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

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

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

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

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

Sincerely,

Bob Dubrish
CHIEF EXECUTIVE OFFICER
GLOBAL BENEFITS GROUP
THANK YOU FOR SELECTING GLOBAL BENEFITS GROUP HEALTH INSURANCE
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1. SCHEDULE OF BENEFITS

This Schedule of Benefits and Policy Face Page form part of the health insurance Policy and are a summary outline of the benefits payable under the Policy. All benefits described are subject to the definitions, limitations, exclusions, and provisions of the Policy Face Page and the Schedule of Benefits. Optional benefits that have been purchased will be listed on the Policy Face Page. All dollar ($) amounts are shown in USD.

The following benefits are per person per Policy Period and subject to the Insured’s Policy Period Deductible. After satisfaction of the Policy Period Deductible, Insurer will pay the eligible benefits set forth in this Schedule at the allowable charge, which is defined as Usual, Customary, and Reasonable (UCR). This is 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 who reside in the same country and whose injury or illness is comparable in nature and severity.

Benefits will be paid on a Usual, Customary, and Reasonable basis, subject to Policy exclusions, limitations and conditions, for the charges listed, if they are:

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

### MAXIMUM BENEFIT

Policy Period Maximum of $500,000

### PROVIDER NETWORK

- **Worldwide excluding USA:** Free choice of Providers.
- **USA:** The Insurer maintains the GBG Global Security Network. In-network benefits are paid at 100%. Out-of-network benefits are paid at 70% UCR.

### HOSPITALIZATION BENEFITS

<table>
<thead>
<tr>
<th>Description</th>
<th>Allowable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private/Semi-private room including; Medical treatment, medicines, laboratory and diagnostic tests and Private Duty Nursing</td>
<td>100% UCR; up to $2,250 per day, for the first 120 days of the Policy Period; then $750 per day thereafter</td>
</tr>
<tr>
<td>Intensive care including; medical treatment, medicines, laboratory and diagnostic tests and private duty nursing</td>
<td>100% UCR; up to $3,000 per day, for the first 30 days of the Policy Period; then $1,000 per day thereafter</td>
</tr>
<tr>
<td>Inpatient Surgery/Inpatient surgeon and consultation</td>
<td>100% UCR; up to $50,000 per Policy Period</td>
</tr>
<tr>
<td>Accommodation charges for companion of a hospitalized member</td>
<td>$100 per day; maximum 20 days per Policy Period</td>
</tr>
</tbody>
</table>

### OUTPATIENT BENEFITS

<table>
<thead>
<tr>
<th>Description</th>
<th>Allowable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient physician/specialist visit</td>
<td>100% UCR; up to $100 per visit; maximum 12 visits per Policy Period</td>
</tr>
<tr>
<td>Diagnostic exams including laboratory and imaging tests</td>
<td>100% UCR; up to $500 per exam</td>
</tr>
<tr>
<td>Outpatient surgery, medical and nursing fees</td>
<td>100% UCR; up to $50,000 per Policy Period</td>
</tr>
<tr>
<td>Physical therapy and rehabilitation services</td>
<td>100% UCR; up to $100 per visit; maximum 30 visits per Policy Period, all therapies combined</td>
</tr>
<tr>
<td>Preventive Care/Checkup (10 month Waiting Period applies)</td>
<td>100% UCR; $150 Maximum per Policy Period; Deductible waived</td>
</tr>
<tr>
<td>Prescribed medication after covered hospitalization or consultation</td>
<td>100% UCR; up to $1,000 per Policy Period</td>
</tr>
</tbody>
</table>
**EMERGENCIES**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground Ambulance</td>
<td>100% UCR; Deductible waived</td>
</tr>
<tr>
<td>Air Ambulance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Emergency room and medical services</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Emergency Dental Care (Limited to accidental injury of sound natural teeth). Services must be completed within 120 days of Accident</td>
<td>100% UCR; up to $25,000 Lifetime Maximum</td>
</tr>
</tbody>
</table>

**SPECIALIZED TREATMENTS**

Transplant Procedures (in the U.S. Institutes of Excellence facilities approved by GBG only)

