# guard.me International Insurance
# Students Inbound to Turkey Only

guard.me International Insurance

GBG Insurance Without Borders℠

ACIBADEM SİGORTA

**Thank you for selecting guard.me International Insurance**

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## Table of Contents

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## Schedule of Benefits

This Schedule of Benefits and Policy Face Page forms part of the health insurance Policy and is a summary outline of the benefits payable under the Policy. All benefits described are subject to the definitions, limitations, exclusions, and provisions of the Policy Face Page and the Schedule of Benefits. All amounts are shown in Turkish Lira.

The following benefits are per person per Policy Period (365 days). The 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 a new 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.

| **Annual Policy Maximum** | **TL 1,000,000** | |
|---|---|---|
| **Inpatient Benefits:** ***Pre-Authorization Required*** | | |
| | **Contracted Network** | **Uncontracted Network** |
| • Inpatient Surgery<br>• Surgeon Expense (per incident)<br>• Hospital Miscellaneous Expenses (plus pre-admission Testing)<br>• Chemotherapy, Radiotherapy<br>• Room and Board (semi-private room)<br>• Intensive Care/Cardiac Care (medically necessary)<br>• Extended Care / Inpatient Rehabilitation: Pre-Authorization Required<br>• Physiotherapy after surgery (20 Sessions)<br>• Dialysis<br>• Physician Visit<br>• Prescription Drugs<br>• Diagnostic X-Ray and Lab | 100% Reimbursement | 80% Reimbursement up to 20.000 TL Annual Limit |
| **Outpatient Benefits** | | |
| | **Contracted Network** | **Uncontracted Network** |
| • Physician Visit<br>• Prescription Drugs<br>• Diagnostic X-Ray and Lab<br>• Advanced Diagnostics including Hi-Tech Scans (CT,MRI&PET)<br>• Physiotherapy (20 Sessions)<br>• Minor Medical Treatment | 100% Reimbursement up to 2.000 TL Annual Limit | 80% Reimbursement up to 2.000 TL Annual Limit |

| Other Benefits | | |
|---|---|---|
| | Contracted and Uncontracted Network | |
| | Reimbursement | Annual Limit |
| • Emergency Dental | 100% | 1.000 TL |
| • Private Duty Nursing: Pre-Authorization Required | 100% | 5.000 TL |
| • Prosthetic Limbs | 100% | 10.000 TL |
| • Ambulance Services (per incident) | 100% | 500 TL |
| • Repatriation of Mortal Remains | 100% | 22,500 TL |
| • Emergency Medical Evacuation | 100% | Unlimited |
| • Repatriation for Medical Treatment | 100% | Unlimited |
| • Accompaniment | 100% | 4.500 TL |
| • Coverage in Country of Residence | 100% | 30.000 TL |
| • Accidental Death & Dismemberment | See Schedule | 30.000 TL |

# 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, **Acibadem Sigorta**, 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 (strategic partner of guard.me)
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA

**Policy Disclaimer**
This Policy is an international health insurance policy. As such, this Policy is subject to the laws of Turkey, 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.

**Minimum Coverage Requirements**
This policy guarantees the minimum coverage of private health insurance required by the Visa and Residency permit requests regulation no.16, dated May 10, 2016

# Administration

## Eligibility and Conditions of Coverage

**Application**
Acceptance is guaranteed, provided eligibility criteria below is met. Individual health information is not required. Acute Onset of a Pre-Existing condition will be covered according to the terms of the policy.

**Eligibility**

- Minimum age 0 to Maximum age of 35,
- Must be an International student enrolled in and attending a recognized education institute outside of their country of residence.
- Students must actively attend classes. 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.
- Your eligibility date will be determined by the Insurer.

**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 school at the time the policy is issued and renewed. It is assumed that all children covered are not students in their Country of Residence.
- 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.

