GLOBAL BENEFITS GROUP

TIECARE INTERNATIONAL

World Care

Group Health Insurance Policy

2005-2006

This policy, along with your identification card, comprises your insurance plan. Please check your Identification Card for the specifics of coverage and limitations.

TIECARE INTERNATIONAL
GLOBAL BENEFITS GROUP
27092 Burbank, Foothill Ranch CA 92610
Tel: 949-470-2100 • Fax: 949-470-2110

WORLD CARE
2005-2006

You are responsible for all terms and conditions found in this policy.

Please pay special attention to the following:

I. **MEMBERS ARE RESPONSIBLE FOR ANY CHARGES IN EXCESS OF THE USUAL AND CUSTOMARY CHARGES.**

II. **CLAIMS MUST BE RECEIVED BY ICS WITHIN 180 DAYS FROM DATE OF SERVICE.**

III. **SOME POLICIES HAVE GEOGRAPHIC RESTRICTIONS, LIMITING TREATMENT IN CERTAIN COUNTRIES. INDIVIDUAL MEMBERS SHOULD CONSULT THEIR CERTIFICATES OF INSURANCE AND THEIR MEMBERSHIP CARDS TO SEE IF THEIR POLICY HAS GEOGRAPHIC RESTRICTIONS.**

IV. **COVERAGE IS SUBJECT TO ELIGIBILITY AT THE TIME CHARGES ARE ACTUALLY INCURRED, AND TO ALL OTHER TERMS, LIMITATIONS, AND EXCLUSIONS OF THE POLICY; PRE-AUTHORIZATION DOES NOT GUARANTEE OR CONFIRM BENEFITS UNDER THE POLICY.**

V. **ONLY TREATMENT AND SERVICES WHICH ARE DEEMED MEDICALLY NECESSARY WILL BE ELIGIBLE FOR REIMBURSEMENT WITHIN THE BENEFIT LIMITS (See Definitions).**

NOTE TO MEMBERS WITH WORLDWIDE COVERAGE:

CERTAIN SPECIFIC PROVISIONS APPLY TO POLICIES WITH NO GEOGRAPHIC RESTRICTIONS. PLEASE SEE PAGE 13 FOR DETAILS ON WORLDWIDE COVERAGE.

I. POLICY DESCRIPTION

1. Policy – This is a group health insurance policy that is issued by TieCare International/Global Benefits Group, Inc, hereinafter called the Company. This policy and your individual Identification Card describes the type of coverage provided and indicates the applicable deductible and co-payment. Unless modified by the Rider, all coverage is as described in this policy.

2. Dependents - You may cover your spouse or individual partner sharing living quarters in a long-term relationship. If your dependent spouse or individual partner under this policy is a resident within a restricted area, the Company must be notified before the purchase of the policy.

You may cover your dependent children. Children include both biological and adopted. Coverage for children will cease at the end of the policy year in which the 21st birthday occurs. If the child is a full-time student, the coverage will cease at the end of the policy year in which the 24th birthday occurs.

Note: International and International Plus members are not allowed to cover dependents residing in a restricted area.

3. Benefits - This policy provides coverage for medically necessary treatment as described in this policy, and is subject to the limitations and exclusions of this policy.

4. Plan Deductibles and Co-Payments - Deductible is the amount paid by each of the insured persons for eligible medical treatment expenses during each policy year. Deductibles are indicated on the Identification Card and Certificate of Insurance.

Employers may choose between the following deductible options:

- Annual deductibles ranging from $0 to $5,000 (Family deductible is always 3 times the individual amount).
- The Company also offers deductibles on a per claim basis. Employers can select a $0, $25, $50, $75, $100, $125 or $150 deductible on a per claim basis.

Co-payment is the portion of a covered expense, after the deductible is paid, that must be paid by the insured individual. There are two types of co-payments: general policy co-payments and benefit specific co-payments.

- The Company currently offers three general policy co-payment plans: 10%, 20% and 30%.
- The co-payment plans and the respective out-of-pocket expenses apply to the first $10,000 USD of covered treatment.
- You may change your policy co-payment plan when you renew your policy.
- In addition to basic co-pay, there may be additional co-payments associated with specific benefits, such as prescription drug coverage.

Each ID card will show what type of deductible and co-payment options have been selected.

5. Preferred Providers – The Company maintains a Preferred Provider Network both inside and outside the United States. There is a 20% co-pay up to a maximum of $2,000 for use of a facility not within our U.S. network, unless a facility within our network is not available.

Outside the US, Company maintains the right to require the use of a Network Provider where available.

Please visit http://www.claimssite.com for a complete list of providers.

6. Usual and Customary Charges - The policy will provide coverage up to the usual and customary fees and charges for the treatment received. Amounts in excess of such usual and customary fees will not be reimbursed, and will be the responsibility of the policyholder. Please see Page 6, number 9 for complete details on Usual and Customary charges.

7. Modifications to Coverage - If a Rider modifies the coverage described in this policy, then the provisions in the Rider shall prevail.

8. Areas of Coverage – The Company offers three areas of coverage: Worldwide, International, and International Plus. Your certificate of insurance and membership card will state the areas of coverage included in your plan.

Worldwide Coverage

Worldwide coverage has no geographic restrictions and provides coverage in any country in the world. For specific features of this coverage that apply to Worldwide policyholders only, see page 13.

International Coverage

International coverage provides for medical treatment throughout the world, with the exception of the United States and Canada; in other specified areas members will be responsible for a co-pay equal to 20% of all covered treatment. This co-pay is in addition to any other co-pays or restrictions relating to specific treatments. For a complete list of restricted areas and facilities visit www.claimssite.com.

Note that the Company reserves the right to add and remove restricted areas at its discretion. Prior to any change in this regard, the Company will provide the insured with written notice 30 days before the change takes effect. Under International Coverage, treatment in the US and Canada, is ***absolutely not covered***, and will ***not*** be reimbursed by the Company.

