2020

INDIVIDUAL HEALTH INSURANCE POLICY

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

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

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

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

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

THANK YOU
FOR SELECTING
GLOBAL BENEFITS GROUP
HEALTH INSURANCE

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1. SCHEDULE OF BENEFITS

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

The following benefits are per person per Policy Period and subject to the Insured's Policy Period Deductible. After satisfaction of the Policy Period Deductible, Insurer will pay the eligible benefits set forth in this Schedule at the allowable charge, which is defined as Usual, Customary, and Reasonable (UCR). This is the lower of: a) the Provider's usual charge for furnishing the treatment, service or supply; or b) the charge determined by the Insurer to be the general rate charged by the others who render or furnish such treatments, services or supplies to persons who reside in the same country and whose injury or Illness is comparable in nature and severity.

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

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

MAXIMUM BENEFIT	
Policy Period Maximum of $1,000,000	
PROVIDER NETWORK	
• **Latin America and the Caribbean:** Free choice of Providers. • **USA:** The Insurer maintains the GBG Global Security network. In-network benefits are paid at 100%. Out-of-network benefits are paid at 70% UCR.	
HOSPITALIZATION BENEFITS	
Private/Semi-private room	100% UCR
Intensive care unit	100% UCR
Medical treatment, medicines, laboratory and diagnostic tests (including cancer treatment, chemotherapy/ radiotherapy)	100% UCR
Inpatient consultation by a physician or specialist	100% UCR
Inpatient surgery, medical and nursing fees	100% UCR
Extended Care / Inpatient Rehabilitation (Must be confined to facility immediately following a Hospital stay)	100% UCR
Private duty nursing	100% UCR
Accommodation charges for companion of a hospitalized Insured	Up to $1,000, up to $100 maximum per day.
Inpatient psychiatric hospitalization	100% UCR
OUTPATIENT BENEFITS	
Outpatient physician/specialist visit	100% UCR, Maximum 6 visits after covered Hospitalization
Diagnostic exams including laboratory and imaging tests: • Pre-surgical testing only, and • A 3-month Waiting Period applies.	100% UCR; $10,000 Policy Period maximum
Outpatient surgery, medical and nursing fees	100% UCR
Physical Therapy and Rehabilitation Services (Following a covered Hospitalization)	100% UCR; maximum 60 visits per Policy Period, all therapies combined
Prescription drugs following a covered Hospitalization or Outpatient surgery. Maximum 6 month coverage from date of discharge	100% UCR
Prescription drugs following a covered Outpatient treatment	Not covered

EMERGENCIES	
Serious Accident Hospitalization (Admitted for 24 hours or more)	100% UCR; Deductible will be waived for an immediate first Hospitalization
Ground Ambulance (Covered if immediately admitted as an Inpatient)	100% UCR
Air Ambulance (Covered if immediately admitted as an Inpatient)	Per event maximum: $50,000, Deductible waived
Emergency Room and Emergency Medical Services (Covered if immediately admitted as an Inpatient)	100% UCR
Emergency Dental Care - Limited to accidental injury of sound, natural teeth. Services must be completed within 120 days of accident.	100% UCR
SPECIALIZED TREATMENTS	
Transplant procedures (in the U.S. Institutes of Excellence facilities approved by GBG only)	**OPTIONAL RIDER** 100% UCR; $750,000 Lifetime Maximum per diagnosis including donor expenses and donor procurement expenses up to $40,000
OTHER BENEFITS	
Oncologic treatment	100% UCR
Dialysis	100% UCR
Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC). A 24 month Waiting Period applies. Benefit is not covered if condition was diagnosed a Pre-existing Condition. Inpatient care only.	100% UCR; $15,000 Lifetime Maximum
GBG Personal Medical Advisor – Medical Second Opinion service	Covered
Home Health Care/Home Care (covered as a follow-up care to a covered Hospitalization)	100% UCR; $6,000 Policy Period maximum
Hospice Care	100% UCR
Durable Medical Equipment (covered as a follow-up care to a covered Hospitalization)	100% UCR; $6,000 Policy Period maximum
Prosthetic Limbs (covered as a follow-up care to a covered Hospitalization)	$30,000 Policy Period maximum; $120,000 Lifetime Maximum
Repatriation of Mortal Remains	Per Insured benefit maximum: $10,000
War and Terrorism Benefit	100% UCR

THE FOLLOWING SERVICES REQUIRE PRE-AUTHORIZATION Failure to pre-authorize a procedure that requires Pre-authorization will result in a 30% penalty. (Except Air Ambulance, organ, bone marrow, stem cell transplants, and other transplant similar procedures not Pre-Authorized by the Company will not be covered)
Hospitalization
Exams or Outpatient procedures that requires more than local anesthesia
All treatment incurred in Brazil, except for life threatening emergency treatment
Oncologic Treatment in excess of $10,000
Home Health Benefits/ Home 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 that is expected to accumulate over $10,000 of medical treatment per Policy Period.

1.1 Deductible Options

POLICY PERIOD DEDUCTIBLES					
Plan	In Country of Residence	Out of Country of Residence	Plan	In Country of Residence	Out of Country of Residence
Plan 1	$0	$1,000	Plan 4	$5,000	$5,000
Plan 2	$1,000	$2,000	Plan 5	$10,000	$10,000
Plan 3	$2,000	$3,000	Plan 6	$20,000	$20,000
Family Maximum Deductible: 2 x Individual Deductible					

PLEASE SEE YOUR POLICY FACE PAGE TO DETERMINE THE DEDUCTIBLE AMOUNTS THAT APPLY TO YOUR COVERAGE

2. GENERAL PROVISIONS

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

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

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

2.3 Entire Policy and Changes
This Policy, Policy Face Page, Schedule of Benefits, the Policyholder application, and any amendments or endorsements (if any) comprise the entire contract between the parties.
No change may be made to this Policy unless it is approved by an officer of the Insurer. A change will be valid only if made by a Policy endorsement/rider signed by an officer of the Insurer, or an amendment of the Policy in its entirety issued by the Insurer. No agent or other person may change this Policy or waive any of its provisions.
The Policyholder understands and agrees that the Policy purchased is written on an annual basis and premium is due for the Policy Period, regardless of the Premium payment mode agreed to by the Insurer as shown on the Policy Face Page.

