INTERNATIONAL GROUP HEALTH INSURANCE

PLAN EMPLOYEE BENEFIT GUIDE

RELIANT MISSION

POLICY #: GASW-13852
GLOBAL ADVANTAGE HEALTH PLAN
WORLDWIDE COVERAGE: *This plan is recognized as Minimum Essential Coverage and satisfies the Affordable Care Act Individual Mandate requirement in the United States.*

REVISED: 27 March 2017

Insurer: GBG

Insurance Limited

Administrative Agent: Global

Benefits Group, Inc

27422 Portola
Parkway, Suite 110
Foothill Ranch, CA
92610

The Employee Benefit Guide includes the Schedule of Benefits that is part of the Policy issued to the Policyholder. This guide is intended to provide plan participants with an overview of their group insurance coverage provided under their company's health insurance plan. The Schedule of Benefits shall prevail in the event of a discrepancy in wording with the Group Master Policy.

The GBG Insurance Limited Policy is an International Health Insurance Policy. As such, the policy is subject to the Laws of Guernsey, Channel Islands and the insured should be aware that laws governing the terms, conditions, benefits and limitations in health insurance policies issued and delivered in the United States are not applicable to this plan of international health insurance. 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.

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Welcome

Your Employer has selected Global Benefits Group (GBG) as your health insurance coverage provider. We look forward to providing you with this valuable health insurance protection while you are living and working outside your home country.

The GBG family of companies has been specializing in the international health care plan market for over two decades. To accommodate the fact that most of our Insured's are assigned to overseas locations, GBG has built a network of facilities through our affiliate, World Medical Network. This network of providers will bill GBG directly; eliminating the requirement for you to pre-pay the provider and file claim forms for reimbursement of services.

In the United States, GBG provides access to a Preferred Provider Network. Insureds have access to one of the nation's largest network of directly contracted, credentialed health care providers.

Should you have any questions regarding your health insurance plan or require assistance related to a claim for benefits, you should call, write or e-mail using the following information:

CLAIMS INQUIRIES
International Claims Services
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA

- Toll Free: +1.877.916.7920 (within the U.S. and Canada)
- Phone: +1.949.916.7941 (outside the U.S. and Canada)
- Website: www.gbg.com
- E-Mail: claims@gbg.com

PRE-AUTHORIZATION, CUSTOMER SERVICE, BENEFIT INQUIRIES
GBG Assist (24 hours/7 days a week)

- Toll Free: +1.866.914.5333 (within the U.S. and Canada)
- Phone: +1.905.669.4920 (outside the U.S. and Canada)
- E-Mail: GBGAssist@gbg.com
- Pre-Authorization Forms: www.gbg.com

Contact information can also be found on the back of your Medical Insurance Identification Card.

We anticipate this Employee Benefit Guide will be of value in outlining your insurance benefits. However, do not hesitate to contact GBG should you require further clarification.

We look forward to servicing you this year.

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The following benefits are subject to the Insured Person's Policy Year Deductible, Coinsurance and any Co-payments that might be included in this plan. After satisfaction of the Policy Year Deductible, Insurer will pay the eligible benefits set forth in this schedule at the Allowable Charge. Once the Policy Year Out-of-Pocket Maximum (Coinsurance Maximum) requirement has been met, eligible benefits are payable at 100% of the Allowable Charge subject to overall Policy limitations for the remainder of the Policy Year. There may be Co-payments still payable after you have met your Policy Year Out-of-Pocket Maximum.

GENERAL FEATURES/PLAN SPECIFICATIONS[1]			
Annual Maximum Per Covered Person (Per policy year) [2]	$1,000,000		
Lifetime Maximum Per Covered Person	Unlimited		
Area of Coverage	Worldwide		
	Outside U.S.	U.S. In-Network	U.S. Out-of-Network
Annual Individual Deductible (Per policy year)[3] • Family Deductible is 2 times Individual	$2,000	$2,000	$2,000
Member Coinsurance (after the deductible)	0%	0%	20%
Plan Coinsurance (after the deductible)	100%	100%	80%
Individual Out-of-Pocket Maximum (Coinsurance Maximum) [4] • Family Out-of-Pocket is 3 times Individual	N/A	N/A	Unlimited
Prescription Drug Benefits	Included/See Attached Schedule of Benefits		
OPTIONAL COVERAGES			
Preventive Care	$400 (not subject to Deductible)		
Dental	Included See Attached Schedule		
Vision	Included See Attached Schedule		
RIDERS: None			
Pre-Existing Conditions Coverage Pre-Existing conditions are covered according to the terms of the policy, without a waiting period.			
Important Note Regarding Your Coverage Effective Date For members enrolling onto the group plan for the first time, coverage for accident and sickness becomes effective when the primary member becomes actively-at-work at their work location. Prior to this occurring, coverage for accident only is in effect.			
New Member Enrollment Requirements Eligible employees and dependents requesting coverage during the policy year must enroll within 31 days of the date of eligibility. Request for enrollment after 31 days of eligibility will require a Health Statement for coverage consideration. Coverage is not guaranteed and subject to underwriting approval.			
Pre-Authorization Requirements and Procedure Certain designated services require Pre-Authorization and depending on the geographical location, Pre-Authorization and utilization of Insurer's Preferred Provider Organization (PPO) Network is required. **Failure to Pre-authorize when required will result in a 40% reduction in the normal benefit. Any penalty will apply to the entire episode of care and there is no Out-of-Pocket maximum**. The Insured Person must obtain a letter of authorization, prior to the performance of those services. See the section titled, Pre-Authorization Requirements and Procedures for benefits requiring pre-authorization and for more details.			