International Plus Coverage

International Plus Coverage is designed to provide the same benefits as International Coverage. In addition, International Plus Coverage provides emergency coverage in the US and Canada.

In order for emergency coverage in the Restricted Areas to be eligible for reimbursement it ***must*** first be approved by the Medical Assistance Company. The Medical Assistance Company contact information can be found on the membership card. If the situation is determined to be a medical emergency then the Medical Assistance Company will direct the insured to the nearest network facility. **If the Medical Assistance Company is not contacted prior to treatment then coverage will be denied.** For more information about the Medical Assistance Company please see page 26.

In situations in which it is not possible to contact the Medical Assistance Company prior to treatment, the member must then contact the Medical Assistance Company within 48 hours after the occurrence of the emergency

The following additional rules apply for both International and International Plus members:

- Members covered under International and International Plus coverage are not permitted to cover dependents residing in a restricted area.
- The Company retains the right to limit or prohibit the use of high cost providers.
- In the event the Company develops a Preferred Provider Network within your geographic location, the Company will retain the right to limit treatment to the Preferred Providers.

Emergency coverage absolutely excludes:

- Treatment related to the condition that occurred before the policy start date.
- Routine medical treatment
- Treatment that could have been postponed until return from Restricted Area.
- Treatment that has been planned in advance.
- Treatment arising from circumstances that could have been reasonably anticipated by the member.

9. Reimbursement Standards

The Usual and Customary fee is defined as the charge for health care that is consistent with the average rate or charge for identical or similar services. To determine the Usual and Customary fee for a specific medical procedure or service, the Company analyzes statistics from its database of fees charged by medical providers. The Company uses these statistics to chart a range of fees applicable to service provided. When a member submits a claim for a specific treatment or procedure, the Company pays all or part of the claim, depending on whether the amount of the claim is within the Usual and Customary allowance.

When the Company disallows a portion of a charge as being in excess of the Usual and Customary allowance, it means only that the charge is in excess of the standard the Company used to determine Usual and Customary. Providers are free to charge whatever fee for service they choose. This Plan is designed to provide benefits up to the plan's Usual and Customary fees, and is priced accordingly.

The Usual and Customary chart reflects the expectation that fees outside of the U.S. and Canada are usually less than within the U.S. and Canada.

10. Medical Emergency

The phrase "Medical Emergency" is used in separate contexts in this policy.

Relating to Evacuation

In determining eligibility for medical evacuation, an emergency is a life-threatening situation that without immediate medical attention may result in pre-mature death or severe life-long injury. Emergency treatment will be provided at the closest facility to location of the life-threatening situation which has the medical ability to perform life saving procedures. (Also see definition of Emergency Medical Transportation)

The Medical Assistance Company must be contacted and must approve the evacuation and treatment in order for it to be covered. *Please see page 26 for further details.*

In the event of an emergency medical evacuation, the Medical Assistance Company has absolute right in determining which facility can be used.

If emergency transportation is not approved in advance by the Medical Assistance Company, the Company reserves the right to withhold payment. The Medical Assistance Company has full discretion to determine whether emergency transportation is justified.

Medical Emergency Under International Plus Policies

The International Plus policy provides for treatment in certain restricted areas only in the event of a "Medical Emergency." For the purpose of this section, a medical emergency is a medical situation which requires immediate attention, and specifically EXCLUDES:

- Routine medical treatment.
- Treatment that could have been postponed until return from Restricted Area.
- Treatment that has been planned in advance.
- Treatment arising from circumstances that could have been reasonably anticipated by the member.

All treatment under these provisions of an International Plus policy must be approved in advance by the Medical Assistance Company, which will be the sole determinant of the availability of treatment under this definition.

11. Pre-Authorization / Coordinated Care

Pre-Authorization

Certain procedures require pre-authorization. Pre-authorization does not guarantee full payment. If preauthorization is not obtained, all applicable procedures will result in an additional 40% co-payment without any out of the pocket limit.

Services requiring notification:

- All inpatient admits and/or treatments;
- Any outpatient surgeries;
- Accidental Dental treatment;
- Durable Medical Equipment;
- Home Health Care;
- Maternity (for complicated pregnancies and during the 3rd trimester prior to all deliveries);
- Notification of any chronic condition that does not meet the above conditions, but is expected to accumulate over $5,000 of medical treatment.

Pre-Authorization ensures that prior to incurring liability for medical treatment, surgeries and other procedures, the member is covered by the policy and will be reimbursed up to the applicable limit by the Company.

Coordinated Care

The Company retains the right to refer certain large claims to its Coordinated Care Department, which will then be responsible for establishing and monitoring the scope and nature of the care provided. When the Company elects to refer a claim to this department, in order for treatment to continue to be eligible for reimbursement under the policy, the member will be required to follow the procedures indicated by this department.

The purpose of Coordinated Care is to:

- verify coverage of members.
- determine whether the services or supplies are covered.
- minimize the out-of-pocket cost to the member.

Coordinated Care will guide you to appropriate facilities and will evaluate the medical necessity of the recommended treatment. This is not to substitute medical judgment of your physician, as the ultimate decision of treatment is up to the patient within the limits of the policy and the cost considerations.

Coordinated Care treatment is approved and monitored by our Coordinated Care Company, which will be the sole determinant of the nature and scope of treatment. For contact information and procedures, please see page 27.

II. ELIGIBILITY

- New hires may be added on as of the date of notification. Addition of new members may be subject to verification of hire date and employment status and/or any additional documents requested by enrollment.
- Individual members are eligible if they are active employees of the employer participating in the World Care Policy and they reside outside of their home country. The policy becomes effective while they are outside of their home country.
- Individual members are eligible to leave the specified coverage area (company location), and will remain eligible for benefits, however, if the member remains outside of the specified coverage area, the Company holds the right to adjust member's premium to reflect new residency.
- Individual members are eligible for coverage if they have not attained age 70 at the time of enrollment. An individual member may renew his policy through age 75. A premium surcharge is applied to members over age 60.
- Members, and/or dependents, added to coverage after the renewal date, who are not new hires, are subject to underwriting review. Coverage may include a waiting period for pre-existing conditions.
- Individual members may renew their policy if they return to their home country to reside and/or work. The premium will be calculated at the rates applicable to the home country.
- Members who are dropped from coverage during the policy year cannot be reactivated until the following policy period.