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

2.5 Administrative Agent
Global Benefits Group
7600 Corporate Center Drive, Suite 500
Miami, FL 33126 USA

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

The policy providing your coverage and the insurer providing this policy have not been approved by the Florida Office of Insurance Regulation.

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

2.8 Late Payment Provision
A period of 30 days will be allowed for payment of any Premium, after the Premium payment due date. The Insurer will suspend coverage during this period if the Premium is not received. If the Premium is received during the 30-day period, the coverage will resume without any interruption in coverage. If the Premium due is not paid, the Insurer will cancel the Policy as of the Premium due date.
All unpaid Premium through the date of cancellation and any other Premium adjustments assessed as a result of cancellation are the

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

2.9 Cancellation

The Company reserves the right to cancel the Policy as described below:

- This Policy will be canceled for non-payment of the Premium, although the Company may at their discretion reinstate the coverage if the Premium is subsequently paid.
- If any Premium due from the Policyholder remains unpaid, the Company may in addition defer or cancel payment of all or any claims for expenditures incurred during the period it remains unpaid.
- While the Company shall not cancel this Policy because of eligible claims made by any Insured, it may at any time terminate an individual or any of their eligible dependents or subject the Insureds coverage to different terms if the individual or the Policyholder has at any time:
  - Misled the Company by misstatement or concealment;
  - Knowingly claimed benefits for any purpose other than are provided for under this Policy;
  - Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to Our detriment;
  - Failed to observe the terms and conditions of this Policy, or failed to act with utmost good faith.

The Insurer retains the right to cancel, non-renew or modify a Policy on a Class basis, and the Insurer will offer the closest equivalent coverage possible to the Insured. No individual Insured shall be independently penalized by cancellation or modification of the Policy due solely to poor claim record.
If the Company does cancel this Policy, they shall give 30 days' notice. The Company will refund the unearned portion of the Premium minus administrative charges and Policy fees.

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

2.10 Policy and Rate Modifications

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

2.11 Change of Product or Deductible

The Policyholder may only request to change to another product or Deductible plan at the anniversary date of the Policy. The new product/Deductible plan chosen must be available in the current Country of Residence. The request for change must be submitted in writing and received before the anniversary date. Some requests will be subject to underwriting – for those cases a Health Application will be requested and approval is not guaranteed.
During the first thirty (30) days from the effective date of the change, benefits payable for any Illness or injury not caused by Accident or infectious disease, will be limited to the lesser of benefits provided by the new product or the prior product, and the higher Deductible plan will apply. During the first ten (10) months after the effective date of the change, benefits for maternity, newborn, and congenital will be limited to the lesser benefit provided by either the new product/Deductible plan or prior product/Deductible plan. During the first six (6) months after the effective date of the change, transplant benefits will be limited to the lesser benefit provided by either the new product or prior product.

2.12 Other Premium Changes

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

2.13 Duration of Coverage

Benefits are paid to the extent that an Insured receives any of the treatments covered under the Schedule of Benefits following the Effective Date, including any additional Waiting Periods and up to the date such individual no longer meets the definition of Insured.

2.14 Alterations

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

2.15 Change of Risk
The Policyholder must inform the Company within 30 days of any changes related to Insureds (such as change of address, Country of Residence, occupation or marital status) or of any other material changes that affect information given in connection with the application for coverage under this Policy. The Company reserves the right to alter the Policy terms, Premiums or cancel coverage for an Insured following a change of residence if it is not possible to maintain GBG's coverage in the new Country of Residence.

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

2.17 Jurisdiction
This Policy shall be governed by and construed in accordance with the Laws of England and Wales and each party agrees to submit to the exclusive jurisdiction of the courts of England and Wales.

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

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

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

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

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

2.23 Areas of Coverage – The Policy area of coverage is Latin America, the Caribbean and the US only.

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

3. ELIGIBILITY AND CONDITIONS OF COVERAGE

3.1 Policy Terms and Pre-Existing Conditions Limitation

All applications are subject to underwriting by the Insurer. Acceptance is not guaranteed. The Insurer will advise in writing if your application has been approved along with the terms and conditions of the approval. Pre-existing conditions not disclosed on the application are never covered. Consult the Policy Face Page for the terms and conditions regarding the issuance of this Policy.

3.2 Eligibility

- You must reside in Latin America or the Caribbean at the time the Policy is issued, and
- Have not attained age 75 at the time of enrollment. There is no maximum renewal age for persons already covered under this Policy.
- Termination of the insurance of the primary member shall also cancel all coverage for dependents, except in the case of death of the primary member.
- Your eligibility date, if your application has been approved, will be determined by the Insurer.

3.3 Insured Dependents

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

- The spouse or domestic partner,
- Dependent children up to age 19 if single, or up to age 24 if single and a full-time student at an accredited college or at the time the Policy is issued and renewed. Dependents that are full-time students up to age 24 are charged the Child/Children rate.
- Dependents, which were covered under a prior Policy with the Insurer and are otherwise eligible for cover under their own separate Policy, will be approved without underwriting for the same product with equal or higher Deductible and with the same conditions and restrictions in effect under the prior Policy. The health insurance application of the former dependent must be received before the end of the grace period for the Policy which previously afforded coverage for the dependent.

Dependent children include the Policyholder's natural children, legally adopted children, and step children. Insured dependents are covered from the date that the Insurer accepts them and the corresponding Premiums are paid.
Note that children over age 18 who have a child will need to apply for their own Policy at the end of the Policy Period after they have attained the age of 18.

Note that children age 19 or older who are not full time students should submit an application separate from their parent(s).