[1] Benefits will be paid on a reasonable and customary basis, subject to all Policy exclusions, limitations and conditions for charges listed if they are incurred as a result of sickness or accidental bodily injury and the benefits must also be medically necessary and given or ordered by a physician.
[2] All references to Annual refer to a Policy Year, not a calendar year.
[3] The Deductible for "Outside U.S." and "U.S. In-Network" is combined. The Deductible for "U.S. Out-of-Network" is separate.
[4] The Annual Out-of-Pocket Maximum for "Outside U.S." and "U.S. In-Network" is combined. The Annual Out-of-Pocket Maximum for "U.S. Out-of-Network" is separate.

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	Outside U.S.	U.S. In-Network	U.S. Out-of-Network
Hospitalization and Inpatient Benefits: *Pre-Authorization Required*			
• Semi-private room • Intensive Care (medically necessary) • Medical treatment, medicines, laboratory and diagnostic tests • Inpatient Consultation by a Physician or Specialist • Inpatient Surgery • Inpatient Surgeon • Inpatient Ancillary Services	100%	100%	80%
Outpatient Benefits			
• Emergency Room • Emergency Medical Services • Outpatient Physician Visit • Consultation by Specialist • Echocardiography, Ultrasound, • CAT Scan, PET Scan, MRI • Endoscopy (e.g. gastroscopy, colonoscopy, cystoscopy) • X-Rays • Laboratory • Outpatient or Ambulatory Surgery *(Pre-Authorization Required)* • Outpatient Surgeon	100%	100%	80%
Non–Emergency Use of Emergency Room			
• Maximum Out-of-Pocket Limit per Incident $1,000	50%	50%	50%
Maternity Benefits: *Pre-Authorization Required*			
• Normal delivery including medically necessary C-section, prenatal and postnatal care. • Dependent Daughters are not covered. • Fertility/infertility services, treatments, drugs and/or procedures are excluded from coverage. Please refer to the "Maternity" section of this Policy for details.	100%	100%	80% to $7,500 50% thereafter
Complications of Pregnancy, Premature Birth, Congenital Conditions, Birth Anomalies for a Newborn Baby			
Complications of pregnancy, premature birth, congenital conditions, and birth anomalies are covered.	100%	100%	80%
Therapeutic Services (Outpatient)			
Physical Therapy, Chiropractic, Occupational Therapy, Vocational Speech Therapy			
**Annual Maximum Benefit, All Therapies Combined: $5,000	100%**	100%**	80%**
Homeopathic and Acupuncture			
• Treatment for a covered illness **Annual Maximum Benefit: $500	100%**	100%**	80%**

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	Outside U.S.	U.S. In-Network	U.S. Out-of-Network
Human Organ, Bone Marrow, Stem Cell Transplants, and other Similar procedures: *Pre-Authorization Required*			
• Expenses for Donor are not covered including search fees and medical expenses	100%	100%	80%
Extended Care / Inpatient Rehabilitation: *Pre-Authorization Required*			
• Must be confined to facility immediately following a Hospital stay • Acute or Sub-Acute Care only for Extended Care Episode	100%	100%	80%
Hospice: *Pre-Authorization Required*			
• Refer to Policy regarding qualifications for care ** Inpatient Lifetime Benefit Maximum: 45 Days **Outpatient Lifetime Benefit Maximum: $5,000	100%**	100%**	80%**
Emergency Ambulance			
• Ground Ambulance • Air Ambulance: Pre-Authorization Required • Refer to Policy for more specific details	100%	100%	80%
Durable Medical Equipment			
• Reimbursement of rental up to purchase price • See Policy for more specific details including Pre-Authorization	100%	100%	80%
Private Duty Nursing, Skilled Nursing, Visiting Nurse, Home Health Nursing: *Pre-Authorization Required*			
• Refer to Policy for specific details **Annual Benefit Maximum: 100 Days Per Year	100%**	100%**	80%**
Diabetic Supplies			
• Includes Insulin Pumps and associated supplies **Annual Maximum Benefit: $5,000	100%**	100%**	80%**
Mental Health			
**Lifetime Benefit Maximum: $25,000 **Inpatient: Annual Benefit Maximum: 180 days; *Pre-Authorization Required* **Outpatient: Annual Benefit Maximum: 20 visits	100%**	100%**	80%**
Alcohol and Drug Abuse: Out-patient & In-patient			
• Rehabilitative treatment only **Annual Benefit Maximum: $2,500	100%**	100%**	80%**

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	Outside U.S.	U.S. In-Network	U.S. Out-of-Network
HIV, AIDS, ARC and Sexually Transmitted Diseases			
Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions • Treatment available if condition is not pre-existing	100%	100%	80%
Emergency Dental Care			
• Limited to accidental injury of sound natural teeth sustained while covered under the policy • Covered under the medical benefit and not the Optional Dental Benefit ** Annual Benefit Maximum: $5,000	100%**	100%**	80%**
Child and Adult Examinations			
Child Wellness			
• Includes child immunizations and routine medical exams • Up to 12 months of age **Maximum 9 visits	100%**	100%**	80%**
Adult Female and Male Examinations			
• Female: PAP Screening and baseline mammogram with office visit • Male: PSA Screening with Office Visit • Other routine examinations and treatments are covered if the Optional Preventive Care is included	100%	100%	80%
Family Medical History Screenings			
• Must be recommended by physician ** Annual Maximum Benefit: $250	100%**	100%**	80%**
Other Benefits			
Repatriation of Remains	$20,000 Maximum Benefit		
War and Terrorism	Included		