III. MEMBERSHIP CARD

In addition to this policy, members receive a card detailing certain features of their coverage. Your membership card will contain the following;

- Deductible amount
- Policy Number
- Co-payment percentage
- Whether you have dental coverage
- Phone number for pre-authorization.
- Whether you have Preventive Care coverage
- Contact number in case of emergency
- How to contact the preferred provider network
- How to file a claim
- Whether you have vision coverage

IV. EXTENSION POLICY

Our extension policy offers the opportunity to extend Group health insurance coverage for 3 months beyond the expiration of the member's current World Care group policy. Preventive Care, Dental and Vision are not available to Extension Policyholders. Co-payment and deductible will be based upon member's current World Care group policy. Premiums will be based upon rates applicable at the time of extension. If members return to their home country, applicable rates will apply.

- Extension rates will be determined based upon residency of each member insured under the extension.
- Members of a group policy must fill out and submit the Extension Application Form 30 days before the expiration date of the group policy.

- The member will then be sent an invoice for payment.
- Full payment must be received before the effective date of the new Extension Policy.
- A new Identification Card and Policy Certificate will be issued to the member.
- For extended coverage longer than three months, please see page 12, section D.

At the end of the extension period, the member can choose to enroll in an annual policy under the Independence Plan at the prevailing Independence rate, and at the benefit levels described in that policy.

This policy provides a maximum benefit of $2,000,000.00 USD per person per policy year.

Benefits are payable after the application of:

- Deductible, if any.
- basic plan co-payment, if any.
- co-payment relating to specific treatment for which benefits are claimed.
- application of Usual and Customary standards.

Other than as described in Section VIII, paragraph K, or as modified by a Rider attached to this policy, pre-existing conditions are covered up to the stated limit.

INPATIENT TREATMENT

A. Accommodations

- Semi-private room and board that is reasonable and customary;
- Personal care items purchased during a hospital stay are not covered.

B. Drugs

- Drugs and dressings prescribed for use while an inpatient.

C. Operating and Emergency Room

- Emergency room treatment (up to policy limit);
- Non-emergency use of Emergency Room (50% coverage after annual deductible).

D. Doctors' Fees

- Fees for surgeons, anesthetists, physicians or medical practitioners.

E. Therapy and Treatment

- Radiotherapy and chemotherapy;
- Consultations, pathology or radiology.

F. Emergency Dental

- Emergency dental treatment and restoration of sound natural teeth; required as a result of an accident;
- Benefits limited to $5,000;
- Routine dental treatment not covered unless purchased as additional coverage;
- See definitions.

G. Mental Illness

- Treatment of mental illness as an in-patient in a medically recognized mental institution and/or hospital having a mental ward or department, up to a maximum of 180 days of consecutive treatment, not to exceed $25,000.

H. Maternity and Infant Care

- Maternity Care up to $10,000 limit per pregnancy, 50% coverage thereafter;
- Well baby care including immunizations up to 24 months. Exams are limited to nine (9) visits;
- Newborn infants coverage without notification for the first fourteen (14) days not to exceed $5,000 maximum;
- Coverage beyond fourteen (14) days after birth requires notification;
- Pre-natal vitamins are covered during the term of the pregnancy only, if prescribed by a physician;
- Two ultrasounds will be allowed per pregnancy. In the event of a high-risk pregnancy or complications, additional ultrasounds will be considered with a letter of medical necessity from the physician.

I. Hospice care

- Must relate to a medical condition that has been the subject of a prior valid claim with the Claims Administrator, with a diagnosis of terminal illness from medical doctor;
- Up to 45 days as an inpatient, and $5,000 as an outpatient, per insured;
- Benefit is payable only in relation to care received by a recognized hospice.

J. Screenings/Examinations

- Routine examinations and consultation fees are generally covered only if the Preventive Care option has been purchased;
- Other then Preventive Care, the following screenings are covered if recommended by a physician:
  - Pap smear
  - Mammogram
  - Prostate
  - Screenings, which are recommended by a physician that are related to Family Medical History ($250 limit per policy period).

K. Immunization/Well Baby Care

- Well baby care including immunizations up to 24 months. Exams are limited to nine (9) visits;
- Other routine immunizations and consultation fees are covered only if the Preventive Care option has been purchased.

OUTPATIENT TREATMENT

A. Referrals

- If needed, your regular physician may refer out treatment or consultations for the following:
  - Physiotherapy, physical therapy, vocational therapy, speech therapy, occupational therapy by a qualified therapist or chiropractor;
  - Pathology; radiology; or chemotherapy.

B. Nursing Care

- Home nursing by skilled nurses immediately following treatment as an inpatient on physician recommendation;
- Maximum of 100 days;
- Benefit is only available where treatment by a physician is taking place, exceptionally and out of necessity, in the insured person's home;
- It is payable only when all charges are reasonable and necessary and are exclusively for exercising nursing skills of which only skilled nurses are capable.

C. Mental Health

- Psychiatry/mental health services crisis intervention only;
- Up to 20 visits per year;
- Bulimia and Anorexia will be treated under these limitations;
- Attention Deficit Disorder (ADD) and Attention Deficit Hyperactive Disorder (ADHD) will be treated under these limitations.

D. Alternative Medicine

- Acupuncture and homeopathy where such is provided as treatment for covered illness;
- Treatment is covered only at certified acupuncture and homeopathy specialist;
- Benefits limited to $500 limit per person, per year;

E. Therapy – ($5,000 benefit)

- Physiotherapy, physical therapy, chiropractic therapy, vocational therapy, speech therapy, and occupational therapy.