3.4 Addition of a Newborn or Newborn Adopted Child

A health application must be submitted disclosing the health status of the newborn child. Coverage is not guaranteed and subject to underwriting approval. If accepted,

- Coverage is effective as of the date determined by the Insurer, and
- A 12-month Pre-existing Conditions limitation is applied.

Note that any newborn care charges incurred in the Hospital under the maternity and related delivery charges are not covered.

3.4.1 Legally Adopted Child, Child born of a Surrogate Mother or as a result of Fertility treatment.

- The child must be less than 19 years old, and
- The Policyholder will provide written notification to the Insurer (an official copy of the legal adoption papers is required with the notification), and
- A health application must be submitted detailing the medical history of the child.
- Coverage will be contingent upon the terms and conditions of the Policy
- Coverage is not guaranteed and is subject to underwriting approval. If approved, coverage will become effective as of the date of application.
- For a period of 12 months from the Effective Date of coverage, Pre-existing Conditions will not be covered.

3.4.2 Newborn Child under the Policy

For the purpose of adding a newborn child to the parent's Policy, a health application must be submitted and will be subject to underwriting, coverage is not guaranteed.

3.5 Waiting Period
This Policy contains a 30-day Waiting Period, during which only Illnesses or injuries caused by an Accident occurring within this period, or diseases of infectious origin that first manifest themselves within this period, will be covered.

The Insurer may waive the Waiting Period only if:
- Other medical expense insurance coverage was in effect with another company for at least one consecutive year, and
- The effective date of this Policy begins within 30 days of the expiration of the previous coverage, and
- The prior coverage is disclosed in the health application, and
- The prior Policy and a copy of the receipt for the last year's Premium payment are submitted with the health application.

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

If the Waiting Period is waived, benefits payable for any condition manifested during the first 30 days of coverage are limited, while the Policy is in effect, to the lesser benefit provided by either this Policy or the prior Policy. See Policy Face Page to determine if this Waiting Period applies to your Policy.

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

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

4. CLAIMS ADJUDICATION AND PRE-AUTHORIZATION PROCEDURES

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

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

4.1.2 Claims submitted by the Insured
If the Insured has already paid the institution or Provider, the Insured must submit the claim with the itemized invoices, the original paid receipts, and claim form directly to Insurer. Claims must be submitted in the official currency where the service was rendered. Photocopies will not be accepted unless the claim is submitted electronically. Insurer will reimburse the Insured in accordance with the terms of this Policy. Refer to the section 13 of this Policy (How to File a Claim) for more information. In case of the death of the claimant Insured, any outstanding medical claims reimbursements will be paid as follows:

Insured	Beneficiary
Death of an insured dependent spouse or child	Medical claims reimbursement will be paid to the Policyholder
Death of the Policyholder, when dependents are insured	Medical claims reimbursement are payable as follows: • Dependent spouse, or • If no dependent spouse, then payment will be paid to the oldest Insured dependent child.
Death of a Policyholder, when no dependents are insured	Medical claims reimbursement are payable to the Policyholder estate.

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

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

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

4.4 Time Limits
Requests for payment of benefits must be received in Insurer's claims administrator office no later than 180 days following the date on which the Insured received the service. Claims received after this date will be excluded from coverage.
Inquiries regarding past claims must be received within 12 months of the date of service to be considered for review.

4.5 Coordination of Benefits
Within the Country of Residence: When an Insured has another insurance Policy that provides benefits also covered under this Policy, benefits will be coordinated with the other Policy and benefits under this Policy reduced to avoid duplication of benefits. All claims incurred in the country of residence must be submitted in the first instance against the other Policy. This Policy shall only provide benefits when such benefits payable under the other Policy have been paid out and the Policy Limits of such Policy have been exhausted. In no event will more than 100% of the allowable charge and/or maximum benefit for the covered services be paid or reimbursed.
The following documentation is required to coordinate benefits: Explanation of Benefits and copy of bills covered by the local insurance company containing information about the diagnosis, date of service, type of service, and covered amount.

Outside the Country of Residence: GBG will function as the primary Insurer and retains the right to collect any payment from local or other Insurers. If a travel insurance policy exists, such Policy will function as primary. For Insureds with two (2) or more international policies, the policy that has been in force the longest will be considered primary.

Special Note for U.S. Citizens: United States citizens who are eligible for U.S. Medicare benefits must apply for coverage under those benefits for medical and prescription services obtained within the U.S.

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

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

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

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

4.10 Lifetime Maximum
Certain payments of benefits are subject to a lifetime aggregate maximum per Insured as indicated in the Schedule of Benefits, as long as the Policy remains in force. The Lifetime Maximum includes all benefit maximums specified in this Policy, including those specified in the Schedule of Benefits, Policy Face Page and in any Policy endorsements, Amendment or riders.

4.11 Pre-Authorization Requirements and Procedures
The Pre-Authorization request shall be sent to the Company within a minimum of five business days prior to the scheduled procedure or treatment date, along with the attending physician request that must include:

- Diagnosis;
- Recommended Treatment;
- Place where treatment will be performed (Institution name),
- Service date and medical fees.

Pre-Authorization is **required** for the following benefits. Failure to obtain Pre-Authorization will result in a 30% reduction in payment of covered expenses, (Except Air Ambulance, organ, bone marrow, stem cell transplants, and other transplant similar procedures not Pre-Authorized by the Company will not be covered)

- Hospitalization
- Exam and Outpatient procedures that requires more than local anesthesia
- All treatment incurred in Brazil, except for life threatening emergency treatment
- Oncologic Treatment in excess of $10,000
- Home Health Benefits/ Home 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 that is expected to accumulate over $10,000 of medical treatment per Policy Period such as, but not limited to:
    - Chronic illness
    - Dialysis
    - Ambulatory services

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

For Residents outside Brazil: Failure to obtain Pre-authorization for non-emergency treatment received in Brazil will result in a denial of benefits. Any such penalty will apply to the entire episode of care. If treatment would not have been approved by the Pre-authorization process, all related claims will be denied.

5. PREFERRED PROVIDER NETWORK

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

In Latin America and the Caribbean (excluding Brazil): The Insured may utilize any licensed Provider.