**Residency**

The primary insured and all dependents must reside in their Host Country to be eligible for full benefits. If the insured or dependents change their residence to a different Host Country than the one originally declared, the Company must be notified in writing of their full-time residence immediately. If the insured or dependents change permanent residency to the U.S., the Company retains the right to modify the benefits or premium.

**Country of Residence**

The country 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 one year and are continually subject to the terms in force at the time of each renewal date. All premiums are payable before coverage under this policy is provided.

**Policy and Rate Modifications**

The Policy term begins on the Effective Date of the Policy as in the policy Face Page and ends at midnight 365 days later for an "annual policy period". Policies of less than 365 days will end on the last day of Policy coverage as listed in your Policy Face Page.
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 or their last date of coverage as listed in the Policy Face Page.

**Compliance with the Policy Terms**

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

**Change of Risk**

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

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

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

If the Policyholder cancels the Policy after it has been issued, reinstated or renewed, the Insurer will not refund the unearned portion of the Premium, unless the Policyholder does not depart on his/her scheduled trip to Turkey.

**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 Turkey and shall be subject to the exclusive jurisdiction of its courts.

**Privacy**
The Company and the Administrative Agent comply with the Data Protection Legislation and Medical Confidentiality Guidelines because confidentiality of information is of paramount concern to us. Information submitted to the Company and the Administrative Agent over our websites 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.

**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.

**Automatic Continuation of Coverage**
If the Insured Person is unable to continue their trip due to a sudden and acute Sickness or Injury covered by the policy, and such Sickness or Injury occurs prior to expiration of the policy but continues beyond the policy expiration date, then upon approval by the Insurer, Coverage will continue until such time that the Insurer's medical advisers, whose opinion shall prevail, declare the Insured Person is fit to travel. Following discharge from Hospital or following medical approval to travel, an additional 48-hour extension will be granted. Notwithstanding the foregoing, extended Coverage shall not exceed 60 days.

## 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 at http://www.acibademsigorta.com.tr/tr/bilgi-bankasi/formlar.aspx.

**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.

**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 under the Coverage in Home Country benefit 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 TL 15,000 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.
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**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.

## Policy Maximums

**Annual Policy Period Maximum**
Certain aggregate payment of benefits or days covered as indicated in the Schedule of Benefits as long as the Policy remains in force. The period covered is up to 365 days. If an additional period of coverage (less than 365 days) is issued by the Company. Your original effective date will be used in calculating the 365 day period

## Pre-Authorization Requirements and Procedures

Certain designated services require Pre-Authorization, and Insureds are required to follow the procedures outlined below.

Pre-Authorization is a process by which an Insured Person obtains approval for certain 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 TL 30,000 (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 TL30,000 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 http://www.acibademsigorta.com.tr/tr/anlasmali-kurumlar.aspx

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**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 is not pre-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 charges in excess of Usual, Customary and Reasonable 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.

## How to File a Claim

Claims Forms are downloadable from http://www.acibademsigorta.com.tr/tr/bilgi-bankasi/formlar.aspx. The Insurer 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. 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.

**Status of claims**

Insureds wishing to request the status of a claim or have a question about a reimbursement received, please visit our website https://www.sencard.com.tr/webSen/. 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
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA

Appeals should be submitted within 60 days of receiving your processed claim. Upon appeal, the member will pay any fees associated with the request of medical records. The GBG Administrative Services appeals committee will review your information and provide a response within 30 business days of receipt.

**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 death 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

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

# Preferred Provider Network (PPO)

The Company maintains a Preferred Provider Network through GBG/Acibadem. For information on the providers and facilities within the Preferred Provider Network, please visit http://www.acibademsigorta.com.tr/tr/anlasmali-kurumlar.aspx. **Please refer to Pre-Authorization Requirements and Procedures**.

**U.S and Turkey 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. All benefits must be obtained through Network Providers.

**All other Countries:** The Insured may utilize any licensed provider. However, we suggest the insured contact the Insurer 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.

## Health Care Coverage and Benefits

**Scope of Coverage**
The Policy covers the Insured Persons for Allowable Charges for covered medical services, including "emergency" 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.