ADDITIONAL COVERAGE INCLUDED IN POLICY

A. Repatriation

A $20,000 USD benefit for either repatriation of mortal remains or local burial is included under this policy.

B. Transportation

The cost of transportation, such as a private ambulance is covered under this policy.

C. Emergency Medical Air Transportation

Under certain conditions, worldwide medical emergency air transportation to hospital as an approved medical evacuation (on medical plane), including the cost of a person accompanying an insured person, is covered under this policy; *see page 16 & 26 for details.*

D. Medical Equipment

Certain durable medical equipment and prosthetics as prescribed by a medical practitioner will be reimbursed under this policy.

E. Diabetic Supplies

Certain Diabetic supplies, including Insulin pumps and associated supplies, are covered under this policy.

- If approved by the Coordinated Care Department, insulin pumps, and all related costs, will be covered under this policy up to $5,000 per policy period.

F. Substance Abuse

Treatment received for alcohol and drug abuse is covered under this policy, through an online substance abuse program. Complete details about this program can be found at www.tiecare.com.

OPTIONAL COVERAGE

The following benefits are only available at extra costs. If purchased by your employer, benefits are indicated on medical card, and are described elsewhere in this policy.

A. Preventive Care

If employer purchases the Preventive Care option, these benefits will be included:

- $200 or $400 yearly maximum, as selected by employer;
- The costs of a full physical examination and the tests and procedures associated with such examination, are covered every other year, not to exceed the yearly maximum for preventive care;
- Adult immunization, routine tests and exams.

B. Vision Coverage

If employer purchases the Vision option, these benefits will be included:

- Examination (each year) $ 75
- Frame allowance: $ 75
- Lens allowance: (members are eligible for one item below per policy period)

Single lens	$ 90
Bifocal	$125
Trifocal	$150
Contact lenses	$150

Sunglasses and/or related accessories are not included in coverage.

C. Group Dental Coverage

If employer purchases the Dental option, these benefits will be included:

Benefit Limits:
- Choice of benefits: $500, $1,200 or $2,000.
- There is a $500 limit on orthodontic treatment.

Deductible:
- $100 deductibles. ($200 deductible for $2,000 benefit).
- Deductible for dental is not related to deductible of health insurance.

Reimbursement Levels
- 100% for Preventive Treatment (deductible is waived).
- 80% for Basic Treatment (after deductible is met).
- 50% for Major Treatment (after deductible is met).

Coverage:
- **Preventive treatment** – including routine examination, dental health instruction, fluoride treatment, scale and polish (Prophylaxis).
- **Basic restorative** – including amalgam or composite fillings and simple extractions, periodontal scaling, and root planing.
- **Major restorative** – including root fillings, crowns and inlays, bridges (including laboratory and anesthetic fees), wisdom teeth extractions.

  *** Orthodontic treatment** - Study models (including pan oral x-rays), impressions, removable string appliances (braces), fixed appliances (including adjustments), extractions, re-cementing of brackets. There is a $500 limit on orthodontic treatment. Orthodontia treatment applies only to members up to the age of 19.
- **Cleanings** – Two routine cleanings per policy period is included in coverage.

Exclusions: Cosmetic treatment that is not medically necessary, False teeth, Dental Implants, on-lays, veneers and all associated costs are not covered.

VI. PRESCRIPTION DRUGS

D. Additional Extended Coverage

Employer may have purchased an option of extended coverage for up to eighteen (18) months. This extension will include the same benefits as defined on page 8, section IV.

E. Premier Benefits Package

This feature allows either an individual member within a group or an entire group to purchase the following benefits package:

- $25,000 Life Insurance Benefit.
- Choice of $500 or $1000 Dental Benefit.
- Up to $3,000 Hospital Cash Benefit.

For complete details, please click the Premier Benefits Package link at www.tiecare.com.

- Prescription drugs are a covered benefit under the World Care policy.
- The usual policy deductible and co-payment does not apply to this benefit.

- Prescription drugs are subject to a 20% co-payment outside of the US pharmacy network.
- Only a 90-day supply of a prescription can be filled at any one time outside of US pharmacy network.
- There is no maximum out of pocket limit for a supply of prescriptions.
- Additional rules apply to prescriptions purchased in the United States and for Worldwide members. Please see page 13, section A for details.

If you choose to purchase a brand-name prescription when a generic equivalent is available, you will have to pay the difference between the cost of the brand-name drug and the generic drug in addition to the regular co-pay. This penalty does not apply to prescriptions filled that your physician has indicated must be dispensed as written.

For members with Worldwide coverage, the following additions apply

A. Prescription Drugs

Prescription drugs are a covered benefit under the World Care policy. The level of benefit is determined by where the prescription drugs are purchased or refilled. The usual policy deductible and co-payment do not apply to this benefit.

Inside United States Network

Co-payment and filling limit is determined by Formulary Drug Guide, which can be found in your renewal package or at www.claimssite.com.

Outside United States Network

- Prescription drugs filled in the U.S. at a non-network pharmacy are subject to a 20% co-payment, in addition to the co-pays applicable to the formulary plan.
- Prescription drugs are medications which are prescribed by a physician and which would not be available without such prescription. Certain treatments and medications, such as vitamins, herbs, aspirin, and cold remedies, medicines, experimental or Investigative drugs, or supplies even when recommended by a physician, do not qualify as prescription drugs.
- A preferred pharmacy network is available in the United States. Failure to use a network pharmacy will result in additional co-pays. Please refer to your identification card or access the web at www.claimssite.com
- Mail Order Drugs (Please see www.claimssite.com for complete details.

B. Preferred Provider Network

For non-emergency treatment within the U.S., outside of the Preferred Provider Network, where an appropriate network provider is available, members will be reimbursed up to the usual and customary charges of the Preferred Provider Network. Amounts in excess of these charges shall be the sole responsibility of the member. Amounts in excess of the usual and customary charges will not count toward the out of pocket limit for deductibles and plan co-pays.