U.S. only
Preferred Provider: Providers who agree to receive direct payment made by the Company.
Non Preferred Provider: Payment to non-preferred Providers will be made through reimbursement up to the UCR, as these Providers may not accept payment made by the Company. The Provider may bill the Insured the difference between the amounts reimbursed by the Insurer and the Provider's billed charges.

In the U.S., in case of the use of a Non-Preferred Provider, the Company will only reimburse 70% of UCR and the remaining balance will be the insured's responsibility.

Residents outside Brazil seeking medical treatment in Brazil: Use of the Preferred Provider Network is mandatory. In case of the use of a Non-Preferred Provider, the Company will only reimburse 70% of UCR and the remaining balance will be the Insured's responsibility.

All other Countries: Not covered.

The Company retains the right to limit or prohibit the use of Providers, which significantly exceed Usual, Customary and Reasonable Charges.

6. HOSPITALIZATION BENEFITS

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

Benefits are provided per the Schedule of Benefits for Medically Necessary Inpatient Hospital care.

- Accommodations: All charges in excess of the allowable private or semi-private rate are the responsibility of the Insured.
- Intensive care units: Benefits will be provided based on the allowable charge for Medically Necessary intensive care services.

6.1 Surgical Services

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

6.2 Anesthesia Services

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

6.3 Inpatient Medical Services

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

6.4 Inpatient Care Duration/ Inpatient Extended Care

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

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

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

6.5 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.

Pre-authorization by GBG is mandatory if more than four 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.

- Therapy must produce significant improvement in the Insured's condition in a reasonable and predictable period of time, and
  - Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist, or
  - Be necessary to the establishment of an effective maintenance program. Maintenance itself is not covered under this benefit. For maintenance coverage, please refer to Section 7. Outpatient services.

6.6 Inpatient Ancillary Hospital Services

If Medically Necessary for the diagnosis and treatment of the Illness or injury for which an Insured is hospitalized, the following services are also covered:

- Use of operation room and recovery room;
- All medicines listed in the U.S. Pharmacopoeia or National Formulary;
- Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services
- Surgical dressings;
- Laboratory testing;
- Durable Medical Equipment;
- Diagnostic X-ray examinations;
- Radiation therapy rendered by a radiologist for proven malignancy or neoplastic diseases;
- Respiratory therapy rendered by a physician or registered respiratory therapist;
- Chemotherapy rendered by a physician or nurse under the direction of a physician;
- Physical and Occupational therapy (if covered) must be rendered by a physician or registered physical or occupational therapist and relate specifically to the physician's written treatment plan.
  Therapy must produce significant improvement in the Insured's condition in a reasonable and predictable period of time, and
  - Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist, or
  - Be necessary to the establishment of an effective maintenance program. Maintenance itself is not covered under this benefit. For maintenance coverage, please refer to Section 7. Outpatient services.

6.7 Companion of a Hospitalized Child

Charges included for overnight Hospital accommodations for the companion of a hospitalized Insured child under the age of 18 will be payable up to a daily maximum. See your Schedule of Benefits for specific benefit maximums.

6.8 Inpatient Psychiatric Hospitalization

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

As set forth in the Schedule of Benefits:

1. Benefits are for Inpatient mental health treatment only in a Hospital or approved facility. A physician or a psychiatrist must provide all mental health care services.
2. Services include treatment for bulimia, anorexia schizophrenia, major depressive disorder, bipolar disorders, paranoia and other serious mental Illnesses.

7. OUTPATIENT SERVICES

This Policy covers Outpatient surgical services provided;

- The surgical services are Medically Necessary, and
- The surgical service was performed in a Hospital Outpatient surgical facility, including an ambulatory care center/ambulatory surgical facility

Surgical services performed in a physician's office, or that could have been performed in a physician's office, but were performed in an alternative facility for the convenience of the Insured, will not be considered a covered service under this Policy.

Benefits are limited to those shown in the Schedule of Benefits and include the following.

- Surgeon charges and when Medically Necessary, assistant surgeon's charges are covered.
- Anesthesia.
- Facility charges including use of operating room and recovery room.
- Prescription Drugs.

7.1 Outpatient Physician Visits
Insurer provides benefits for medical visits to a pysician/specialist in the physician's office if Medically Necessary and as follow-up care to a covered Hospitalization. Benefits are limited to one visit per day per Insured. Services for routine physicals, routine foot care, including related diagnostic services are not covered. All Outpatient visits are payable in accordance with the Schedule of Benefits.

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

7.3 Pre-Surgical Testing
Testing required prior to an approved surgical procedure meeting the criteria as described under this Policy is covered provided;

- The test meets generally accepted medical standards as determined by the Insurer for evaluation of the diagnosis, and
- The tests must be performed within 15 days of the anticipated date of surgery.

Such tests include; X-Ray, Laboratory, ECG, Ultrasound, CAT scan, PET scan, MRI and Endoscopy.

Such testing is subject to a Waiting Period and the benefit maximum as shown in the Schedule of Benefits.

7.4 Prescription Drugs
Prescription Drugs that are administered during a surgical procedure are a covered benefit. Immediately following discharge, Prescription Drugs are covered for the medical condition resulting in the surgical procedure, for the specific period and benefit maximum as shown in the Schedule of Benefits.

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

8. EMERGENCY SERVICES / MEDICAL EVACUATION

8.1 Serious Accident Hospitalization
An unforeseen trauma occurring without the Insured's intention, which implies a sudden external cause and violent impact on the body, resulting in demonstrable bodily injury that requires immediate Inpatient hospitalization for 24 hours or more within the next few hours after the occurrence of the severe injury to avoid loss of life or physical integrity. Severe injury shall be determined to exist upon agreement by both the treating physician and the Insurer's medical consultant, after review of the triage notes, emergency room and Hospital admission medical records.

8.2 Emergency Ground Ambulance Services
Benefits are provided (if immediately admitted as an Inpatient) for Medically Necessary Emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care and are payable in accordance with the current Schedule of Benefits. The use of ambulance services for the convenience of the Insured, which is not Medically Necessary, will not be considered a covered service.