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Pharmacy Benefits
Plan Type: Prescription Drug Benefit, Reimbursement Plan
Worldwide

PRESCRIPTION DRUG CARD[1]			
BENEFIT HIGHLIGHTS	OUTSIDE U.S.	U.S. In-Network Pharmacy	U.S. Out-of-Network Pharmacy
Prescription Drugs • Generic[2] • Brand Generic Drugs are Required if Available	20% Member Coinsurance 90 Day Supply per Prescription Fill is available	20% Member Coinsurance 180 Day Supply per Prescription Fill is available	40% Member Coinsurance 180 Day Supply per Prescription Fill is available
Mail Order Drugs • Generic • Brand	Contact ICS Customer Service *(Only Available for delivery within the U.S.)*	Contact ICS Customer Service *(Only Available for delivery within the U.S.)*	Contact ICS Customer Service *(Only Available for delivery within the U.S.)*
Claim Filing	• Pay for the prescription • Request a receipt • Submit receipt claim form for reimbursement	• Pay for the prescription • Request a receipt • Submit receipt claim form for reimbursement	• Pay for the prescription • Request a receipt • Submit receipt claim form for reimbursement
Prescription Drugs are medications which are prescribed by a physician and which would not be available without such prescription. Certain treatments and medications, such has 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. • The medical plan deductible does not apply to the pharmacy benefit. • Your Coinsurance or Co-Payment amounts for the pharmacy benefit do not accrue to your medical plan Out-of-Pocket Maximum.			
Pre-Authorization through GBG Assist is required if you have a medication that will be in excess of $3,000 per refill, otherwise, it may not be covered under this plan.			
Formulary Plan – A schedule of prescription drugs approved for use by your health plan, if not otherwise excluded. A preferred list of drugs within a therapeutic class for purposes of drug purchasing, dispensing, and/ or reimbursement.			
Inside of the U.S. Mandatory use of Insurer's U.S. Pharmacy Network is required for Prescription Drugs obtained in the United States. The necessary U.S. prescription drug discount information is printed on the bottom front side of the Insured's Insurance Identification Card and should be presented to the Network Pharmacy when filling a prescription. The U.S. participating Pharmacy Network listing is available at www.gbg.com. Generic Brands are required, unless otherwise designated by your physician indicating it must be dispensed as written.			

[1] Co-payments are not applicable to your deductible or to your Out-of -Pocket Maximum
[2] Designated as per generally accepted industry sources and adopted by GBG

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Vision Services Plan (VSP)
Discount Only Access Program

VSP Access Plan / VSP Signature Network	
The VSP Access plan is a **discount only program;** all out-of-pocket expenses applied after the discounts are the responsibility of the member. To find a doctor participating in the VSP program, visit **www.vsp.com** (or call 800.877.7195) • Click on Members • Click on Find a Doctor At your appointment, tell your doctor that you are enrolled in the VSP discount program. • No special ID Card necessary; only your Name and Member ID number as shown on the Member Identification Card. • Your VSP number will be the last four digits of the primary insured's GBG Member Identification number.	
Plan Coverage	
Well Vision Exam	• 20% off thorough eye exam
Glasses	• 20% off unlimited complete pairs of prescription glasses[1] • 20% off all lens options • 20% off unlimited non-prescription sunglasses[1]
Contact Lenses	• 15% off contact lens services, excluding materials • Exclusive offers for VSP members include: Mail-in rebate savings[2] up to $110 on eligible Bausch & Lomb contacts and up to $125 on eligible ACUVUE Brand Contact Lenses.
Value-Added Benefits	
Laser Vision Care Program	• VSP-contracted laser centers provide discounts for laser surgery including PRK, LASIK, and Custom LASIK[3] • Discounts average 15% off or 5% off is the laser center is offering a promotional price[4]
Exclusions	
The following items are excluded under the plan: • Medical or surgical treatment. • Orthoptics, vision training, or supplemental testing. • Experimental vision services, treatments, and materials.	Items not covered under the contact lens coverage: • Insurance policies or service agreements • Additional office visits for contact lens pathology. • Contact lens modification, polishing, or cleaning.

[1] Discounts valid through any VSP Preferred Provider within 12 months of the last covered eye exam.
[2] Rebates subject to change.
[3] Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member.
[4] LaserVision Care discounts are only available from VSP-contracted facilities.

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Dental Insurance

DENTAL SCHEDULE OF BENEFITS[1]	
Annual Maximum Per Covered Person (per policy year) (Class 1, Class 2, & Class 3 Services included)	$1,500
Annual Dental Deductible (Class 2 and Class 3)	$100
Orthodontic Treatments (Class 3) (Must be under age 19) 50% Benefit up to Lifetime Orthodontic Maximum	$500 Maximum
Covered Services and Benefit Levels[2]	
Class 1 Dental Services – Preventive (Not subject to dental deductible) The insurance pays 100% of the Allowable Charge with no Annual Dental Deductible for necessary diagnostic examinations And preventive treatment subject to the Annual Dental Maximum	100%
Class 2 Dental Services – Basic insurance pays 80% of the Allowable Charge after Annual Dental Deductible for Basic Restoration, Periodontal Treatments and Oral Surgery subject to the Annual Dental Maximum	80%
Class 3 Dental Services – Major The insurance pays 50% of Allowable Charge after the Annual Dental Deductible for necessary crowns, bridges, endodontic (root canals), and extraction of wisdom teeth subject to the Annual Dental Maximum. Covered expenses include the necessary supplies and services of a Physician for installation or replacement.	50%
Class 3 Dental Services – Orthodontic (Available to insureds up to age 19) Study models (including pan oral x-rays), impressions, removable string appliances (braces), fixed appliances (including adjustments), extractions, re-cementing of brackets.	50%
Dental Exclusions • Cosmetic surgery or supplies or procedures • Replacement of lost, missing or stolen crown, bridge or dentures • Services or supplies which do not meet general accepted dental standards • Experimental treatment and treatment which is not medically necessary • Implantology and all related services • Treatment for temporomandibular joint disorders (TMJ) and complications thereof, except as otherwise covered under the Policy. • Inlays; dentures or false teeth • Night mouth guards or other services for teeth grinding	

[1] Dental Coinsurance does not apply to the Medical Out-of-Pocket Maximum

[2] The expenses described in the Dental Schedule are reimbursed at the indicated percentage subject to the Annual Dental Deductible and Annual Dental Maximum Benefit.