All inpatient and outpatient treatment received is required to be pre-authorized to avoid additional co-payments. (See Pre-Authorization)

For information on the providers and facilities within the Preferred Provider Network, consult your membership card or www.claimssite.com.

Pre-authorization is required for any inpatient or outpatient procedure that is performed at an out of network facility within the United States. Pre-authorization approval does not guarantee payment, and additional co-payments and out of pocket expenses may apply. Failure to comply with pre-authorization procedures will result in a 40% co-payment without any out of pocket limit. Contact International Claims Services on the back of your I.D. Card.

Special Note: A co-pay of 20% of the first $10,000, up to a maximum of $2,000 per person, will be assessed under the following conditions:

- Treatment is received outside of the Preferred Provider Network, and a Preferred Provider was reasonably accessible.

C. Pre-authorization

Pre-authorization is required for any inpatient or outpatient procedures. Pre-authorization approval does not guarantee payment, and additional co-payments and out of pocket expenses may apply. Failure to comply with pre-authorization

VII. ADDITIONAL CONDITIONS FOR WORLDWIDE MEMBERS

VIII. EXCLUSIONS FROM COVERAGE

procedures will result in a 40% co-payment without any out of pocket limit. Contact International Claims Services on the back of your I.D. Card.

*Benefits **WILL NOT** be available for the following*

A. Reproductive Treatment

- For male and female birth control;
- Vasectomies and sterilization;
- Sexual dysfunction;
- Abortion, except for emergency; Cost of abortion and its consequences if performed for psychological or social reasons;
- Infertility; other than for reasonable costs of investigations into the causes of infertility where both husband and wife:
    - Have been continuously covered by the Company for at least two years at the time of incurring such costs;
    - Had been unaware of the existence of infertility at the relevant date of entry and any form of assisted reproduction.
- Reversal of previous sterilization;
- Transsexual surgery;
- "Viagra" or other sexual enhancement drugs and their respective generic equivalents will be not covered for any purpose.

B. Treatment as a result of Substance Abuse and Self-Inflicted Injury

- For alcoholism, solvent abuse, drug abuse or addictive conditions of any kind, and treatment of any illness or injury arising directly or indirectly from any such abuse or addiction;
- Treatment resulting from self-inflicted injury and attempted suicide.

C. Elective Surgery and Corrective Devices

- Cosmetic treatment whether or not for psychological purpose, including dental treatment;
- Elective Surgery and procedures, treatment and/or surgery, that is not medically necessary, as defined by a qualified, licensed medical practitioner; including Laser eye surgery to correct vision;
- Received in health hydros, nature cure clinics, or similar establishments, or private beds registered as a nursing home attached to such establishments;
- Eyeglasses; contact lenses; sunglasses; hearing aids; dentures; other optical; dental appliances; orthotics;
- Milieu therapy for rest and/or observation; services or treatment in any long term care facility, spa, hydroclinic, rehabilitation institution, sanatorium or home for the aged that is not a hospital as defined in this policy;
- All expenses of any cryopreservation and the implantation or reimplantation of living cells;
- Orthopedic shoes or other supportive devices for the feet, such as, but not limited to, arch supports and orthotic devices or any other preventative services and supplies; any devices resulting from the diagnosis of weak, strained, unstable or flat feet or fallen arches; or any tarsalgaia, metatarsalgia; or specified lesions of the feet, such as corns, calluses, and hyperkeratosis, toenails or bunions, except for operations which involve the exposure of bones, tendons, or ligaments;
- Weight reduction and the cost of any and all treatments for weight reduction or weight reduction programs.

D. Referrals

Without approval from the insured person's medical practitioner; except for treatment in emergencies when the insured person's medical practitioner is kept fully informed of the treatment so that he/she is able to support a claim for benefit.

E. Experimental Medical Treatment

- Treatment that is not scientifically or medically recognized.

F. Restricted Areas

- Certain policies contain exclusions for treatment received in restricted areas as described on page 5.
- Consult your membership card and certificate of insurance to see if your policy has geographic exclusions. A complete list of restricted areas is available at www.claimssite.com

G. Routine Treatment

- All dental treatment unless defined in the policy;
- For routine eye, ear, and foot examinations;
- For routine medical examinations other than as expressly defined in this policy;
- Immunization; other than provided for under well baby coverage; or optional Preventive Care benefit.

H. Excluded Costs

- Charges in excess of the usual and customary for any covered procedure;
- If the hospital effectively becomes, or could be treated as, being the insured person's home or permanent abode;
- Where admission to the hospital is arranged wholly or partly for domestic reasons;
- All transportation costs for obtaining medical treatment (other than a local ambulance), unless part of an emergency medical evacuation as defined in this policy;
- Claims and costs for medical treatment occurring after the expiration date of the policy, resulting from accidents, sicknesses, or maternity during the policy year period, unless the policy has been renewed, including any portion of a covered prescription to be used after the expiration of the policy.

I. Exceptional Risks

- Treatment as a consequence of injury sustained while participating in or training for any professional sport;
- Treatment as a consequence of injury sustained while participating in, or training for, or as a consequence of: war (declared or not), acts of foreign enemy hostilities, civil war, rebellion, revolution or insurrection;
- Chemical contamination;
- Contamination by radioactivity from any nuclear material or from the combustion of nuclear fuel.

J. Equipment

- Instructions for use and care of durable medical equipment;
- Customizing any vehicle, bathroom facility or residential facility;
- Cost of all over the counter medical devices;
- 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;
- *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.

K. Pre-Existing Conditions

- For pre-existing conditions of children adopted after date of birth see page 17, section J.
- Treatment of sexually transmitted diseases including Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV, **IF TREATED AS A PRE-EXISTING CONDITION**.

