person will be reimbursed up to the cost of an airplane ticket in economy class only to the covered person's Country of Residence – Maximum $2000 per person.

Emergency Dental
Emergency dental treatment and restoration of sound natural teeth; required as a result of an accident is included. All treatment must be completed within 120 days of the accident or before the expiration date of the Policy.

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

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

Refer to Schedule of Benefits for details.

Child/Adult Examinations / Screenings

Child Examinations/Screenings/Immunizations (Children over six months) – Refer to Schedule of Benefits for Policy Maximum. This benefit includes Well Child Routine Medical Exams and Child Preventive Care Services, Health History, Development Assessments, Physical Examinations, and Age Related Diagnostic Tests. The deductible is waived for this benefit.

Adult Exams and Preventive Health Care - Refer to Schedule of Benefits for Policy Maximum. The deductible is waived for this benefit.
Routine examinations and treatments may include diagnostic studies and vaccinations.

Accidental Death and Disability

Coverage is provided for the Primary Insured Person, Insured dependent spouse, and Insured dependent children if death by accident, injury, or illness occurs while insured under this Policy, and the covered person continues to meet all other eligibility criteria and Policy terms and conditions. Refer to the Policy Face Page for the amount of coverage insured under this Policy.

Coverage ceases:

- At the end of the policy period following attainment of age 65;
- If premiums cease to be paid by the Insured;
- Termination of the Policy;
- If the Insured Person no longer meets the eligibility criteria under this Policy

Exclusions and Limitations

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

1. Charges in excess of Usual, Reasonable and Customary allowable charges for any covered procedure.
2. Non-Emergency treatment that is not pre-authorized according to the policy terms and conditions.
3. Charges and Services where claims are not received within 180 days of the date of service
4. Maternity related treatment or complications for the mother or newborn during the 10-month waiting period.
5. Claims and costs for medical treatment, occurring before the effective date of coverage (including waiting periods) or after the expiration date of the policy. Claims and costs for medical services with dates of service after the policy termination date that are related to accidents, sicknesses, or maternity originating during the policy year, unless the policy has been renewed. This includes any portion of a covered prescription to be used after the expiration of the current policy year.
6. Services, supplies, or treatment including drugs and/or emergency services that are provided by or payment is available from; (a) Workers' Compensation law, Occupational Disease law or similar law concerning job related conditions of any country, (b) the Insured Person, a family member or any enterprise owned partially or completely by the aforementioned persons, (c) another insurance company or government, (d) under the direction of public authorities related to epidemics.
7. Services, supplies or treatments, including drugs, that are not scientifically or medically recognized for a specific diagnosis, or that is considered as off label use, experimental or not approved for general use are considered experimental or investigational and therefore not eligible services..
8. Any services, supplies, treatments including drugs and/or emergency air services; (a) not ordered by a Physician, (b) not medically necessary, not recommended or approved by a physician, (c) not rendered under the scope of the Physician's licensing, (d) medical and dental services that do not meet professionally recognized standards or are determined by Insurer to be unnecessary for proper treatment.
9. Telephonic consultations (other than for Mediconsult), missed appointments, or "after hours" expenses.
10. Personal comfort and convenience items including but not limited to television, housekeeping services, telephone charges, take home supplies, ambulance services (other than those provided by this Policy), and all other services and supplies that are not medically necessary including expenses related to travel and hotel costs incurred for medical or dental care.