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Vision Insurance

VISION SCHEDULE OF BENEFITS[1]	
Examination (each policy year)	$75
Frame Allowance	$75
Lens Allowance • Single Lens • Bifocal • Trifocal • Contact Lenses	 $90 $125 $150 $150
Exclusions • Optional Lens Coating for anti-glare, anti-scratch, UV sun protection • Sunglasses and/or related accessories are not included in coverage	

[1] Allowable charges for vision benefits do not accrue to the medical Out-of-Pocket Maximum or the deductible

SECTION ONE
YOUR AREA OF COVERAGE

Geographic Areas of Coverage

GBG offers three areas of coverage; Worldwide, International, and International Plus. Your Schedule of Benefits and Medical Identification card will state the area of coverage included in your plan. These areas have rules associated with them that must be followed to maximize your benefits.

Worldwide Coverage has no geographic restrictions and provides coverage in any country in the world.

International Coverage provides for medical treatment throughout the world, with the exception of the United States and Canada; in other restricted areas Insureds will be responsible for a Co-payment equal to 20% of all covered treatment. This Co-payment is in addition to any other Coinsurance or Co-payments or payments or restrictions relating to specific treatments. For a complete list of restricted areas and facilities visit www.gbg.com.

Note that the Company reserves the right to add or remove restricted areas at its discretion. Prior to any change in this regard, the Company will provide the Insured with written notice 30 days before the change takes effect. Under International Coverage, treatment (including prescriptions) in the United States and Canada, is not covered, and will not be reimbursed by the Company. Expenses incurred as a result of a medical emergency are also not covered, and will not be reimbursed by the Company.

International Plus Coverage is designed to provide the same benefits as International Coverage. In addition, International Plus Coverage provides the following:

- Emergency coverage in the United States and Canada.
- When Emergency treatment is received in a "Restricted area," the Co-payment will be waived if treatment meets the Emergency Criteria.

In order for emergency coverage to be eligible for reimbursement, GBG Assist must first approve it. If the situation is determined to be a Medical Emergency, then GBG Assist will direct the Insured to the nearest network facility. If GBG Assist is not contacted prior to treatment then coverage will be denied. In situations in which it is not possible to contact GBG Assist prior to treatment, the Insured Person or their designee must then contact GBG Assist within 48 hours after the occurrence of the emergency (See your Policy or this handbook for more details on what qualifies as an Emergency).

The following additional rules apply for International and International Plus Insureds

Insured's covered under International or International Plus coverage cannot reside in a restricted area and are not permitted to cover dependents residing in a restricted area. The Company retains the right to limit or prohibit the use of providers whose fees significantly exceed reasonable and customary charges. In the event the Company develops a Preferred Provider Network within your geographic location, the Company will retain the right to limit treatment to the Preferred Providers.

Special Conditions: Where a dependent spouse or children are in the USA or Canada while the Covered Employee is working outside of North America, special arrangements must be made in advance with GBG. Please contact your employer and advise GBG.

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

SECTION TWO
PRE-AUTHORIZATION REQUIREMENTS AND PROCEDURES

Certain designated services require Pre-Authorization and depending on the geographical location, Pre-Authorization and utilization of Insurer's Preferred Provider Organization (PPO) Network is required. Failure to Pre-Authorize and to utilize the appropriate network when required will result in a 40% reduction in the normal benefit. Any penalty will be applied to the entire episode of care and there will be no Out-of-Pocket maximum. You must obtain a letter of authorization, prior to the performance of those services. In order to appeal the application of the 40% Co-payment, you will need to provide proof of Pre-Authorization.

Notwithstanding the requirement to Pre-Authorize, Pre-Authorization approval does not guarantee payment of a claim in full, as additional Co-payments and Out-of-Pocket expenses 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.

In the event of an emergency that requires medical evacuation, contact the GBG Assist 24-hour Department, in advance in order to approve and arrange such emergency medical air transportation. The Operations Center, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. Approved medical evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment only. The GBG Assist contact information can be located on the Insured's Identification card. In the event of an emergency, Pre-Authorization is required for International Plus Insureds who require treatment in a restricted area.

If the following services are received within the United States, use of the PPO Network is also required. Failure to receive Pre-Authorization and/or use the appropriate Network as required will result in a 40% penalty for the entire episode of care. The following services require Pre-Authorization worldwide:

- Any Hospitalization including Maternity Delivery;
- Outpatient or Ambulatory Surgery;
- Skilled or Private Duty Nursing – (When 4 or more visits are required);
- Hospice Care;
- Organ, Bone Marrow, Stem Cell Transplants, and other similar procedures;
- Air Ambulance – Air Ambulance service will be coordinated by Insurer's air ambulance provider;
- Any condition, including cancer treatment or any chronic condition, which does not meet the above criteria, but are expected to accumulate over $10,000 of medical treatment per policy year;
- Prescription medications in excess of $3,000 per refill; and
- Durable Medical Equipment expected to accumulate over $10,000 in costs per policy year including motorized wheelchairs or beds.