L. Additional Excluded Coverage

- Supportive treatment of renal failure including dialysis
  - The Company may at their discretion, pay for the cost of renal dialysis incurred immediately pre-and post operatively during any kidney transplant.
  - Attempted transplants and in connection with acute secondary failure when the dialysis is part of intensive care.
- Treatment for (TMJD) or Malocclusion Temporomandibular Joint Disorders;

- Maternity/Delivery Preparation Classes;
- Circumcisions;
- Sleep studies and other treatments relating to sleep apnea;
- Myopia or presbyopia; including radial keratotomy surgery;
- Diet and Nutrition Education.

IX. TERMS AND CONDITIONS

The following terms and conditions must be followed to insure proper coverage.

A. Date

The relevant date for determining the benefits available for treatment shall be the actual date that treatment is administered.

B. Covered Charges

Amounts payable shall be limited to the reasonable, usual, and customary charges for hospital and medical services in the region where such services are provided.

In calculating such charges the company utilizes many factors relating to the difference between US and overseas rates and the level of care available in the overseas region. For specific questions relating to the application of this standard in your region, contact claims@claimssite.com

Preferred Provider Network – The Company maintains an international network of medical providers and facilities with which it has arranged direct billing procedures.

Please refer to your Identification card to locate Preferred Providers, or access a list of providers at www.claimssite.com.

As Preferred Providers are paid directly, use of a Network Provider eliminates the need for the member to file a claims form.

There is a 20% co-pay up to a maximum of $2,000 for use of a facility not within our network, unless a facility within our network is not available.

Special terms and conditions apply to the Preferred Provider Network in the United States for those members with Worldwide coverage. Please see page 13 for details.

D. Time limit for filing claims

All claims under this policy must be received by claims administration within 180 days from date of service.

All claims made after the specified 180 days will be denied.

E. Medical Evacuation

Utilization of the medical evacuation provision requires the prior approval of the Medical Assistance Company. In the event of an emergency that may require medical evacuation, contact the 24-hour Operations Center in advance in order to approve and arrange such Emergency Medical Air Transportation. The Operations Center, on behalf of the insurer, retains the right to decide the medical facility to which the insured person shall be transported. The Medical Assistance Company's contact information can be located on the membership card. See page 26 for more details about the Medical Assistance Company.

F. Residence

The residence of primary insured and all dependents is assumed to be the location of the employer. If the spouse or dependents are living in another location, the Company must be notified in writing of their full-time residence immediately. Further, it is assumed that primary insured is residing in location of employer during the employment year. Any change must be immediately reported to the Company.

If the spouse or dependent of an insured is living full-time in the specified restricted areas, the premiums will be adjusted according to the applicable surcharge.

G. Compliance with the Policy Terms

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

H. Change of Risk

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

I. Policy Duration and Premiums

This policy is subject to the following conditions:

- The policy and rates shall be for one year and are continually subject to the terms in force at the time of each renewal date.
- Premiums will be payable in U.S. dollars.
- The premium rate shall be that prevailing generally at the policy effective date, or if later, the appropriate renewal date.
- The Company may change the premium payable periodically. However, this policy will not be subject to any alteration in premium rates generally introduced until the next renewal date.
- All premiums are payable before coverage under this policy is provided.
- Late premium payments may result in non-payment of claims and/or cancellation of policy.

J. Children

Children may be covered under this policy, and will be subject to the following conditions:

- Coverage for insured persons who are dependent children will cease at the end of the policy year in which their 21st birthday occurs (or their 24th birthday if they are a full time student).
- Addition of a new baby or legally adopted child:
  Newborn babies of TieCare/GBG members are automatically covered under their current policy during the first fourteen (14) days, up to a $5,000 maximum. All regular deductible and plan co-payments will apply. In order to continue the baby's benefits after 14 days a member may request coverage for a new baby or legally adopted child, providing all of the following conditions are met:
  - Fourteen (14) day notification:
    A newborn child shall be accepted for full coverage from the date of birth regardless of health, provided written notification has been received within fourteen days of the date of birth.
  - Appropriate coverage must apply:
    Should the policyholder have a baby or adopt a child while covered under a Single or Married policy, then the fourteen day written notification must also include a request to change coverage to either a Single-Parent Family or Family policy so that the child will be covered on the date of birth or legal adoption.
    Any request received beyond the fourteen-day notification period shall result in coverage only being effective from the date of notification (except for the first 14 days, which are covered regardless of notification).
  - In the case of an insured that adopts a child after the date of birth of the child, then for a period of 12 months from the date such adoption becomes official, pre-existing conditions shall not be covered.

K. Transfer

- If the primary insured dies, this policy will automatically be transferred to the oldest insured person 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.

- A dependent that is no longer eligible for coverage with a TieCare/GBG plan (as a dependent) has no transfer or continuation rights or privileges with the Company.

L. Claims Procedure

In order for your claim to be properly accepted, the following steps must be followed:

- A claim form must be completed as soon as reasonably possible and sent to the Claims Administrator. The Company reserves the right to reject any claim that is not received within 180 days from the date of service.
- All original documents or materials (including but not limited to accounts, certificates and x-rays) that the Company requires to support a claim, an application for coverage or change in coverage, shall be provided without expense to the Company (including, if requested by the Company, a medical report from the insured person's medical practitioner or physician). Such original documents will become our property to use or dispose of as the Company considers appropriate, but photocopies will be provided upon receipt of a written request within three months of submission to the Company.
- Claims may be made only for treatment actually given during the policy period and benefits will be available only for expenditures incurred prior to the expiration or termination of such policy period.
- All procedures and deadlines adopted by the Claims Administrator must be adhered to. The Company retains the right to reject any claim, which does not adhere to such procedures and deadlines.
- Inquiries regarding past claims must be received within 12 months of the date of service to be considered for review.