8.3 Air Ambulance and Medical Evacuation
Utilization of the medical evacuation provision requires the prior approval of GBG. In the event of an Emergency that may require medical evacuation, contact GBG in advance in order to approve and arrange such Emergency medical air transportation. If the Insured fails to follow these conditions, he will be liable for the full costs of any transportation. GBG retains the right to decide whether the evacuation proceeds and the medical facility to which the Insured shall be transported. GBG contact information can be located on the

Insured's medical I.D. card. The cost of a person accompanying an Insured is covered under this Policy, when possible.

- Emergency evacuation only covered if immediately admitted as an Inpatient and if related to a covered condition under this Policy, for which treatment cannot be provided locally, and transportation by any other method would result in loss of life or limb. GBG retains the right to decide the medical facility to which the Insured shall be transported. Emergency transportation must be provided by a licensed and authorized transportation company to the nearest medical facility. The vehicle or aircraft used must be staffed by medically trained personnel and must be equipped to handle a medical Emergency.
- Approved medical evacuations will be to the nearest medical facility capable of providing the necessary medical treatment.
- The Insured agrees to hold the Insurer and any company affiliated with the Insurer by way of similar ownership or management, harmless from negligence resulting from such services, or negligence regulating from delays or restrictions on flights caused by the pilot, mechanical problems, or governmental restrictions, or due to operational conditions.
- Within 90 days of the medical evacuation, the return flight for the Insured and an accompanying person will be reimbursed up to the cost of an airplane ticket in economy class only to the Insured's Country of Residence – Maximum $2,000 per person.

8.4 Emergency Dental

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

9. SPECIALIZED TREATMENTS

9.1 Transplant Procedures

(*Refer to the Policy Face Page to determine if the coverage is included under your plan*)

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

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

10. OTHER BENEFITS

10.1 Nose and Nasal Septum Deformity

When nose or nasal septum deformity is the result of trauma during a covered Accident, surgical and physician treatment will only be covered if the evidence of trauma in the form of fracture must be confirmed radiographically (X-rays, CT Scan, etc.) prior to the procedure.

10.2 HIV, AIDS and ARC

Benefits are available for Medically Necessary, non-experimental services, supplies and drugs for the treatment of Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), only if caused by an Accident or blood transfusion, provided the condition(s) are not considered Pre-existing Conditions. A 24-month Waiting Period applies. Sexually transmitted diseases and all related conditions are not covered.

10.3 Sports and Hazardous Activity
This Policy provides coverage for a wide range of activities and sports, excluding professional sports. Listed below are examples of activities and sports not covered:

- Mountain Climbing, mountaineering, alpinism;
- Aviation Sports (aerobatics, parachuting, paragliding, parasailing, sky diving and wingsuit flying);
- Bungee Jumping
- Off piste skiing
- Scuba Diving below 60 feet
- Water Rafting above class 3
- Cliff Diving
- Off track or on track motor vehicle racing

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

10.4 Home Health Care/Home Care
An initial period of 30 days will be covered if pre-authorized and as a follow-up care to a covered Hospitalization. An advanced treatment plan signed by the treating Physician is required for
the proper treatment of the Illness or injury and used in place of Inpatient treatment. Home Health Care includes the services of a skilled licensed professional (nurse or therapist) outside the Hospital and does not include Custodial Care.

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

The Insurer considers home nursing care Medically Necessary when recommended by the member's primary care and/or treating physician and **both** of the following circumstances are met:

- Member has skilled needs; **and**
- Placement of the nurse in the home is done to meet the skilled needs of the member only; not for the convenience of the family caregiver.

10.5 Special Treatments and Highly Specialized Drugs
Prosthesis, appliances, orthotic Durable Medical Equipment, and implants will be covered, but must be pre-authorized in advance by GBG. Highly specialized drugs for specific uses will be covered, but must be pre-authorized and coordinated in advance by GBG. These drugs include, but are not limited to the following; Interferon beta-1-a, PEGylated Interferon alfa 2a, Alfa, Interferon beta-1-b, Etanercept, Adalimumab, Bevacizumab, Cyclosporine A, Azathioprine, and Rituximab. When necessary, and if possible, the Company will coordinate the delivery of such medications. Experimental drugs and drugs not approved by the FDA are not covered.

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

Covered services are available in home, Outpatient (following an Inpatient Hospitalization) and Inpatient settings up to the amount listed on the Schedule of Benefits. Admission to a Hospice program is made on the basis of patient and family need.
The Hospice care:

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

10.7 Durable Medical Equipment
Insurer provides benefits for prosthetic devices (artificial devices replacing body parts), orthopedic braces and Durable Medical Equipment (including wheelchairs and Hospital beds) as follow-up care to a covered Hospitalization. The Policy will pay the Usual, Customary and Reasonable Charges for Artificial Devices listed, provided such Durable Medical Equipment (DME) is:

1. Prescribed by a physician, and
2. Customarily and generally useful to a person only during an Illness or injury, and
3. Determined by Insurer to be Medically Necessary and appropriate.

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

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

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

10.8 Prosthetic Limbs

Includes artificial arms, hands, legs, and feet and are covered up to the maximum benefit shown in the Schedule of Benefits as follow-up care to a covered Hospitalization. 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 Insured 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. Special high performance prosthetics for sports or improvement of sports performance will not be covered by this benefit.
Insurer will allow for two breast prosthesis for cancer patients who have a mastectomy while covered under this Policy. Post surgical bra will be a covered expense.

10.9 Repatriation of Mortal Remains

The necessary clearances for the return of an Insured's mortal remains by air transport to the Country of Residence will be coordinated by Insurer.

A benefit for either repatriation of mortal remains or local burial (if death occurs outside of country of residence) is included under this Policy. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar personal burial preferences.

Refer to Schedule of Benefits for details.