Emergency Services must be received within 48 hours of the admission or procedure. In instances of an 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.

To obtain a Pre-Authorization and verification of Network utilization the Insured, the Provider, or the Insured's representative must call the number listed on the back of the Medical Identification Card. Customer Service representatives are available 24 hours a day, everyday. Network lookup information can also be found at www.gbg.com.

GBG Assist offers a 24/7 assistance service to answer any medical emergency around the world no matter the time or day. Case managers, nurse case managers, and the GBG Assist Medical Director work as a team to manage all aspects of a case from initial referral until the patient returns home. They coordinate admissions, Pre-Authorize services, and coordinate discharge planning. They provide patient advocacy while monitoring costs.

GBG Assist case management services include coordination of treatment, assistance to patient and family Insureds, monitoring and review of treatment, and coordination of air ambulance needs if necessary. GBG Assist should be contacted immediately when there is any medical issue. Your claim reimbursement will be maximized and they will help to handle many of the issues that come up during an illness, accident, or emergency illness.

Pre-Authorization Appeals follow the same process as 'Claims Appeals' except there is an expedited process available if all requirements are met. See Section 5 – Claims.

SECTION THREE
EMERGENCY SERVICES

"Medical Emergency", is 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 24 hours after the onset) and in the absence of which care an Insured would be expected to suffer severe life-long injury or premature death.

Medical Emergency Pre-Authorizations must be received within 48 hours of the admission or procedure. In instances of an emergency, you or 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. Contact GBG Assist.

Emergency 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.

Emergency Coverage – The following treatment is excluded for those whose geographic coverage is International Plus:

- Treatment related to a condition that existed prior to arrival in the United States or Canada or a Restricted Area;
- Routine medical treatment;
- Treatment that could have been postponed until return from United States or Canada or a Restricted Area;
- Treatment that has been planned in advance;
- Treatment arising from circumstances that could have been reasonably anticipated by the Insured; and
- Maternity treatment.

Emergency Air Ambulance (Medical Evacuation) Services

Reimbursement of emergency Air Ambulance (medical evacuation) and repatriation of mortal remains is covered under this Policy and outlined in the current Schedule of Benefits, including any exclusions and requirements specified in this Policy. The cost of a person accompanying and Insured Person is covered under this policy.

Medical Evacuation

Utilization of the medical evacuation provision requires the *prior approval of GBG Assist*. In the event of an emergency that may require medical evacuation, contact GBG Assist in advance in order to approve and arrange such Emergency Medical Air Transportation. 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. *Approved Medical Evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment.*

Should treatment be available locally but the Insured Person chooses to be treated elsewhere, transportation expenses shall be the responsibility of the Insured Person. 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. 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. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

Repatriation of Mortal Remains

A benefit for either repatriation of mortal remains or local burial is included under this plan. The necessary clearances for the return of an Insured Person's mortal remains by air transport to the home country will be coordinated by Insurer's GBG Assist department.

SECTION FOUR
HOW TO USE MY HEALTH PLAN

Choosing a Provider

We recommend you try to establish a relationship with primary health care providers in your location before you require care. GBG maintains a Worldwide Provider Network for the ease and convenience of our Insured's in accessing healthcare around the world. You can access a list of International Provider Facilities online at www.gbg.com and in the United States you can find provider information at the same website. If you haven't established a relationship with a health care provider and are experiencing symptoms, please call GBG Assist. They can refer you to an appropriate provider. They can also provide additional provider referrals including specialists. Outside the United States, the Company maintains the right to require the use of a Network Provider where available.

All inpatient treatment and outpatient surgeries received are required to be Pre-Authorized to avoid additional Co-payments (See Pre-Authorization section for more details of services requiring preauthorization.)

The Company maintains a Preferred Provider Network both inside and outside the United States. GBG is expanding this network on a daily basis and we welcome Insured recommendations. The list of facilities that are currently participating in these networks are available on line at www.gbg.com and click on Provider Directory. Contact GBG Assist for the latest list and to make sure that your services are Pre-Authorized.

World Medical Network – Outside USA

To accommodate the fact that most of our Insureds are assigned to overseas locations, Global Benefits Group has built a network of health care facilities through our affiliate, World Medical Network. These facilities are known for the care they provide in their local environment, but also have been chosen for their expertise in dealing with expatriates. They maintain an English speaking staff, have many western trained staff, and provide quality and professional medical care.

In addition, all Network Providers will bill GBG directly. Present your GBG Health Insurance Identification card and these network providers will bill GBG directly, eliminating the requirement for you to pre-pay the provider and file claims for reimbursement.

Preferred Provider Network – Inside USA

GBG utilizes one of the nation's largest networks of hospitals and outpatient care providers, helping to control medical insurance costs. The network's doctors and nurses continually evaluate the service they deliver to you, to their clients, and to health care professionals who participate in the network. Approximately 99% of network hospitals and doctors remain in the network each year. In the United States and Canada, provider choices and reimbursement assessment will be based upon the following three tiers of provider network type.

- U.S. In-Network Preferred Provider: This Tier consists of all Network 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. This results in lower out-of-pocket costs to you.

- U.S. Out-of-Network Providers: Utilizing providers that are Out-of-Network is a more costly financial option for the Insured. The Insurer reimburses such providers up to a reasonable and customary amount as determined by the Insurer. The provider may bill the Insured the difference between the amounts reimbursed by the Insurer and the provider's billed charge. Additionally, the Insured will pay a coinsurance amount that is higher than if an In-Network provider were used.