11. Health check-ups, inoculations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.).
12. Immunizations, other than provided for under the Preventive Care benefit as listed on the schedule.
13. Over-the-counter (OTC) drugs, supplies or medical devices, which do not require a Physician prescription, even if recommended 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 Maternity), sexual enhancement devices, supplements, herbs or drugs, for any reason.
14. Services and supplies related to visual therapy, Radial keratotomy procedures, Lasik, or eye surgery to correct refractive error or deficiencies, including myopia or presbyopia
15. Rest cures, custodial care, home-like care, assistance with activities of daily living (ADL), milieu therapy for rest and/or observation; whether or not prescribed by a Physician. Any admission to a nursing home, home for the aged, long term care or rehabilitation facility, sanatorium, spa, hydro clinic or similar facilities that do not meet the policy definition of a hospital. Any admission, arranged wholly or partly for domestic reasons, where the hospital effectively becomes or could be treated as the Insured's home or permanent abode.
16. Elective and or 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. 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.
17. Any medical complications arising directly or indirectly as a result of a non-authorized elective or cosmetic procedure.
18. Sleep studies and other treatments relating to sleep apnea including restless leg syndrome.
19. Weight related treatment; any expense, service or treatment for obesity, 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.
20. Organ transplant and related procedures except as specified in the Transplant Services section of this Policy, including but not limited to; (a) donor search expense is excluded, (b) supportive services are not automatically covered and must be approved and managed by GBG Assist, (c) all expenses of cryopreservation and the implantation of living cells on a deceased person or in conjunction with infertility or reproductive treatments, (d) medically necessary organ, blood or cell transplants may be covered on a case by case basis when pre-authorized and managed by GBG Assist.
21. 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, pre-natal care, complications of that pregnancy, delivery and postpartum care are also excluded. Genetic counseling, screening, testing or treatment.
22. Elective abortions; any voluntarily induced termination of pregnancy, unless the mother's life is in imminent danger.
23. 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.
24. Maternity/Delivery Preparation Classes
25. Circumcisions, unless medically necessary and preauthorized
26. Treatment of any injury arising directly or indirectly from alcohol or drug abuse or addiction. This includes but is not limited to treatment for any injuries caused by, contributed to or resulting from the Insured's use of alcohol, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purposed prescribed by the Insured's Doctor.
27. Treatment for any conditions as a result of self-inflicted illnesses or injuries, suicide or attempted suicide, while sane or insane, or emergency air services for the same.
28. Injuries and/or illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law by an Insured Person.
29. Eyeglasses; contact lenses; sunglasses.
30. Prosthesis and corrective devices which are not medically required intra-operatively or equivalent appliances; except prosthesis or durable medical equipment used as an integral part of treatment prescribed by a physician, meeting the covered categories of durable medical equipment or prosthesis and approved in advance by GBG Assist.
31. Durable Medical Equipment does not include: motor driven wheelchairs or bed; additional wheels; comfort items such as telephone arms and over bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies; exercycles, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment; and similar items or the cost of instructions for the use and care of any durable medical devices. The customizing of any vehicle, bathroom facility, or residential facility is also excluded.
32. Routine podiatry or other foot treatment not resulting from an illness or injury. Orthopedic shoes or other supportive devices for the feet, such as, but not limited to, arch supports and orthotic devices or any other preventative services and supplies; any devices resulting from the diagnosis of weak, strained, unstable or flat feet or fallen arches; or any tarsalgaia, metatarsalgia; or specified lesions of the feet, such as corns, calluses, and hyperkeratosis, toenails or bunions. Pedicures, special shoes and inserts of any form or type.
33. Growth Hormones, unless medically necessary and preauthorized by GBG Assist. This includes treatment by a bone growth stimulator, bone growth stimulation or treatment related to growth hormone, regardless of the reason for prescription.
34. Health care services associated with conditions as a result of travel, following the receipt of advice against travel because of health reasons from any health care provider.

35. Hearing Aids, Hearing Devices and Bone Anchored Hearing Aids.
36. Exceptional Risks; (a) treatment as a consequence of injury sustained while participating in or training for professional sports; (b) treatment as a consequence of injury sustained while participating in, or training for, or as a consequence of: war (declared or not), acts of terrorism , acts of foreign enemy hostilities, civil war, rebellion, revolution or insurrection; (c) .chemical contamination; (d) contamination by radioactivity from any nuclear material or from the combustion of nuclear fuel (e) treatment for any loss or expense of nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily injury, except in an endeavor to save human life.
37. Hazardous Activities includes any activity that exposes the participant to any foreseeable danger or risk. Examples of hazardous activities include but are not limited to aviation sports, rafting or canoeing involving white water rapids in excess of grade 5, tests of velocity, scuba diving at a depth of more than thirty metres, bungee jumping, and participation in any extreme sport.
38. Treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the HIV Virus, if diagnosed as a pre-existing condition. If diagnosed after the effective date of the Policy and it is proven to be caused by a blood transfusion or accident, a 24 month waiting period applies.
39. Except for accidental injury to sound, natural teeth, dental Care is excluded from coverage; treatment, services or supplies related to (a) the teeth; and (b) the gums other than tumors; and (c) any other associated structures; (d) the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces, or other mechanical aids; and (e) dental implants, regardless of cause.
40. Treatment services or supplies as the result of prognathism, retrognathism, microtrognathism, or any treatment, services, or supplies to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible. This includes treatment for (TMJD) or Temporomandibular Malocclusion Joint Disorders.
41. This Policy will not cover any services received by any parties or in any countries where otherwise prohibited by the US/UN/EU law.