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant Procedures</td>
<td>100% UCR; $175,000 Lifetime Maximum per diagnosis includes donor expenses and donor procurement expenses up to $15,000. OPTIONAL RIDER: Additional $350,000 added to Lifetime Maximum</td>
</tr>
</tbody>
</table>

**OTHER BENEFITS**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncologic treatment</td>
<td>100% UCR; up to $80,000 per Policy Period</td>
</tr>
<tr>
<td>GBG Personal Medical Advisor - Medical Second Opinion</td>
<td>Included</td>
</tr>
<tr>
<td>Home Health Care/ Home Care</td>
<td>100% UCR; up to $100 per day; maximum 30 days per Policy Period</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100% UCR; up to $750 per day; maximum 120 days</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100% UCR; up to $2,000 per Policy Period</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>100% UCR; up to $1,000 Lifetime Maximum</td>
</tr>
<tr>
<td>War and Terrorism Benefit</td>
<td>100% UCR</td>
</tr>
<tr>
<td>Repatriation of Mortal Remains</td>
<td>$7500 maximum per Insured</td>
</tr>
</tbody>
</table>

**THE FOLLOWING SERVICES REQUIRE PRE-AUTHORIZATION**

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

- Hospitalization
- Exams or Outpatient procedures that requires more than local anesthesia
- Oncologic treatment in excess of $10,000
- Home Health Benefits/ Home Care
- Organ, bone marrow, stem cell transplants, and other similar procedures
- Specialty Treatments and Highly Specialized drugs
- Any condition that is expected to accumulate over $10,000 of medical treatment per Policy Period.

**1.1 Deductible Options**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Outside the USA</th>
<th>Inside the USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 1</td>
<td>$3,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Plan 2</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Plan 3</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

Deductible per Individual

*PLEASE SEE YOUR POLICY FACE PAGE TO DETERMINE THE DEDUCTIBLE AMOUNTS THAT APPLY TO YOUR COVERAGE*
2. GENERAL PROVISIONS

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.

2.1 Policyholder, the covered person whose name is indicated in the Policy Face Page as “Policyholder”, hereinafter shall be referred to as the “Policyholder”.

2.2 Insurer, the Second party, GBG Insurance Limited, hereinafter shall be referred to, sometimes collectively, as the “Insurer”, “We”, “Us”, “Our” or “Company”.

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

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

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

2.6 Policy Disclaimer
This GBG Insurance Limited Policy is an international health insurance Policy. GBG Insurance Limited is an insurance company incorporated in Guernsey with registration number 42729 and licensed by the Guernsey Financial Services Commission to conduct insurance business under the Insurance Business (Bailiwick of Guernsey) Law, 2002 as amended. As such, this Policy is subject to the laws of the Bailiwick of Guernsey, and the Insured should be aware that laws governing the terms, conditions, benefits and limitations in health insurance policies issued and delivered in other countries including the United States are not applicable to this Policy. If any dispute arises as to the interpretation of this document, the English version shall be deemed to be conclusive and taking precedence over any other language version of this document.

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

2.8 Late Payment Provision
A period of 30 days will be allowed for payment of any Premium, after the Premium payment due date. The Insurer will suspend coverage during this period if the Premium is not received. If the Premium is received during the 30-day period, the coverage will resume without any interruption in coverage. If the Premium due is not paid, the Insurer will cancel the Policy as of the Premium due date. All unpaid Premium through the date of cancellation and any other Premium adjustments assessed as a result of cancellation are the obligation of the Policyholder. There will be a service fee for any checks returned for insufficient funds, closed accounts, or for stop payments on checks. Returned checks will be treated as non-payment of Premiums.
2.9 Cancellation
The Company reserves the right to cancel the Policy as described below:

- This Policy will be canceled for non-payment 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, it may at any time terminate an individual or any of their eligible dependents or subject the Insureds coverage to different terms if the individual 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 Our detriment;
  - Failed to observe the terms and conditions of this Policy, or failed to act with utmost good faith.