- Out-of-Market Area: When there are no network providers located within a 30-mile radius of your local residence, charges from such providers will be treated the same as a U.S. In-Network provider.

SECTION FIVE
CLAIMS: HOW TO FILE A CLAIM, CLAIMS STATUS, AND CLAIM APPEAL

International Claims Services (ICS) must receive claims within 180 days of treatment to be eligible for reimbursement of covered expenses. Claim forms should be submitted only when the medical service provider does not bill ICS directly, and when you have out-of-pocket expenses to submit for reimbursement. All claims worldwide are subject to Reasonable and Customary charges as determined by GBG 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.

Releasing Necessary Information

By applying for enrollment, the Insured Employee agrees to let any physician, hospital, pharmacy, provider, or Insured to give the Insurer all medical information determined by Insurer to be necessary, including a complete medical history and/or diagnosis, maternity questionnaire, medical accident questionnaires etc. Insurer will keep this information confidential. In addition, by applying for coverage, the Insured Employee authorizes GBG 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.

Claims Filing

The best way to file your claim is to submit it online at www.gbg.com. Log into the Member Area and select Submit Claim, and then follow the instructions to complete the online claim form. After submitting the claim, you will receive a claim reference number, and an electronic receipt for the claim will be sent to you by email.

If you are unable to submit your claim electronically, you can mail your completed claim form (available at www.gbg.com) and copies of supporting documentation or you can submit them by fax.

Submit claims by:

- Web:
  www.gbg.com
- Mail:
  International Claims Services
  27422 Portola Parkway, Suite 110
  Foothill Ranch, CA 92610 USA
- Fax:
  +1 949-271-2330

Reimbursement Options

Claims reimbursements will be made by:

- Electronic Direct Deposit for members where the receiving bank is located in the US
- Wire Transfer for members and overseas providers where the receiving bank is located outside of the US
- Check sent to member or provider where electronic payment is not possible

Status of Claims

Members can check the claims status online by logging on to our website at www.gbg.com. All Explanation of Benefits will be provided electronically to members through the same website at www.gbg.com. Questions about a particular claim or claim reimbursement can be emailed to us via our website or to our Customer Service department at claims@gbg.com. Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.

Claims Appeal

If you do not agree with the outcome of a processed claim, you may submit an appeal/grievance online at www.gbg.com. (See Online Forms/Applications.) Alternatively, you can send a completed Appeal/Grievance Form (available at www.gbg.com) along with all the supporting documents to:

International Claims Services
Attention: Appeals Department
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA
www.gbg.com

Appeals Procedure

For the purposes of this section, any reference to "you"', "'your", or Insured Person also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

The company has a two-step appeals/grievance procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal/grievance in writing within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal or grievance should be approved and include any information supporting your appeal/grievance. You may send it to the address above, or go to the website where you can complete an appeal form and submit it to us.

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 or a grievance within 180 days.

Your appeal/grievance will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity, clinical appropriateness, or experimental and investigational will be considered by a health care professional.

For Level One Appeals, we will respond in writing or electronically with a decision within 15 calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing or electronically to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) 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 (b) your appeal involves non-authorization of an admission or continuing inpatient stay. Our Medical Review Agent in consultation with the treating Physician will decide if an expedited review is necessary. When an appeal is expedited, we will respond within 72 hours, followed up in writing or electronically within five days.

LEVEL TWO APPEAL

If you are dissatisfied with our Level One appeal decision, you may request a second review. To start a Level Two Appeal, 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 acknowledge in writing or electronically 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.

You may request that the Level Two appeal process be expedited if, (a) 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 (b) your appeal involves non-authorization of an admission or continuing Inpatient stay. Our medical review agent in consultation with the treating Physician will decide if an expedited review is necessary. When an appeal is expedited, we will respond within 72 hours, followed up in writing or electronically within five calendar days.

INDEPENDENT REVIEW PROCEDURE

If you are not satisfied with the final adverse benefit determination decision of the Level Two appeal review regarding your Medical Necessity, clinical appropriateness, or experimental or investigational issue, 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 or 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, when requested and when a delay would be detrimental to your condition, as determined by your physician and the external review agent, the review shall be completed within 72 hours upon receipt of required information.

Request for Reproduction of Records

GBG reserves the right to charge a fee for reproductions of claims or records requested by the Insured or Enrollee's representative.

Time Limits

All requests for payment of benefits must be received in GBG's claims administrators' 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 you have coverage under another 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 you filed a claim for them (See Policy for more detailed information).

Subrogation

If you or your Insured Dependents receive benefits under this plan that result from an event for which a third party is or may be liable, you and your dependents have certain obligations and the Company has certain subrogation and reimbursement rights (See policy for more detailed information).