Accidental Death and Disability Exclusions: In addition to the Exclusions and Limitations shown above, the following Exclusions also pertain to the Term Life/Mortal Benefit Coverage.

42. Any loss caused directly or indirectly from extortion, kidnap & ransom or wrongful detention of the Insured or hijacking of any aircraft, motor vehicle, train or waterborne vessel on which the Insured is traveling.
43. Any loss resulting as a fare-paying passenger in a scheduled aircraft or in an employer owned or hired jet or helicopter for transportation of employees.

How to File a Claim

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

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

Mail the Claim Form and documentation to:

GBG Administrative Services, Inc.

26000 Towne Centre Drive, Suite 130
Foothill Ranch, CA 92610

Submission of claims by Scan or Online

- Scan claims to: eclaims@gbg.com
- Log-on to www.gbg.com

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

Claims Appeal

GBG Administrative Services, Inc.
Attention: Appeals Department
26000 Towne Centre Drive, Suite 130
Foothill Ranch, CA 92610 USA

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

Accidental Death and Disability
To substantiate a claim for benefits covered by the terms of this Policy, the following initial documents must be submitted:

1. An official certificate of death, indicating date of birth of the Insured;
2. A detailed medical report at the onset and course of the disease, bodily injury or accident that resulted in the death or disability. In the event of no medical treatment, a medical or official certificate stating the cause and circumstances of death;
3. The Insurer will pay the benefit as soon as the validity of the claim for benefits has been reasonably satisfied. Expenses incurred in relation to the substantiation of a claim will not be the responsibility of the Insurer.

GBG Assist

GBG Assist must be contacted for the following services:

- Pre-Authorization
- Emergency Services / Medical Evacuation
- Case management

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

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

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

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

For Treatment in All Countries: GBG ASSIST (24 hours)

- Inside USA/Canada Toll Free: +1.866.914.5333
- Worldwide Collect: +1.905.669.4920
- Email: GBGAssist@gbg.com

Definitions

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

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

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

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

Acupuncture – Treatment of a medical condition, which is covered under the terms of this policy, by needles or laser provided by or ordered by a licensed physician as defined in this policy.

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

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

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

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

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

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

Birth Center means a facility that: a) is mainly a place for the delivery of a child or children at the end of a normal pregnancy; b) and meets one or both of the following tests: (1) it is licensed as a Birth Center under the laws of the jurisdiction where it is located; and/or (2) it meets all the following requirements: (i) it is operated in accordance with the laws of the jurisdiction where it is located; (ii) it is equipped to perform all necessary routine diagnostic and laboratory tests; (iii) it has trained staff and equipment required to properly treat potential emergencies of the mother and of the child; (iv) it is operated under the full-time supervision of a Physician or a Registered Nurse (R.N.); (v) it has at all times a written agreement with at least one Hospital in the area for immediate acceptance of a patient in the event of a complication; (vi) it maintains medical records for each patient; (vii) and it is expected to discharge or transfer each patient within 48 hours after the delivery.