M. Claims - Our Rights

The Company reserves the right to withhold payment under certain circumstances as described below:

- The individual member must, without delay, give the Company or procure from the relevant insured person, written notification of any claim or right of action against any party arising out of any circumstances that gave rise to the claim under this policy.
- The insured person must continue to keep the Company fully informed in writing and take all steps they reasonably require in making a claim upon the other party.
- The Company shall be entitled to prosecute in any insured person's name for our own benefit any claim for indemnity or damages or otherwise, which relates to any benefits and costs paid or payable under this policy.
- The Company shall have full discretion in the conduct of any such proceedings and in the settlement of any such claim.
- The Company may refuse payment of any and all claims, if they determine that this policy was issued based on misleading or incomplete information.

N. Coordination of Benefits

Where another policy is in existence which provides benefits also covered by this plan, all claims must be made in the first instance against the other policy, and this plan only shall provide benefits when such benefits as payable under the other policy have been exhausted. The insurer has full right of subrogation.

To determine the Primary Policy, the following guidelines will be used:

The Plan is Primary if it covers the claimant as an active *Employee*.

- If two Plans cover the claimant as an *Employee*, the Plan that has covered him for the longer period of time is the Primary Plan.
- If an *Employee* is covered as an active *Employee* under the Plan and as a retired or laid off *Employee* under another Plan, the Plan that covers him as an active *Employee* is the Primary Plan. The Plan covers him as a retired or laid off *Employee* is the Secondary Plan.
- In all cases in which a member is eligible for Medicare, then Medicare will be considered the primary plan.

O. Alterations

The Company may alter any of the terms of this policy at any renewal date. A copy of the current policy terms will be sent to at such time.

P. Cancellation

The Company reserves the right to cancel any policy if the following conditions are not met:

- This policy will be canceled automatically upon nonpayment of the premium, although the Company may at their discretion reinstate the coverage if the premium is subsequently paid.
- If any premium due from the policyholder remains unpaid, the Company may in addition defer or cancel payment of all or any claims for expenditures incurred during the period it remains unpaid.
- While the Company shall not cancel this policy because of eligible claims made by any insured person, they may at any time terminate a group member's and/or eligible dependent's membership of group or subject his/her coverage to different terms if she/he or the policyholder has at any time:
  - Misled the Company by misstatement or concealment;
  - Knowingly claimed benefits for any purpose other than are provided for under this policy;
  - Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to our detriment;
  - Failed to observe the terms and conditions of this policy, or failed to act with utmost good faith.
- If the Company does cancel this policy, they shall give 30 days notice.
- Coverage for a group member and his/her eligible dependents (if any) shall cease immediately upon the policyholder deleting an insured person from the group.

Q. 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.

R. Waiver

Waiver by the Company of any term or condition of this policy will not prevent us from relying on such term or condition thereafter.

S. Settlement of Claims

All claims will be settled in US dollars. If the insured paid for treatment in currency other than US dollars, or receives a bill for covered services in currency other than US dollars, including bills sent directly to the Company or its Claims Administrator, such payments and bills shall be converted to US dollars at the exchange rate in effect at the time such service was rendered.

T. Jurisdiction

This policy is governed by, and shall be construed in accordance with the laws of Guernsey, U.K. and shall be subject to the exclusive jurisdiction of its' courts.

U. Conversion

Should the group member leave the group for any reason (excluding fraud or other insurance related criminal act) and if there is no lapse in coverage, then this policy may be continued as an "individual policy". The premium would be calculated at the prevailing individual rate based on applicable country rate. As long as the member is not then eligible for *Medicare*; and has been insured under this policy for at least 3 consecutive months.

V. Modifications to Coverage

This policy can be modified by a Rider. If the rider modifies the coverage described in this policy, then the Rider shall prevail.

W. Annual Policy

The Company undertakes to reimburse the medical risks outlined in this policy on the express understanding that unless otherwise indicated in a Rider attached to this policy, the policy has been issued for a full 12-month term. In the event of a cancellation by the policyholder, there will be no reimbursement of premium already paid, or any waiver of premium due from the policyholder that has not yet been paid to the Company.

X. Pre-Authorization/Coordinated Care

The Company retains the right to refer certain large claims to its Coordinated Care department, which will then be responsible for establishing and monitoring the scope and nature of the care provided. When the Company elects to refer a claim to this department, in order for treatment to continue to be eligible for reimbursement under the policy, the member will be required to follow the procedures indicated by this department. For Treatment utilizing Coordinated Care, please see page 7 for complete details.

X. DEFINITIONS

To avoid confusion, the following words or expressions, wherever used in this policy, have the specific meanings given below.

Accident - Any sudden and unforeseen event occurring during the policy year period, resulting in bodily injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control.

Active Service - An employee will be considered in active service on any day if he/she is then performing in the customary manner all the regular duties of his/her employment as performed or were capable of being performed on the last regularly scheduled work day.

Acupuncture - Treatment of a medical condition, which is covered under the terms of this policy, by needles or laser provided by or ordered by a licensed physician as defined in this policy.

Agreement - The agreement between the Company, and the policyholder; who is providing coverage under this policy.

Attention Deficit Disorder (ADD) - Attention Deficit Disorder is a biologically based condition causing a persistent pattern of difficulties resulting in one or more of the following behaviors: inattention; hyperactivity; impulsivity.

Attention Deficit Hyperactivity Disorder (ADHD) - is a problem with inattentiveness, over-activity, impulsivity, or some combination of these. For these problems to be diagnosed as ADHD, they must be out of the normal range for the child's age and development.

Catastrophic Illness - For the purposes of this policy, catastrophic illness is defined as the following four conditions:

1. Cancer: The presence of uncontrolled growth, and the spread of malignant cells and invasion of tissue. Incontrovertible evidence of such invasion of tissue or definite histology of a malignant growth must be produced. The term "Cancer" also includes leukemia, lymphomas and Hodgkin's disease. Non-invasive carcinomas in situ, localized non-invasive tumors showing only early malignant changes, tumors in the presence of any human immune-deficiency virus and all skin Cancers except malignant melanomas are excluded from the definition of Catastrophic Illness.

2. Major Organ Transplants: The process, as a recipient, of a transplant of kidney, heart or liver.

3. Heart Attack: Death of a portion of heart muscle as a result of abrupt interruption of adequate blood supplies to the area.