**Coverage for Pre-Existing Conditions**
This Policy will cover an Acute Onset of a Pre-existing Condition up to the limits specified in the Schedule of Benefits if the Insured has not been hospitalized, treated by a physician or has received any medical treatment within six months prior to and including the Policy Start Date. Any other medical expenses for Pre-existing, Chronic, or Recurrent Medical Conditions will not be covered.

**Areas of Coverage**
Turkey and Country of Residence.

**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; including Advanced Diagnostics (CT, MRI, & PET);
- 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.

**Hospital Miscellaneous Expense Benefit**
We will pay for services, supplies and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule per day. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

### Surgical and Medical Benefits

**Surgeon (Inpatient or Outpatient) Benefit**
We will pay charges for:

1. A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries.
2. A Physician, for assistant surgeon duties up to the Maximum Benefit shown in the in the Schedule of Benefits.

**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.

**Radiation/Chemotherapy Expense Benefit**
We will pay the Covered Percentage for the Covered Expenses incurred by a Plan Participant for drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as:

1. the drug is ordered by a Physician for the treatment of a specific type of neoplasm;
2. the drug is approved by the FDA for use in antineoplastic therapy;
3. the drug is used as part of an antineoplastic drug regimen;
4. current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and
5. the Physician has obtained informed consent from the patient for the treatment regimen that includes FDA approved drugs for off-label indications.

**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. When medically necessary, assistant surgical fees will be paid. **Reconstructive surgery** as a result of an accident or illness will be covered as long as it is determined that it is medically necessary.

**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. The Insurer 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.

## 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:**

- Minor surgical procedures;
- Medically necessary covered emergency services, as defined herein.

**Outpatient or Ambulatory Surgery Benefit**
We will pay Day Surgery Miscellaneous benefits for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an outpatient basis. This includes **endoscopy services** as well as Advanced Diagnostics including Hi-tech scans (CT,MRI, and PET).

**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.

**Physiotherapy Expense Benefit**
We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Plan Participant. We will pay Usual, Reasonable and Customary expenses in excess of the Deductible as stated in the Schedule of Benefits. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Expenses during any one period of individual coverage.
For the purpose of this section, Physiotherapy means charges for physiotherapy if recommended by a Physician for the treatment of a specific Disablement or following hospitalization and administered by a licensed physiotherapist as an outpatient, up to up to the maximum amount shown in the Schedule of Benefits per day for the Outpatient Physiotherapy benefit.
Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microthermal, adjustments, manipulation, or any form of physical therapy.

**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.

**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.

**Home Health Care Including Private Duty Nursing, Skilled Nursing, Visiting Nurse**
An initial period of 30 days will be covered if preapproved. An advanced treatment plan signed by the treating Physician is required for the proper treatment of the illness or injury and used in place of in-patient treatment. Home health care includes the services of a skilled licensed professional (nurse or therapist) outside the hospital and does not include custodial care.
These services need to meet specified medical and circumstantial criteria to be covered. Thorough case manager review is required.

1. The Insurer considers home nursing care medically necessary when recommended by the member's primary care and/or treating physician and ***both*** of the following circumstances are met:
   - Member has skilled needs; ***and***
   - Placement of the nurse in the home is done to meet the skilled needs of the member only; not for the convenience of the family caregiver
2. 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.

**Emergency Dental**
This policy will cover emergency dental treatment and restoration of sound natural teeth as a result of a traffic accident. All treatment must be completed within 120 days of the accident or before the expiration date of the Policy.

## Other Benefits

**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 Rituximab.

**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.

**Repatriation of Mortal Remains**
Reimbursement for either repatriation of mortal remains or local burial is included in this Policy. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar person burial preferences. All Repatriation benefits must be coordinated and pre-approved by GBG Assist or claims will not be paid or authorized.