SECTION SIX
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 reasonable and customary allowable charges for any covered procedure.
2. Services obtained in a Restricted Area or in a sanctioned country may be excluded.
3. Charges and Services where claims are not received within 180 days of the date of service.
4. Claims and costs for medical treatment, occurring before the effective date of coverage (including waiting periods) or after the expiration date of the policy. This includes any portion of a covered prescription to be used after the expiration of the current policy year.
5. 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; or
   d. Under the direction of public authorities related to epidemics.
6. Exceptional Risks: Under "War and Terrorism", the Policy does not provide benefits if the Insured Person is an active participant, or in training, for activities described under the War and Terrorism section of this Policy. Additionally, benefits are not provided if nuclear, chemical, or biological weapons are used, regardless of the participation status of the Insured Person.
7. Services, supplies or treatments, including drugs, which are deemed to be experimental or investigational.
8. Any services, supplies, treatments including drugs and/or emergency air services:
   a. Not ordered by a Physician;
   b. Not medically necessary, not recommended or approved by a physician;
   c. Not rendered under the scope of the Physician's licensing; or
   d. Medical and dental services that do not meet professionally recognized standards or are determined by Insurer to be unnecessary for proper treatment.
9. Telephonic consultations, missed appointments, and after hours expenses.
10. Personal comfort and convenience items including but not limited to: television, private rooms, housekeeping services, guest meals and accommodations, special diets, telephone charges, take home supplies, ambulance services (other than those provided by this Policy), and all other services and supplies that are not medically necessary including expenses related to travel and hotel costs incurred for medical or dental care.
11. Health check-ups, inoculations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.), other than provided for under the optional preventive care benefit.
12. Immunizations, other than provided for under well baby coverage, or optional Preventive Care benefit.
13. Over-the-counter (OTC) drugs, supplies or medical devices, which do not require a Physician prescription, even if recommended by a Physician, including but not limited to; smoking cessation drugs, appetite suppressant, hair regenerative drugs or products, anti-photo aging drugs, cosmetic and beauty aids, acne and rosacea drugs (including hormones and retin A) for cosmetic purposes, Megavitamins, vitamins, (other than pre-natal as described under Maternity), sexual enhancement devices, supplements, herbs or drugs, for any reason.
14. Services and supplies related to visual therapy, Radial Keratotomy procedures, Lasik, or eye surgery to correct refractive error or deficiencies, including myopia or presbyopia.
15. Rest cures, custodial care, home-like care, assistance with activities of daily living (ADL), Milieu Therapy for rest and/or observation whether or not prescribed by a Physician. Any admission to a nursing home, home for the aged, long term care or rehabilitation facility, sanatorium, spa, hydro clinic, or similar facilities that do not meet the policy definition of a hospital. Any admission, arranged wholly or partly for domestic reasons, where the hospital effectively becomes or could be treated as the Insured's home or permanent abode.
16. Elective and or cosmetic surgery, procedures, treatments, technologies, drugs, devices, items and supplies that are not medically necessary treatments.
17. Services or supplies for aesthetic treatment and cosmetic surgery, unless required because of a non-occupational injury that occurs while covered under the Policy.
18. Treatment for hair loss including but not limited to Hairplasty for male pattern alopecia or any alopecia; hair transplants to correct permanent hair loss that is caused by disease or injury; for male pattern baldness or age related thinning in women; the temporary removal of hair by laser; electrolysis; waxing; or any other means. Charges or treatment for breast reduction or augmentation; treatment of superficial, non-cystic or non-pustular acne or rosacea; treatment or removal of benign skin lesions not demonstrating evidence of suspicious cellular activity, or recent changes in size, shape, and color.

19. Any medical complications arising directly or indirectly as a result of a non-authorized elective or cosmetic procedure.
20. Sleep studies and other treatments relating to sleep apnea, except as described under Sleep Studies or testing section, and as Pre-Authorized by GBG Assist.
21. Smoking cessation treatments whether or not recommended by a Physician.
22. Weight Reduction and the cost of all treatments, supplies, services or drugs for weight reduction or weight reduction programs. Medical fast diets, weight loss programs, and educational dietary counseling related to weight loss efforts.
23. Health care services and associated 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.
24. Organ transplants and related procedures except as specified in the Transplant Services section of this Policy including but not limited to the following:
    a. All donor expense is excluded
    b. services are not automatically covered and must be approved and managed by GBG Assist
    c. All expenses of cryopreservation and the implantation of living supportive cells on a deceased person or in conjunction with infertility or reproductive treatments
    d. Medically necessary organ, blood, or cell transplants may be covered on a case by case basis when Pre-Authorized and managed by GBG Assist
25. Fertility/infertility services, 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.
26. Genetic counseling, screening, testing, or treatment.
27. Elective abortions and complications thereof, except for emergencies.
28. Reproductive treatments including but not limited to male and female birth control, vasectomies and sterilization, any expenses for male or female reversal of sterilization. Treatments for sex change or implantation or treatments for sexual transformation, sexual dysfunctions or inadequacies.
29. Viagra" or other sexual enhancement drugs and their respective generic equivalents will not be covered for any purpose.
30. Pregnancy and related conditions for a dependent child.
31. Maternity/Delivery Preparation Classes; Elective C-sections.
32. Circumcisions, unless medically necessary, and Pre-Authorized by GBG Assist.
33. Rehabilitative treatment for alcoholism, solvent abuse, drug abuse, or addictive conditions of any kind is limited to the benefit shown in the Schedule of Benefits. Treatment of any illness arising directly or indirectly from alcohol or drug abuse or addiction is excluded from coverage. 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 intended purpose prescribed by the Insured's Doctor.
34. 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.
35. Injuries and/or illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law by an Insured Person.
36. Eyeglasses, contact lenses, or sunglasses unless the Optional Vision coverage has been purchased and they are included as a covered benefit.
37. Dental care is limited to accidental injury of sound, natural teeth sustained while covered under this plan, unless the Optional Dental coverage has been purchased. Accidental injury does not include damage to teeth incurred while chewing food or foreign objects. Dental Services at a hospital, including general anesthesia are not covered under the medical plan.
38. Treatment for (TMJD) or Malocclusion Temporomandibular Joint Disorders.
39. 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.
40. Durable Medical Equipment does not include the following: 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.