The Insurer retains the right to cancel, non-renew or modify a Policy on a Class basis, and the Insurer will offer the closest equivalent coverage possible to the Insured. No individual Insured shall be independently penalized by cancellation or modification of the Policy due solely to poor claim record.

If the Company does cancel this Policy, they shall give 30 days' notice. The Company will refund the unearned portion of the Premium minus administrative charges and Policy fees.

If the Policyholder or a dependent cancels the Policy after it has been issued, reinstated, or renewed, the Insurer will not refund the unearned portion of the Premium. In case of death of any Insured covered in this Policy, the Company will refund the unearned Premium minus administrative fees, if the death was caused by a condition covered under this Policy.

2.10 Policy and Rate Modifications
The Policy term begins on the Effective Date of the Policy as shown on the Policy Face Page and ends at midnight, 365 days later. The Policy terms and rates shall be guaranteed for one year. The Insurer has the right to change the Policy terms or Premium on the renewal date. The Insurer will notify the Policyholder of any such change to Policy terms or rates, at least 30 days before the change is made.

2.11 Change of Product or Deductible Plan
The Policyholder may only request to change to another product or Deductible plan at the anniversary date of the Policy. The new product/Deductible plan chosen must be available in the current Country of Residence. The request for change must be submitted in writing and received before the anniversary date. Some requests will be subject to underwriting – for those cases a Health Application will be requested and approval is not guaranteed.

During the first thirty (30) days from the effective date of the change, benefits payable for any Illness or injury not caused by Accident or infectious disease, will be limited to the lesser of benefits provided by the new product or the prior product, and the higher Deductible plan will apply. During the first ten (10) months after the effective date of the change, benefits for maternity, newborn, and congenital will be limited to the lesser benefit provided by either the new product/Deductible plan or prior product/Deductible plan. During the first six (6) months after the effective date of the change, transplant benefits will be limited to the lesser benefit provided by either the new product or prior product.

2.12 Other Premium Changes
- Premium changes due to Addition of a new Insured: resulting premium changes will occur immediately on the addition date.
- Changes in an Insured’s age are considered changes in the demographics of the Policyholder. Resulting Premium changes will occur and are assessed upon renewal date.

2.13 Duration of Coverage
Benefits are paid to the extent that an Insured 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.

2.14 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.
2.15 Change of Risk
The Policyholder must inform the Company within 30 days, of any changes related to Insureds (such as change of address, Country of Residence, 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, Premiums or cancel coverage for an Insured following a change of residence if it is not possible to maintain GBG’s coverage in the new Country of Residence.

2.16 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 by the Company.

2.17 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.

2.18 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.

2.19 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.

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

2.21 Transfer
If the primary Insured dies, this Policy will automatically be transferred to the oldest Insured 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.

2.22 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.

2.23 Scope of Coverage
The Policy covers the Insured for allowable charges for covered medical services provided in the areas of coverage selected in the Policy Face Page, including Hospitalization, surgery, Outpatient services, medical treatment and medical supplies incurred while such Insured 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’s injury or sickness for which insurance is provided under the Policy.

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

2.25 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 Period Deductible, Co-payments and any other limitations set forth in the Policy, unless otherwise noted.
3. ELIGIBILITY AND CONDITIONS OF COVERAGE

3.1 Policy Terms and Pre-Existing Conditions Limitation
All applications are subject to underwriting by the Insurer. Acceptance is not guaranteed. The Insurer will advise in writing if your application has been approved along with the terms and conditions of the approval. A 12-month Waiting Period will apply to all Pre-existing Conditions declared on the application. Pre-existing conditions not disclosed on the application are never covered. Consult the Policy Face Page for the terms and conditions regarding the issuance of this Policy.

3.2 Eligibility
- You must reside in Latin America or the Caribbean at the time the Policy is issued, and
- Must be 60 years or older and have not attained age 90 at the time of enrollment. There is no maximum renewal age for person’s already covered under this Policy.
- Termination of the insurance of the primary member shall also cancel all coverage for dependents, except in the case of death of the primary member.
- Your eligibility date, if your application has been approved, will be determined by the Insurer.