**Emergency Medical Evacuation**
The plan covers UCR charges for emergency evacuation when appropriate medical treatment is not available locally and deemed necessary and is pre-approved by GBG Assist, their medical advisors and the attending Physician, to a suitable location that will render immediate and appropriate care which may or may not be the Country of Residence. If the Insured Person does not obtain pre-approval from GBG Assist, the Insurer reserves the right to deny coverage or apply substantial co-payments for the associated costs to a maximum of 50% of the evacuation cost.

**Repatriation for Medical Treatment**
The Insurer reserves the right to review and repatriate any Insured Person who is medically stable and upon advice of the Attending Medical Doctors, can be evacuated, at the Insurer's discretion, to the Country of Residence. The Insurer shall not be liable for any form of treatment or surgery which in the same medical opinion can be delayed until the Insured Person returns to their Country of Residence. If the Insured Person refuses to accept repatriation once medically stable, the Insurer reserves the right to deny further medical coverage and benefits

**Accompaniment**
The insurance allows for the travel and accommodation expenses of one person (i.e., a relative or friend who is a resident of Insured Person's Country of Residence), whom, upon medical advice is advised to join, accompany, remain with or escort the Insured Person. Transportation costs will be by most economical means and determined by the Insurer.

**Coverage in Home Country:**
This benefit covers the Insured Person for an Injury or Sickness while residing in their Country of Residence to a maximum of 30 days and up to the amount specified in the Schedule of Benefits. The Injury or Sickness must have occurred during the Policy Period and was covered by the Insurer. No benefit will be paid when an emergency evacuation has occurred. When an Insured Person has coverage under another health insurance contract, 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. Refer to Coordination of Benefits under the Claims section for more information.

**Accidental Death, Dismemberment and Permanent Total Disability**
We will pay according to the following scale if an Insured Person sustains Accidental bodily Injury which, solely and independently of any other cause results in Death or Disability within 12 calendar months from the date of the Accident. This benefit is paid only when the Death or Disability is directly related to an incident which occurred while traveling on a Common Carrier.

| **Loss Description** | **Percentage of Principal Sum** |
|---|---|
| Loss of Life<br>Permanent Total Disability | 100%<br>100% |
| Loss of Speech and Loss of Hearing | 100% |
| Loss of Speech and one Loss of Hand, Loss of Foot or Loss of Sight of One Eye | 100% |
| Loss of Hearing and one Loss of Hand, Loss of Foot or Loss of Sight of One Eye | 100% |
| Loss of Hands (both), Loss of Feet (both), Loss of Sight or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of One Eye | 100% |
| Quadriplegia | 100% |
| Paraplegia | 75% |
| Hemiplegia | 50% |
| Loss of Hand, Loss of Foot or Loss of Sight of One Eye (any one of each) | 50% |
| Uniplegia | 25% |
| Loss of Thumb and Index Finger of the same hand | 25% |

In the event of a claim, a medical adviser or advisers appointed by the Insurer shall be allowed as often as the Insurer shall deem it necessary to examine the Insured Person. Payment of the Permanent Total Disability benefit shall be made only on certification by a medical board that the Insured Person has been totally disabled from engaging in any gainful occupation for 12 consecutive months and at the end of that time is beyond the ability to make future improvement in order to return to work.

If an Insured Person dies due to a covered Event, the surviving beneficiary, immediate parent or legal guardian must provide:

- Verification of eligibility of the Insured Person and legal status of the beneficiary;
- Copy of the death certificate;
- Proof of travel.

The Insurer shall not be liable for:

- Any claim arising from medical or surgical treatment (unless rendered necessary by Accidental bodily Injury);
- Conditions arising from motorcycling as either a driver or passenger.

