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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U.S Network: AETNA Passport

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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Covered Services and Benefit Levels: Subject to Deductible, Coinsurance, Co-payments, and Benefit Maximum.	PLAN REIMBURSEMENT Once the Annual Out-of-Pocket Maximum (Coinsurance Maximum) is met, the Plan reimbursement is 100%		
	Outside U.S.	U.S. In-Network	U.S. Out-of-Network
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

<table>
<tr><th colspan="2">VSP Access Plan / VSP Signature Network</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><th colspan="2">Plan Coverage</th></tr>
<tr><td>Well Vision Exam</td><td>• 20% off thorough eye exam</td></tr>
<tr><td>Glasses</td><td>• 20% off unlimited complete pairs of prescription glasses[1]
• 20% off all lens options
• 20% off unlimited non-prescription sunglasses[1]</td></tr>
<tr><td>Contact Lenses</td><td>• 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.</td></tr>
<tr><th colspan="2">Value-Added Benefits</th></tr>
<tr><td>Laser Vision Care Program</td><td>• 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]</td></tr>
<tr><th colspan="2">Exclusions</th></tr>
<tr><td>The following items are excluded under the plan:
• Medical or surgical treatment.
• Orthoptics, vision training, or supplemental testing.
• Experimental vision services, treatments, and materials.</td><td>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.</td></tr>
</table>

[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