3.3 Insured Dependents
Coverage under this Policy can be extended to the following family members. Insured dependents may include:
- The spouse or domestic partner

3.4 Waiting Period
This Policy contains a 60-day Waiting Period, during which only Illnesses or injuries caused by an Accident occurring within this period, or diseases of infectious origin that first manifest themselves within this period, will be covered.

The Insurer may waive the Waiting Period only if:
- Other medical expense insurance coverage was in effect with another company for at least one consecutive year, and
- The effective date of this Policy begins within 60 days of the expiration of the previous coverage, and
- The prior coverage is disclosed in the health application, and
- The prior Policy and a copy of the receipt for the last year’s Premium payment are submitted with the health application.

Failure to notify the Insurer at the time of Application may result in a denial of the requested waiver of the waiting period.

If the Waiting Period is waived, benefits payable for any condition manifested during the first 60 days of coverage are limited, while the Policy is in effect, to the lesser benefit provided by either this Policy or the prior Policy. See Policy Face Page to determine if this Waiting Period applies to your Policy.

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

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

4. CLAIMS ADJUDICATION AND PRE-AUTHORIZATION PROCEDURES

4.1 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 latam.gbg.com.
4.1.1 Claims submitted by the provider
The claims may be submitted to Insurer directly by the institution or Provider. Claims must be submitted in the official currency where the service was rendered. Bills coming from Providers within the United States should be submitted on HCFA 1500 or UB92 formats.

4.1.2 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. Claims must be submitted in the official currency where the service was rendered. 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 13 of this Policy (How to File a Claim) for more information. In case of the death of the claimant Insured, any outstanding medical claims reimbursements will be paid as follows:

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

4.1.3 Claim Payment Information
All paid claims will be available to view on Our website latam.gbg.com. You must log in and then you will have access to claim status and claim payment or Explanation of Benefit information. All communication regarding the Explanation of Benefits will be electronic. Claim payments are subject to copayments, coinsurance, Deductible and charges in excess of Usual, Customary, and Reasonable.

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

4.3 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.

4.4 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.

4.5 Coordination of Benefits
**Within the Country of Residence:** When an insured has another insurance Policy that provides benefits also covered under this Policy, benefits will be coordinated with the other Policy and benefits under this Policy reduced to avoid duplication of benefits. 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. In no event will more than 100% of the allowable charge and/or maximum benefit for the covered services be paid or reimbursed. 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. If a travel insurance policy exists, such Policy will function as primary. For Insureds with two (2) or more international policies, the policy that has been in force the longest will be considered primary.
Special Note for U.S. Citizens: United States citizens who are eligible for U.S. Medicare benefits must apply for coverage under those benefits for medical and prescription services obtained within the U.S.

4.6 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.

4.7 Deductible
Deductible is the first dollar amount paid by each of the Insured of the allowable charges for eligible medical treatment expenses during each Policy Period before the Policy benefits are paid. Deductibles for In and Out of the U.S. accumulate on a combined basis. Deductibles are shown on the medical identification card and the Policy Face Page. If the Deductible was not met in a given Policy Period, any eligible charges incurred by an Insured during the last three months of that Policy Period will be carried over to be applied towards that Insured’s Deductible for the following Policy Period, unless the family Deductible was met.

4.8 Application of Deductible
When claims are presented to the 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 charges will be paid at 100% of UCR up to the listed maximum amounts outlined in the Schedule of Benefits.
Note that the amount of allowable charges applied towards the Deductible also reduces the applicable benefit maximum by the same amount.

4.9 Family Deductible
There is only one Deductible per person, per Policy Period. For families we apply a maximum equivalent of the sum of two individual Deductibles on your Policy, per Policy Period.

4.10 Lifetime Maximum
Certain payments of benefits are subject to a lifetime aggregate maximum per Insured 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, Amendment or riders.

4.11 Pre-Authorization Requirements and Procedures
The Pre-Authorization request shall be sent to the Company within a minimum of five business days prior to the scheduled procedure or treatment date, along with the attending physician request that must include:
• Diagnosis;
• Recommended Treatment;
• Place where treatment will be performed (Institution name),
• Service date and medical fees.