10.10 War and Terrorism

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

1. War, hostilities or warlike operations (whether war be declared or not),
2. Invasion,
3. Act of an enemy foreign to the nationality of the Insured or the country in, or over, which the act occurs,
4. Civil war,
5. Riot,
6. Rebellion,
7. Insurrection,
8. Revolution,
9. Overthrow of the legally constituted government,
10. Civil commotion assuming the proportions of, or amounting to, an uprising,
11. Military or usurped power,
12. Explosions of war weapons,

13. Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Insured whether war be declared with that state or not,
14. Terrorist activity

Please refer to Schedule of Benefits for maximum benefit limitations.

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

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

11. EXCLUSIONS AND LIMITATIONS

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

1. Claims and costs for medical treatment, occurring before the Effective Date of coverage (including Waiting Periods) or after the expiration date of the Policy. Claims and costs for medical services with dates of service after the Policy termination date that are related to Accidents, sicknesses, or maternity originating during the Policy Period, unless the Policy has been renewed. This includes any portion of a covered prescription to be used after the expiration of the current Policy Period.
2. Services, supplies, or treatment including drugs and/or Emergency services that are provided by or payment is available from: (a) Workers' Compensation law, Occupational Disease law or similar law concerning job related conditions of any country, (b) the Insured, a family member or any enterprise owned partially or completely by the aforementioned persons, (c) another insurance company or government, (d) under the direction of public authorities related to epidemics.
3. Services, supplies or treatments, including drugs, that are not scientifically or medically recognized for a specific diagnosis, or that are considered as off label use, experimental or not approved for general use are considered Experimental or Investigational and therefore not eligible services.
4. Diabetic supplies including Insulin Pumps and associated supplies.
5. Any services, supplies, treatments including drugs and/or Emergency air services; (a) not ordered by a physician, (b) not Medically Necessary, not recommended or approved by a physician, (c) not rendered under the scope of the physician's licensing, (d) medical and dental services that do not meet professionally recognized standards or are determined by Insurer to be unnecessary for proper treatment.
6. Telephonic consultations, missed appointments, or "after hours" expenses.
7. Personal comfort and convenience items including, but not limited to television, housekeeping services, telephone charges, take home supplies, ambulance services (other than those provided by this Policy), and all other services and supplies that are not Medically Necessary including expenses related to travel and hotel costs incurred for medical or dental care.
8. Health check-ups, inoculations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.).
9. Immunizations.
10. Over-the-counter (OTC) drugs, supplies or medical devices, which do not require a physician prescription, even if recommended by a physician, including, but not limited to, smoking cessation drugs, appetite suppressant, hair regenerative drugs or products, anti-photo aging drugs, cosmetic and beauty aids, acne and rosacea drugs (including hormones and retin A) for cosmetic purposes, megavitamins, vitamins, (other than pre-natal as described under maternity), sexual enhancement devices, supplements, herbs or drugs, for any reason.
11. Services and supplies related to visual therapy, radial keratotomy procedures, Lasik, or eye surgery to correct refractive error or deficiencies, including myopia or presbyopia, unless stated on the Schedule of Benefits.

12. Rest cures, Custodial Care, home-like care, assistance with Activities of Daily Living (ADL), milieu therapy for rest and/or observation; whether or not prescribed by a physician. Any admission to a nursing home, home for the aged, long term care or Rehabilitation facility, sanatorium, spa, hydro clinic or similar facilities that do not meet the Policy definition of a Hospital. Any admission, arranged wholly or partly for domestic reasons, where the Hospital effectively becomes or could be treated as the Insured's home or permanent abode.
13. Elective and or cosmetic surgery, procedures, treatments, technologies, drugs, devices, items and supplies that are not Medically Necessary treatment of a covered Accidental injury or Illness or disease, and that may only be provided for the purpose of improving, altering, enhancing, or beautification unless required due to the treatment of an injury, deformity, or Illness that compromises functionality and that first occurred while the Insured was covered under this Policy. This also includes any surgical treatment for nasal or septal deformity that was not induced by trauma. Cosmetic surgery is defined as surgery or therapy performed to improve or alter appearance for self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
14. Any medical complications arising directly or indirectly as a result of a non-authorized elective or cosmetic procedure.
15. Sleep studies and other treatments relating to sleep apnea, sleep disorders including restless leg syndrome.
16. Weight related treatment; any expense, service or treatment for obesity, nutritionist consultation (related to any diagnosis, conditions and/or symptoms), weight control, or any form of food supplement. This includes expenses related to or associated with treatment of morbid or non-morbid obesity, including, but not limited to, gastric bypass, gastric balloons, gastric stapling, jejunal ileal bypass, and any other procedures or complications arising there from, unless stated on the Schedule of Benefits.
17. Maternity related treatment or complications for the mother or newborn.
18. Any fertility/infertility services, tests, treatments and/or procedures of any kind, including, but not limited to, fertility/infertility drugs, including drugs to regulate the menstrual cycle/ovulation for family planning purposes, artificial inseminations, in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), surrogate mother and all other procedures and services related to fertility and infertility. Any pregnancy resulting from such treatments, complications of that pregnancy, and postpartum care are also excluded, unless stated on the Schedule of Benefits.
19. Genetic counseling, screening, testing or treatment, unless stated on the Schedule of Benefits.
20. Elective abortions; any voluntarily induced termination of pregnancy, unless the mother's life is in imminent danger.
21. 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. Cervical Cancer will be covered under Oncology Benefits, unless pre-existing.
22. Maternity/Delivery preparation classes.
23. Circumcisions, unless Medically Necessary and pre-authorized.
24. Treatment for alcoholism, solvent abuse, drug abuse or addictive conditions of any kind, and treatment of any Illness arising directly or indirectly from alcohol or drug abuse or addiction. This includes, but is not limited to treatment for any injuries caused by, contributed to or resulting from the Insured's use of alcohol, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed by the Insured's doctor.
25. 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.
26. Injuries and/or Illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law by an Insured.
27. Eyeglasses, contact lenses, sunglasses.
28. 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.
29. Durable Medical Equipment does not include: motor driven wheelchairs or beds, additional wheels, comfort items such as telephone arms and over bed tables, items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners), disposable supplies, exercycles, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment and similar items or the cost of instructions for the use and care of any Durable Medical Equipment. The customizing of any vehicle, bathroom facility or residential facility is also excluded.
30. Routine podiatry or other foot treatment not resulting from an Illness or injury. Pedicures, special shoes, inserts of any kind or any other supportive devices for the feet such as, but not limited to, arch supports and orthotic devices or any other preventive services and supplies. Any treatments, services or devices for diagnosis of weak, unstable, flat feet or fallen arches; or any specified lesions of the feet such as corns, calluses, hyperkeratosis, toenails or bunions (hallux valgus).