41. 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.
42. Growth Hormones, unless medically necessary and preauthorized by GBG Assist.
43. When a Health care provider advises against travel, heath care services incurred during such period of travel will not be covered.
44. Hearing Aids, Hearing Devices and Bone Anchored Hearing Aids.
45. Exceptional Risks
    a. Treatment as a consequence of injury sustained while participating in a hazardous activity or training for any professional sport;
    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 (see Policy for definition);
    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.
46. 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, if defined as a pre-existing condition.
47. This policy will not cover any services received by any parties or in any countries where prohibited by US/UN/EU law or sanctions.
48. 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.

SECTION SEVEN
DEFINITIONS

This is a list of Defined Terms that you will see used in this guide. It is important to understand their meaning and how they affect your benefits and coverage.

Allowable Charge: The fee or price Insurer determines to be the 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 the service, then there is no balance due) All services must be medically necessary. Once an allowable charge is established then the deductible, coinsurance, co-payments and any excess charges must be paid by the Insured.

Coinsurance: Coinsurance is the percentage amount of the Allowable Charges that the Insured and the Insurer will share after the deductible is met. Coinsurance does not include deductibles or co-payments or any excess fees. The Coinsurance Maximum is the maximum amount of out-of-pocket expenses the Insured will pay for allowable charges during the Policy year after the deductible is met.

- Once the Policy Year Coinsurance Maximum set forth in the Schedule of Benefits is reached, the Insurer shall pay 100% of eligible covered expenses for the remainder of the Policy Year.
- The out-of-pocket expenses apply to the first $10,000 USD or any amount agreed to between the Policyholder and the Company of covered treatment.
- The Policyholder may change the coinsurance level at the time of the policy renewal.
- In addition to basic coinsurance requirements, there may be additional co-payments associated with specific benefits, such as prescription drug coverage and/or physician office visits.
- The Coinsurance Maximum does not include any of the expenses covered under the optional Dental or Vision benefits.

Co-payment A designated amount, either a percentage or a fixed dollar amount that may be applied per office visit for each time medical services including consultations and follow ups, are received. Ancillary services such as Laboratory and Radiology service (i.e. blood tests, x-rays) that may be in conjunction with an office visit do not require a co-payment. Co-payments are also applicable to some pharmacy benefits and other covered services. Co-payments do not apply to the Deductible or to the Out-Of-Pocket Maximum.

Deductible: The amounts of covered Allowable Charges payable by the Insured Person during each policy year before the Policy benefits are applied. Such amount will not be reimbursed under the Policy. The Deductible is not considered part of the annual Out-Of-Pocket Maximum.

Exclusions and Limitations: If the term excluded is used on your schedule of benefits, then these services are not part of the coverage chosen by your employer. In addition to excluded services, there are also some coverages that are considered benefit limitations and exclusions. This is in addition to services that you have received, but that did not meet the terms and conditions of the policy or that you did not get Pre-Authorization for.

Experimental and/or Investigational: Any treatment, procedure, technology, facility, equipment, drug, drug usage, device, or supplies not recognized as accepted medical practice by Insurer.

Hazardous Activity: Activities that might heighten the risk of disease or death to an individual.

Insured Dependent: Refers to member of the Insured's family who is enrolled under the Policy with the Company after meeting all the eligibility requirements of the Employer Group and the Company and for whom premiums have been received by the company (See Eligibility and Conditions of Coverage Section).

Insured Employee: The person who is actively at work and employed by the Policyholder on a full time basis, or who is otherwise eligible on his own behalf and not as a Dependent to be Insured under this Policy, as agreed to between the Policyholder and the Insurer.

Insured Person: An Insured Employee or his Insured Dependents enrolled in and entitled to coverage under this Policy and for whom the required Premium has been paid.

Lifetime Maximum: Payment of benefits is subject to a lifetime aggregate maximum per individual Insured Person as indicated in the Schedule of Benefits, as long as the Policy remains in force. The Lifetime Maximum includes all benefit maximums specified in the Policy, including those specified in the Schedule of Benefits and in any Policy Endorsements or Riders.

Maximum Benefit: 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, coinsurance, co-payments and any other applicable costs.

Medically Necessary: Those services or supplies which are provided by the hospital, physician or other approved medical provider that are required to identify or treat an illness or injury and which, as determined by the Insurer, are as follows:

- Consistent with the symptom, or diagnosis and treatment of condition, disease or injury;
- Appropriate with regard to standards of accepted professional practice;
- Not solely for the Insured Person's convenience, the Physician's convenience or any other provider's convenience;
- 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 conditions require that the services or supplies cannot be safely provided as an outpatient;
- Is not a part of or associated with the scholastic education or vocational training of the patient;
- Is not Experimental or Investigative; and

Out-of-Pocket Maximum (Coinsurance Maximum): An amount of allowable expenses as designated in the Schedule of Benefits that is the responsibility of each Insured Person to meet before the Company will begin paying the expenses at 100%. It does not include Deductibles, Co-payments or Excess Charges. Once the Out-of-Pocket Maximum is met, the Policy will begin paying 100% of allowable Reasonable and Customary costs for the remainder of the Policy year, not to exceed Policy limits. The out-of-pocket maximum does not apply to any of the expenses covered under the Prescription Benefit, or the optional Dental and Vision benefits.

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

Reasonable and Customary Charge: The lower of: a) the Provider's usual charge for furnishing the treatment, service or supply; or b) the charge determined by GBG 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 area (zip code) 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" refers to a city, county, or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment, based upon United States standards.

In the United States, when PPO providers are available within a 30-mile radius of your local residence, the reasonable and customary charge may be the negotiated PPO provider fee for such services. If you do not use a network provider, the excess charges will be your responsibility and will not accrue to the Out-of-Pocket Maximum.