Pre-Authorization is required for the following benefits. Failure to obtain Pre-Authorization will result in a 30% reduction in payment of covered expenses:
• Hospitalization
• Exams or Outpatient procedures that requires more than local anesthesia
• Oncologic Treatment in excess of $10,000
• Home Health Benefits/Home Care
• Organ, bone marrow, stem cell transplants, and other similar procedures
• Specialty treatments and highly specialized drugs
• Any condition, which do not meet the above criteria, but are expected to accumulate over $10,000 of medical treatment per Policy Period, such as, but not limited to:
  - Chronic illness
  - Ambulatory services

Medical Emergency Authorizations must be received within 72 hours of the admission or procedure. In instances of medical emergency, the Insured should go to the nearest Hospital or Provider for assistance even if that Hospital or Provider is not part of the Network.
If treatment would not have been approved by the pre-authorization process, all related claims will be denied.
5. PREFERRED PROVIDER NETWORK

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

In Latin America and the Caribbean: The Insured may utilize any licensed Provider.

U.S. only:

Preferred Provider: Providers who agree to receive direct payment made by the Company.

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

In the U.S., in case of the use of a non-preferred Provider, the Company will only reimburse 70% of UCR and the remaining balance will be the Insured’s responsibility.

All other countries: The Insured may utilize any licensed Provider. However, we suggest the Insured contacts GBG 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, Customary and Reasonable Charges.

6. HOSPITALIZATION BENEFITS

Hospitalization services include, but are not limited to, private or 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 or 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.

6.1 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.

6.2 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 procedure.

6.3 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.

6.4 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 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.

6.5 Inpatient Ancillary Hospital Services
If Medically Necessary for the diagnosis and treatment of the Illness or injury for which an Insured 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 under this benefit. For maintenance coverage, please refer to Section 7. Outpatient services.

6.6 Companion of a Hospitalized Member
Charges included for overnight Hospital accommodations for the companion of a hospitalized Insured will be payable up to a daily maximum. See your Schedule of Benefits for specific benefit maximums.

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

- Treatment of accidental injury within 48 hours of the Accident;
- Minor surgical procedures;
- Medically Necessary covered Emergency services, as defined herein.

7.1 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.

7.2 Physical Therapy and Rehabilitation Services
Insurer will provide benefits for Medically Necessary Physical Therapy and Rehabilitation Services treatment rendered to an Insured as an Outpatient of a Hospital, Provider’s office, or approved independent facility. Benefits for facility and professional services for Physical Therapy and Rehabilitation Services are payable, if shown on the Schedule of Benefits. Benefits are provided for a covered illness and must be pursuant to a physician’s written treatment plan, which contains short and long term treatment goals and is provided to Insurer for review. Services must produce significant improvement in the Insured’s condition in a reasonable and predictable period of time;

- 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; or
- Be necessary to the establishment of an effective maintenance program.
7.3 Preventive Care/ Check-up
Adult Preventive Health Care – Refer to Schedule of Benefits for Policy maximum. Routine examinations and treatments may include diagnostic studies and vaccinations. The Deductible is waived for this benefit.

7.4 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.
This benefit is subject to the Deductible. Refer to Schedule of Benefits for details.

8. EMERGENCY SERVICES / MEDICAL EVACUATION

8.1 Emergency Ground Ambulance Services/ Medical Evacuation
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 is not Medically Necessary, will not be considered a covered service.

8.2 Emergency Dental
Emergency dental treatment and restoration of sound natural teeth; required as a result of an Accident, covered by the Policy, is included. All treatment must be completed within 120 days of the Accident.

9. SPECIALIZED TREATMENTS

9.1 Transplant Procedures
Coverage for human organ, bone marrow, blood and stem cells transplants. This coverage applies only when the transplant recipient is an Insured under this Policy. In the United States, the use of the Institutes of Excellence for transplants approved by GBG is mandatory. This transplant benefit begins once the need for transplantation has been determined by a physician and has been certified by a second surgical or medical opinion, and includes:

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

An optional rider is available that increases the Lifetime Maximum benefit. Refer to the Policy Face Page to determine if this rider is included under your plan.