31. Growth Hormones, unless Medically Necessary and pre-authorized by GBG. This includes treatment by a bone growth stimulator, bone growth stimulation or treatment related to growth hormone, regardless of the reason for prescription.
32. Hearing aids, hearing devices and bone anchored hearing aids.
33. Exceptional Risks: (a) treatment as a consequence of injury sustained while participating in a hazardous activity or training for professional sports, or as a consequence of: war (declared or not), acts of terrorism , acts of foreign enemy hostilities, civil war, rebellion, revolution or insurrection; (b) chemical contamination; (c) contamination by radioactivity from any nuclear material or from the combustion of nuclear fuel (d) treatment for any loss or expense of nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily injury, except in an endeavor to save human life.
34. Except for accidental injury to sound, natural teeth, dental care is excluded from coverage; treatment, services or supplies related to the teeth; and (b) the gums other than tumors; and (c) any other associated structures; (d) the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces, or other mechanical aids; and (e) dental implants, regardless of cause.
35. Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism, or any treatment, services, or supplies to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible. This includes treatment for Temporomandibular Malocclusion Joint Disorders (TMJD).
36. Treatment, diagnostic procedures, services, supplies for mental, nervous or behavioral conditions and all mental health services on an outpatient basis. Serious mental Illness is covered as noted in the Policy.
37. This Policy will not cover any services received by any parties or in any countries where otherwise prohibited by the U.S./UN/EU law.
38. Coverage is excluded for treatment and services related to infectious diseases declared to be an outbreak, epidemic, or public emergency by the World Health Organization(WHO), Center for Disease Control and Prevention (CDC), or any other government or government agency or ruling body of the country where the outbreak or epidemic has occurred in. Additionally, such coverage is also excluded if there has been an official warning issued against travel to the area, by the State Department, Embassy, airline or other governmental agency, prior to travel to the affected country. This exclusion will not apply if exposure occurs accidentally or unknowingly while travelling to or from areas not declared to be at risk, or if exposure occurs as a result of residing or working in the area prior to the outbreak.

12. HOW TO FILE A CLAIM

The claims form is downloadable from latam.gbg.com. The Company must receive completed form within 180 days of the treatment's date of service to be eligible for reimbursement of covered expenses.
The claim form must be used only when a Provider does not bill the Company directly, and when you have Out-of-pocket expenses to submit for reimbursement.

12.1 Mail the Claim Form and documentation to:

Global Benefits Group
7600 Corporate Center Drive, Suite 500
Miami, FL 33126 USA

Submission of claims by scan or online:

- Scan claims to: eclaims360@gbg.com
- Log-on to latam.gbg.com

12.2 Status of Claims

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

12.3 Complaints Procedure

At times, you may have a concern You would like to tell Us about or disagree with a decision made regarding Your coverage. You can make a compliant or file an appeal to get help for Your situation. The following procedures must be followed for a complaint to be reviewed.

12.4.1 Who to Contact?

The most important factors in getting Your complaint dealt with as quickly and efficiently as possible are:

- Be sure You are talking to the right person; and
- That You are providing the necessary information.

When You Contact Us

Please provide the following information:

- Your name, telephone number, and email address;
- Your policy and/or claim number and the plan of benefits (medical, travel, disability) You are insured for; and
- Please explain clearly and concisely the reason for Your complaint.

12.4.2 Step One: Making a Complaint

If Your complaint relates to:

1. **The sale of the policy You purchased or any information You were given during the sales process:**
   a. If You purchased the policy using a broker or other intermediary, please contact them first.
   b. If You purchased the policy directly from Us either from a local representative, using the website, or through a group plan of benefits, please contact Us directly at:

Toll Free	Phone	E-mail
+1.866.914.5333 (within the USA & Canada)	+1.786.814.4125 (outside the USA & Canada)	complaints@gbg.com

   c. You may also submit Your complaint via Our Complaint Form, which may be accessed by visiting Our website and navigating to the Forms page: www.gbg.com/#/oursolutions/forms.

2. **A claim for benefits, the terms and conditions of the policy, or other benefit related information:**
   a. Complaints related to a claim denial should be submitted as soon as possible. We will review the information and provide a response within four weeks or will request additional time, if needed.
   b. Claims and benefits related complaints should be referred to Our Complaints Department:

Toll Free	Phone	E-mail
+1.877.916.7920 (within the USA & Canada)	+1.949.916.7941 (outside the USA & Canada)	customerservice@gbg.com

   c. You may also submit Your complaint via Our Appeal Form, which may be accessed by visiting Our website and navigating to the Forms page: www.gbg.com/#/oursolutions/forms.
   GBG Insurance Limited is licensed and regulated by the Guernsey Financial Services Commission under the Insurance Business (Bailiwick of Guernsey) Law, 2002.
   We always aim to resolve Your complaint and provide a final response within four weeks, but if it looks like it will take Us longer than this, We will let You know the reasons for the delay and regularly keep You up to date with Our progress.

12.4.3 Step Two: Beyond Your Insurer

If We can't respond fully to Your complaint within three months after You contact Us, or You are unhappy with Our final response, you can refer Your complaint to the Channel Islands Ombudsman (CIFO).