Catastrophic Illness – For the purposes of this policy, catastrophic illness is defined as the following conditions:

- **Cancer**: The presence of uncontrolled growth, and the spread of malignant cells and invasion of tissue. Incontrovertible evidence of such invasion of tissue or definite histology of a malignant growth must be produced. The term "Cancer" also includes leukemia, lymphomas and Hodgkin's disease. Non-invasive carcinomas in situ localized non-invasive tumors showing only early malignant changes, tumors in the presence of any human immune-deficiency virus and all skin Cancers except malignant melanomas are excluded from the definition of Catastrophic Illness.
- **Major Organ Failure and/or Transplant**: The process, as a recipient, of a transplant of any major organ and the medical treatment preceding and following the approved transplant.
- **Heart Attack**: Death of a portion of heart muscle as a result of abrupt interruption of adequate blood supplies to the area. The diagnosis will be based upon all of the following criteria: a history of typical chest pain, new electrocardiograph changes, and an elevation in cardiac enzyme levels.

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.

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

Chronic Condition – An injury, illness or condition, which does not require hospitalization, which may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by recurrences requiring continuous or periodic care as necessary.

Complications of Pregnancy means a condition;

- Caused by pregnancy; and
- Requiring medical treatment prior to, or subsequent to termination of pregnancy; and
- The diagnosis of which is distinct for pregnancy; and
- Which constitutes a classifiably distinct complication of pregnancy.

A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

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

Congenital Condition means any heredity condition, birth defect, physical anomaly and/or any other deviation from normal development present at birth, which may or may not be apparent at that time. These deviations, either physical or mental, include but are not limited to, genetic and non-genetic factors or inborn errors of metabolism.

Country of Residence means the country where; a) the insured resides and has been issued a Passport from.

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

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

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

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

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

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

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

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

Emergency Dental Treatment – Emergency dental treatment is urgent treatment necessary to restore or replace sound natural teeth damaged as a result of an accident. Sound teeth do not include teeth with previous crowns, fillings, or cracks. Damage to teeth caused by chewing foods does not qualify for emergency dental coverage.

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

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

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

Examinations means the Company and the Claims Administrator shall have the right and opportunity, through their medical representatives, to examine any person whenever and as often as they may reasonably require within the duration of any claim. The Insured Person shall make available all medical reports and records, as well as requested health information questionnaires, and where required, shall sign all authorization forms necessary to give the Company a full and complete medical history. The Company and the Claims Administrator shall have the right and the opportunity to require an autopsy in the case of death, unless forbidden by law or religious beliefs.

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

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

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

Homeopathy means a system of alternative medicine that seeks to treat patients by administering small doses of medicines that would bring on symptoms similar to those of the patient in a healthy person. For example, the homeopathic treatment for diarrhea would be a miniscule amount of a laxative.

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

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

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

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

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

Illness means a physical sickness, disease, pregnancy and complications of Pregnancy of an Insured Person. This does not include Mental Illness.

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

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

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

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

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

Maternity Care – The cost of prenatal care, delivery, C-Sections (see Definitions), and postnatal treatment subject to the specific limit. Any complications related to pregnancy including C- section will be treated as maternity and will be subject to the specified limits. Maternity also includes Pre-natal vitamins.

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

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

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

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

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

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

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

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

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

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

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

Pre-Authorization – Pre-Authorization is a process by which an Insured Person obtains written approval for certain medical procedures or treatments, from GBG Assist (see the back of your I.D. Card) prior to the commencement of the proposed medical treatment. Certain medical procedures will require the Pre-Authorization process to be followed in order for the service to be covered and to maximize the benefits of the Insured. For full information on how to pre-authorize medical treatment and relevant contact information, refer to pre-authorization section.

Pre-Existing Condition means any illness or injury, physical or mental condition, for which an Insured Person received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident 90 days prior to the effective date. (The Terms and Conditions related to this plan's Pre-existing Conditions are described in the Schedule of Benefits.

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

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

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

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

Prescription Drug Formulary – A schedule of prescription drugs approved for use which will be covered, if not otherwise excluded by the plan and dispensed through participating pharmacies. It may include tiers in which a different level of copayment applies to each tier.

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

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

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

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

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

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

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

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

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

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

When PPO providers are available within a 30-mile radius of the Insured's local residence, the Usual, Reasonable and Customary charge may be the negotiated PPO provider fee for such services.

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

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

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Global Benefits Group offers worldwide expertise,
Products and services unbound by geographic constrains.

Any Country.

Any Nationality.

GBG Corporate Headquarters
Southern California, USA