10. OTHER BENEFITS

10.1 Sports and Hazardous Activity
This Policy provides coverage for a wide range of activities and sports, excluding professional sports. Listed below are examples of activities and sports not covered:
• Mountain Climbing, mountaineering, alpinism;
• Aviation Sports (aerobatics, parachuting, paragliding, parasailing, sky diving and wingsuit flying);
• Bungee Jumping
• Off piste skiing
• Scuba Diving below 60 feet
• Water Rafting above class 3
• Cliff Diving
• Off track or on track motor vehicle racing

GBG is available to provide clarification if a specific sport or activity would be covered under the Policy. GBG should be contacted prior to engagement in such sport or activity. Please contact your GBG Elite Team for clarifications.

10.2 Home Health Care/Home Care
An initial period of 30 days will be covered if pre-authorized. An advanced treatment plan signed by the treating Physician is required for the proper treatment of the Illness or injury and used in place of Inpatient treatment. Home Health Care includes the services of a skilled licensed professional (nurse or therapist) outside the Hospital and does not include Custodial Care.
These services need to meet specified medical and circumstantial criteria to be covered. Thorough case manager review is required.
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.

10.3 Special Treatments and Highly Specialized Drugs
Prosthesis, appliances, orthotic Durable Medical Equipment, and implants will be covered, but must be pre-authorized in advance by GBG.
Highly specialized drugs for specific uses will be covered, but must be pre-authorized and coordinated in advance by GBG. 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 Rituximab. When necessary, and if possible, the Company will coordinate the delivery of such medications. Experimental drugs and drugs not approved by the FDA are not covered.

10.4 Hospice Care
Hospice care is a program approved by the Insurer to provide a centrally administered program of palliative and supportive services to terminally ill persons and their families. Terminally ill means the patient has a prognosis of 240 days or less. Services are provided by a medically supervised interdisciplinary team of professionals and volunteers.
Covered services are available in home, Outpatient (following an Inpatient Hospitalization) and Inpatient settings up to the amount listed on the Schedule of Benefits. Admission to a Hospice program is made on the basis of patient and family need.
The Hospice care:
  • Must relate to a covered medical condition that has been the subject of a prior valid claim with the Insurer, with a diagnosis of terminal illness from physician;
  • Benefits are provided as outlined in the Schedule of Benefits per Insured;
  • Benefit is payable only in relation to care received by a recognized Hospice.

10.5 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 Policy will pay the Usual, Customary and Reasonable Charges for Artificial Devices listed, provided such Durable Medical Equipment (DME) is:
1. Prescribed by a physician, and
2. Customarily and generally useful to a person only during an Illness or injury, and
3. Determined by Insurer to be Medically Necessary and appropriate.

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

Charges for repairs or replacement of artificial devices or other Durable Medical Equipment originally obtained under this Policy will be paid at 50% of the allowable Usual, Customary and Reasonable 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 Equipment. The customizing of any vehicle, bathroom facility, or residential facility is also excluded.

**10.6 Repatriation of Mortal Remains**
The necessary clearances for the return of an Insured’s mortal remains by air transport to the Country of Residence will be coordinated by Insurer.

A benefit for either repatriation of mortal remains or local burial (if death occurs outside of country of residence) 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.

**10.7 War and Terrorism**
This Policy covers bodily injury directly or indirectly caused by certain acts of War and Terrorism.

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

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

Please refer to Schedule of Benefits for maximum benefit limitations.

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

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

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

1. Claims and costs for medical treatment, occurring before the Effective Date of coverage (including Waiting Periods) or after the expiration date of the Policy. 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 Period, unless the Policy has been renewed. This includes any portion of a covered prescription to be used after the expiration of the current Policy Period.