You must contact CIFO about Your complaint within six months of the date of Our final response to Your complaint or CIFO may not be able to review Your complaint. You must also contact CIFO within six years of the event complained about or (if later) two years of when You could reasonably have been expected to become aware that You had a reason to complain.

You may contact CIFO at:

Address	E-mail	Guernsey local phone
Channel Islands Financial Ombudsman PO Box 114 Jersey, Channel Islands JE4 9QG	complaints@ci-fo.org **Website** www.ci-fo.org	+44 (0)1481 722218 **International phone** +44 1534 748610

13. HOW TO CONTACT GBG

GBG must be contacted for the following services:

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

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

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

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

15. NOTICE OF PRIVACY PRACTICES

This notice describes how personal information about You may be used and disclosed and how You can get access to this information. Please review it carefully.

The confidentiality of Your personal information is of paramount concern to Us. We maintain records of the services we cover (claims), and we also maintain information about You that we have used for enrolment processing. We use these records to administer Your policy benefits and coverage; we may also use these records to ensure appropriate quality of services provided to You and to enhance the overall quality of Our services, and to meet Our legal obligations. We consider this information, and the records We maintain, to be protected personal information. We are required by law to maintain the privacy of personal information and to provide Our insureds with notice of Our legal duties and privacy practices with respect to personal information. This notice describes how We may use and disclose Your personal information. It also describes Your rights and Our legal obligations with respect to Your personal information.

How We May Use or Disclose Your Personal Information

We collect and processes Your personal information as necessary for performance under Your insurance policy or complying with Our legal obligations, or otherwise in Our legitimate interests in managing Our business and providing Our products and services. These activities may include:

- Use of sensitive information about the health or vulnerability of You, or others involved in Your assistance guarantees, in order to provide the services described in Your insurance policy;

- Disclosure of personal information about You and Your insurance cover to companies within the GBG group of companies (subject to local laws within each applicable jurisdiction), to Our service Providers and agents in order to administer and service Your insurance cover, for fraud prevention, to collect payments, and otherwise as required or permitted by applicable law;
- Monitoring and/or recording of Your telephone calls in relation to coverage for the purposes of record-keeping, training and quality control;
- Technical studies to analyze claims and premiums, adapt pricing, support subscription processes and consolidate financial reporting (including regulatory); detailed analyses on claims/calls to better monitor Providers and operations; analyses of customer satisfaction and construction of customer segments to better adapt products to market needs;
- Obtaining and storing any relevant and appropriate supporting evidence for Your claim, for the purpose of providing services under Your insurance policy and validating Your claims; and
- Sending feedback requests or surveys relating to Our services, and other customer care communications.

These activities are carried out within the UK and European Economic Area (EEA), and outside the EEA in countries for which an adequate level of data protection has not yet been determined by the EU Commission. However, we have taken appropriate measures to ensure that your personal data remains protected in accordance with applicable data protection laws, including conclusion of the EU standard contractual clauses for the transfer of personal data. Further details on the appropriate safety precautions taken are available on request and further information is available under website privacy policy under http://www.gbg.com/#/AboutGBG/PrivacyPolicy

According to the applicable data protection laws, you are entitled, on request, to a copy of the personal information we hold about you, and you have other rights to deletion, correction, object, restriction, data portability in relation to how we use your data (as set out in our website privacy policy under https://www.gbg.com/" \l "/AboutGBG/PrivacyPolicy). Please let us know if you think any information we hold about you is inaccurate, so that we may correct it.

If You have any questions about this Notice of Privacy Practices or Our use of Your personal information You may contact the Data Protection Officer. Contact details are below:

GBG Insurance Limited
Data Protection Officer
Fourth Floor, Albert House
South Esplanade, St Peter Port - Guernsey, GY1 1AW
E-mail: dataprotection@gbg.com

14. DEFINITIONS

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

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

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

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

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

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

Class: the Insureds of all Policies of the same type, including, but not limited to benefits, Deductibles, age group, country, product, plan, year groups or a combination of any of these.

Complications of Maternity and Perinatal means a condition

- Caused by pregnancy; and
- Requiring medical treatment prior to, or subsequent to termination of pregnancy; and
- The diagnosis of which is distinct for pregnancy; and
- Causes complications in the newborn unrelated to Congenital or Hereditary Conditions.

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

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

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

Durable Medical Equipment: equipment customarily and generally useful to a person only during an Illness or injury.

Effective Date: the date upon which an Insured's coverage will become effective under this Policy.

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

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

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

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

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

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

Home Health Care is a program:

a. for the care and treatment of an Insured in his home;
b. established and approved in writing by his attending physician; and
c. certified, by the attending physician, as required for the proper treatment of the injury or Illness, in place of Inpatient treatment in a Hospital or in an Extended Care Facility.

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

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

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

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

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

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

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

a. It is only a convenience to the Insured, the Insured's family or the service Provider; or
b. It is not considered appropriate for the diagnosis or treatment of the Insured; or
c. Exceeds the level of care required to allow diagnosis and appropriate treatment, or
d. Do not follow the standard of practice, as established by the professional councils of its field (medicine, physiotherapy, nursing, etc.)

The Company reserves the right to determine the medical necessity of a planned treatment.

Outpatient: any medical services/procedures (surgical or not) performed for less than 24 hours in a Hospital setting or not.

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

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

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

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

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

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

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

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

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

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

Private Duty Nursing: Skilled nursing care provided in a Hospital by a licensed RN. Must be Medically Necessary for members requiring individual and continuous skilled care when ordered by the member's treating physician as part of a Treatment Plan for a covered condition. Excludes Custodial Care.

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

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

Rehabilitation: therapeutic services within a predetermined time period, designed to return/improve a function that was lost/affected as a result of a covered medical condition or accident.

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

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

Usual, Customary and Reasonable Charge means the lower of:

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

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

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

Utilization Review Measures: the Company retains the right to determine the medical necessity of a planned treatment according to medical protocols approved for each condition.

Waiting Period: the period from the Insured Effective Date, during which benefits will be limited or no benefit will be available.

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

Any Country.
Any Nationality.

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