# 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. Expenses incurred in your Country of Residence over the allowed amount as shown on the Schedule of Benefits.
3. Any incurred expenses after medical repatriation has been offered by the company and turned down by the insured Person.
4. Non-Emergency treatment that is not pre-authorized according to the policy terms and conditions.
5. Charges and Services where claims are not received within 180 days of the date of service.
6. Claims and costs for medical treatment, occurring before the effective date of coverage (including waiting periods) or after the expiration date of the policy; for Inpatient confinement, any services provided more than 60 days after the expiration date of the policy termination.
7. 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.
8. 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.
9. 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.
10. Telephonic consultations, missed appointments, or "after hours" expenses.
11. 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.
12. Health check-ups, inoculations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.).
13. Immunizations and/or vaccinations
14. 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); Megavitamins, vitamins, sexual enhancement devices, supplements, herbs or drugs, for any reason.
15. Services and supplies related to visual therapy, Radial keratotomy procedures, Lasik, or eye surgery to correct refractive error or deficiencies, including myopia or presbyopia.
16. 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.
17. 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.
18. Any medical complications arising directly or indirectly as a result of a non-authorized elective or cosmetic procedure.
19. Medical expenses resulting from a motor vehicle accident which is payable under any other valid and collectible insurance.
20. Sleep studies and other treatments relating to sleep apnea including restless leg syndrome.
21. 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.
22. Organ transplant and related procedures including but not limited to; (a) donor search expense, (b) supportive services , (c) all expenses of cryopreservation and the implantation of living cells on a deceased person or in conjunction with infertility or reproductive treatments.

23. 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.
24. Genetic counseling, screening, testing or treatment.
25. Pregnancy, childbirth/delivery, any charges related to pregnancy, elective abortions; any voluntarily induced termination of pregnancy, unless the mother's life is in imminent danger.
26. 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.
27. Maternity/Delivery Preparation Classes.
28. Circumcisions, unless medically necessary and preauthorized.
29. 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.
30. 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.
31. Injuries and/or illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law by an Insured Person.
32. Eyeglasses; contact lenses; sunglasses.
33. 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.
34. 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.
35. 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.
36. 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.
37. 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.
38. Hearing Aids, Hearing Devices and Bone Anchored Hearing Aids.
39. 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.
40. 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.
41. 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.
42. Except for accidental injury to sound, natural teeth as the result of a traffic accident 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.
43. 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.
44. This Policy will not cover any services received by any parties or in any countries where otherwise prohibited by the US/UN/EU law and sanctions.
45. Benefits for enrolling solely for the purpose of obtaining medical treatment, while on a waitlist for a specific treatment, or while traveling against the advice of a Physician.
46. 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.

# 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/School** – 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/studies as performed or were capable of being performed on the last regularly scheduled work/school day.

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

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

**Acute Onset of a Pre-Existing Condition** means a sudden and Unexpected Outbreak or Recurrence of a Pre-Existing Condition(s) which occurs spontaneously and without advance warning either in the form of Physician recommendations or symptoms, is of short duration, is rapidly progressive, and requires urgent care. The Acute Onset of a Pre-Existing Condition(s) must occur after the effective date of the Policy. Treatment must be obtained within 24 hours of the sudden and Unexpected Outbreak or Recurrence of a Pre-Existing Condition(s). A Pre-Existing Condition that is a chronic or congenital condition or that gradually becomes worse over time will not be considered Acute Onset of a Pre-Existing Condition. This benefit does not include coverage for known, scheduled, required, or expected medical care, drugs or Treatments existent or necessary prior to the Effective Date of coverage.

**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 the 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.

**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.

**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.

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

**Country of Residence** means the country where 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 condition 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.

**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.

**Eligibility** means the requirements that an Insured, including the primary Insured Person and/or his dependents 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 a traffic 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 Insured's I.D. Card. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

**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.

**Host Country** means the country or countries other than the Country of Residence that the Insured Person is traveling to/in.

**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.

**Illness** means a physical sickness or disease 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.

**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.

**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 http://www.acibademsigorta.com.tr/tr/anlasmali-kurumlar.aspx.

**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 **Country of Residence**, or the preparation and local burial of the mortal remains of an Insured Person who dies outside his/her **Country of Residence**. This benefit is excluded where death occurs in their **Country of Residence**.

**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.

**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.