2. Services, supplies, or treatment including drugs and/or Emergency services that are provided by or payment is available from: (a) Workers’ Compensation law, Occupational Disease law or similar law concerning job related conditions of any country, (b) the Insured, a family member or any enterprise owned partially or completely by the aforementioned persons, (c) another insurance company or government, (d) under the direction of public authorities related to epidemics.

3. Services, supplies or treatments, including drugs, that are not scientifically or medically recognized for a specific diagnosis, or that are considered as off label use, experimental or not approved for general use are considered Experimental or Investigational and therefore not eligible services.

4. Diabetic supplies including insulin pumps and associated supplies.

5. 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.

6. Telephonic consultations, missed appointments, or “after hours” expenses.

7. 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.

8. Health check-ups, inoculations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.).

9. Immunizations, other than provided for under the Preventive Care benefit as listed on the Schedule of Benefits.

10. 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, sexual enhancement devices, supplements, herbs or drugs, for any reason.

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

12. 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.

13. 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.

14. Any medical complications arising directly or indirectly as a result of a non-authorized elective or cosmetic procedure.

15. Sleep studies and other treatments relating to sleep apnea, sleep disorders including restless leg syndrome.

16. Weight related treatment; any expense, service or treatment for obesity, nutritionist consultation (related to any diagnosis, conditions and/or symptoms), weight control, or any form of food supplement. This includes expenses related to or associated with treatment of morbid or non-morbid obesity, including, but not limited to, gastric bypass, gastric balloons, gastric stapling, jejunal ileal bypass, and any other procedures or complications arising there from, unless stated on the Schedule of Benefits.
17. Any fertility/infertility services, tests, treatments and/or procedures of any kind, including, but not limited to, fertility/infertility drugs, including drugs to regulate the menstrual cycle/ovulation for family planning purposes, artificial inseminations, in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), surrogate mother and all other procedures and services related to fertility and infertility. Any pregnancy resulting from such treatments, complications of that pregnancy, and postpartum care are also excluded, unless stated on the Schedule of Benefits.

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

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

20. 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.


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

23. Treatment for alcoholism, solvent abuse, drug abuse or addictive conditions of any kind, and treatment of any illness arising directly or indirectly from alcohol or drug abuse or addiction. This includes, but is not limited to treatment for any injuries caused by, contributed to or resulting from the Insured's use of alcohol, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed by the Insured's doctor.

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

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

26. Eyeglasses, contact lenses, sunglasses.

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


29. Durable Medical Equipment does not include: motor driven wheelchairs or beds, additional wheels, comfort items such as telephone arms and over bed tables, items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners), disposable supplies, exercise cycles, 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 Equipment. The customizing of any vehicle, bathroom facility or residential facility is also excluded.

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

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

32. Hearing devices and bone anchored hearing aids.

33. Exceptional Risks: (a) treatment as a consequence of injury sustained while participating in a hazardous activity or training for any professional sport or activity, or as a consequence of: war (declared or not), acts of terrorism, acts of foreign enemy hostilities, civil war, rebellion, revolution or insurrection; (b) chemical contamination; (c) contamination by radioactivity from any nuclear material or from the combustion of nuclear fuel (d) 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.

34. Except for accidental injury to sound, natural teeth, dental care is excluded from coverage; treatment, services or supplies related to 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.

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

36. Treatment, diagnostic procedures, services, supplies for mental, nervous or behavioral conditions and all mental health services on an outpatient/inpatient basis. Serious mental Illness is covered if noted in the Policy.
37. Treatment of sexually transmitted diseases including Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the HIV Virus.

38. This Policy will not cover any services received by any parties or in any countries where otherwise prohibited by the U.S./UN/EU law.

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

12. HOW TO FILE A CLAIM

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

The claim form must be used only when a Provider does not bill the Company directly, and when you have Out-of-pocket expenses to submit for reimbursement.

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

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

12.2 Status of Claims

Insureds wishing to request the status of a claim or have a question about a reimbursement received, should contact the Company. Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review. Claim payment information including status and payment will be available electronically for your review.

12.3 Claims Appeal

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

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

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

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

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

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

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

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

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

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

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

13. HOW TO CONTACT GBG

GBG must be contacted for the following services:

- All services that require Pre-authorization,
- Emergency Services / Medical Evacuation,
- Locating preferred Providers

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

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

- Worldwide Collect: +1. 305.697.1778
- Email: preauthorizations@gbg.com
- Mexico local number: 55.1454.2772
- Venezuela local number: 212.720.7411
- Colombia local number: 1.508.5170
- Brazil local number: 11.4380.3493

14. DEFINITIONS

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

**Accident:** any sudden and unforeseen event occurring during the Policy Period, resulting in bodily injury, in which the cause is external and occurs beyond the victim's control.

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

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

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

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

**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.

**Complications of Maternity and Perinatal** 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
- Causes complications in the newborn unrelated to Congenital or Hereditary Conditions.

**Congenital Condition:** any inherited disorders or illnesses that exist prior to childbirth regardless of cause, whether or not they have manifested or been diagnosed during childbirth or years thereafter.

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

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

**Durable Medical Equipment:** equipment customarily and generally useful to a person only during an Illness or injury.
**Effective Date:** the date upon which an Insured's coverage will become effective under this Policy.

**Emergency:** an injury or Illness that is acute, with sudden onset of symptoms and poses an immediate risk to a person's life or long term health and requires medical care within 24 horas from the time such symptoms first occur.

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

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

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

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

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

**Home Health Care** is a program:

a. for the care and treatment of an Insured in his home;

b. established and approved in writing by his attending physician; and

c. certified, by the attending physician, as required for the proper treatment of the injury or Illness, in place of Inpatient treatment in a Hospital or in an Extended Care Facility.

**Hospice:** treatment provided to patients suffering from advanced, progressive and incurable diseases and who have a prognosis of less than 240 days of life and such treatment has as primary objective the relief of suffering and improvement of the quality of life.

**Hospital:** is a legally licensed institution for the provision of clinical and surgical services under the supervision of medical professionals. The term Hospital does not include nursing homes, rest home, health resorts, homes for the aged, infirmaries or establishments for domiciliary care.

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

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

**Insured:** the person(s) listed on the Policy Face Page and covered by this Policy, and for whom the correspondent Premium was paid.

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

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

a. It is only a convenience to the Insured, the Insured's family or the service Provider; or

b. It is not considered appropriate for the diagnosis or treatment of the Insured; or

c. Exceeds the level of care required to allow diagnosis and appropriate treatment, or

d. Do not follow the standard of practice, as established by the professional councils of its field (medicine, physiotherapy, nursing, etc.)

The Company reserves the right to determine the medical necessity of a planned treatment.
Outpatient: any medical services/procedures (surgical or not) performed for less than 24 hours in a Hospital setting or not.

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

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

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

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

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

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

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

Preferred Provider Organization (PPO): a participating Provider, such as Hospital, clinic or physician that has entered into an agreement to provide health services to Insureds by the Insurer. The Company also maintains an international network of medical Providers and facilities with which it has arranged direct billing procedures.

Premium(s): is the consideration owed by the Policyholder to the Insurer in order to secure benefits under this Policy.

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

Preventive Care/Check-Up: exams and consultation without the presence no symptoms or diagnosis.

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

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

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

Rehabilitation: therapeutic services designed to improve a patient’s medical condition within a predetermined time period through establishing a maintenance program designed to maintain the patient’s current condition, prevent it from deteriorating and assist in recovery.

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

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

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 Usual, Reasonable and Customary charge for a treatment, service or supply that is unusual, or not often provided in the area, or that is provided by only a small number of Providers in the area, will be determined by the Insurer. The Insurer will consider such factors as:

1. Complexity;
2. Degree of skill needed;
3. Type of specialist required;
4. Range of services or supplies provided by a facility; and
5. The prevailing charge in other areas. The term “area” means a city, a country or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment.

Utilization Review Measures: the Company retains the right to determine the medical necessity of a planned treatment. 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: the period from the Insured Effective Date, during which benefits will be limited or no benefit will be available.
Global Benefits Group offers worldwide expertise,
Products and services unbound by geographic constrains.

Any Country.
Any Nationality.