The diagnosis will be based upon all of the following criteria:

- a history of typical chest pain.
- new electrocardiograph changes.
- an elevation in cardiac enzyme levels.

4. Stroke: Any cerebrovascular incident producing neurological sequelae lasting more than 24 hours and including infarction of brain tissue, hemorrhage or immobilization from an extra cranial source. Evidence of permanent neurological deficit must be produced. The catastrophic illness must be diagnosed by a registered medical practitioner and must be supported by clinical, radiological, histological, and laboratory evidence acceptable to the insurer.

Certificate of Insurance - The document (among others) that describes the outline of the policy type, the name of the policyholder, and endorsements (if any).

Chronic Illness - An injury, illness or condition, which does not require hospitalization, which may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by recurrences requiring continuous or periodic care as necessary.

Claims Administrator - The Claims Administrator is the company appointed by the underwriter for the processing and evaluation of claims. All claims must be submitted to the Claims Administrator to the address listed on page 25.

Compulsory Plan - A plan when all eligible persons must be included.

Co-payment - The portion of the eligible medical treatment expenses that the insured person must pay in addition to the annual deductible as stated on the Certificate of Insurance and the member's Identification Card.

There are two types of co-payments: general policy co-payments and benefit specific co-payments. Co-payments apply to the first US$10,000 of each individual's medical costs.

The co-payment options are defined in this policy. A co-payment will be applied to each insured person per policy year.

Critical Condition - An immediate life threatening or perilous illness or conditions due to an accident or natural causes, which requires urgent specialized treatment without delay.

Deductible - The amount paid on an annual or per claim basis by each of the insured persons for eligible medical treatment expenses. Deductibles are indicated on the Identification Card and Certificate of Insurance and can range from $0 to $5,000 on an annual basis, or from $0, $25, $50, $75, $100, $125 to $150 on a per claim basis.

Note: Deductibles on a per claim basis refers to each and every claim made during the policy period. The designated deductible will be applied per visit for each time medical services, including consultations and follow-ups, are received. This does not apply to bills received for Ancillary services such as Laboratory and Radiology services (i.e. blood tests and x-rays).

Effective date - The date shown on the Health Coverage List attached to the Certificate of Insurance on which an insured person was included under this policy.

Eligibility - In order to be covered under this policy, each individual is subject to the following conditions:

- The maximum age of enrollment is 70 years old; the policy may be renewed up to age 73.
- Employees shall be eligible for insurance from the effective date of the policy. However, any one not in active service at the effective date for reasons other than an authorized routine paid leave shall not be eligible for insurance until resuming full-time continuous employment and completing one month's active service.
- Coverage will automatically cease at the first renewal date following an insured person's 73rd birthday.
- Coverage will automatically cease at the insured person's permanent return to his/her home country unless pre-arranged with the Company.
- Termination of the insurance of the employee shall also cancel all coverage for dependents.
- The group plan is not available to United States and Canadian nationals residing in their home country.

Eligible dependent(s) - A group member's spouse and/or children, who are legally dependent under 21 years of age (under 24 years of age if a full-time student) who are included in the group pursuant to the agreement. Coverage for dependent

children will cease at the end of the policy year in which the dependent's 21st birthday occurs or their 24th birthday if they are a full-time student.

Emergency Dental treatment - Emergency dental treatment is emergency treatment necessary to restore or replace sound natural teeth damaged in an accident. Sound teeth do not include teeth with previous crowns, fillings, or cracks. Damage to teeth caused by chewing foods does not qualify for emergency dental coverage.

Emergency Medical Transportation – In a Medical Evacuation when appropriate treatment is not available locally, this policy provides Emergency Medical Transportation to the closest medical facility capable of providing the required care. Should treatment be available locally but the insured person chooses to be treated elsewhere, transportation expenses shall be the responsibility of the insured person.

In the event of such emergency, the 24-hour Operations Center must be contacted in advance in order to approve and arrange such Emergency Medical Air Transportation. The Operations Center, on behalf of the insurer, retains the right to decide the medical facility to which the insured person shall be transported. If the person chooses not to be treated at the facility and location arranged by the Operations center, then transportation expenses shall be the responsibility of the insured person.

All emergency medical transportation must be arranged, in advance, with the 24 hour Emergency medical assistance operation center located on the back of the membership card. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

Employee - An insured person is in active service on a full time basis with the employer or on contract employment. It does not mean a person in casual employment.

Individuals who are on a leave of absence may be considered eligible under this policy, however, the Company must be informed immediately, and the Company reserves the right to determine whether or not such individuals may continue coverage under the Group Plan.

Examinations – The Company and the Claims Administrator shall have the right and opportunity, through their medical representatives, to examine any person whenever and as often as they may reasonably require within the duration of any claim. The insured person shall make available all medical reports and records, and where required, shall sign all authorization forms necessary to give the Company a full and complete medical history. The Company and the Claims Administrator shall have the right and the opportunity to require an autopsy in the case of death, unless forbidden by law or religious beliefs.

Health Coverage List - The document attached to the Certificate of Insurance, which lists all insured persons who are designated by the policyholder to be insured for medical coverage.

HIV - Acquired Immune Deficiency Syndrome (AIDS) and all diseases caused by and/or related to the virus HIV positive.

Home Country - The home country of any insured individual under this policy is deemed to be the country from which the primary insured holds a passport. In the event that a citizen of the United States holds more than one passport, the United States shall be deemed the home country.

Homeopathy – A system of alternative medicine that seeks to treat patients by administering small doses of medicines that would bring on symptoms similar to those of the patient in a healthy person. For example, the homeopathic treatment for diarrhea would be a miniscule amount of a laxative.

Hospice - A hospice, part of a hospital or recognized in-home medical care unit devoted to the care of patients with progressive disease where curative treatment is no longer possible; as an inpatient or domicile basis.

Hospital - An institution that is legally licensed as a medical or surgical hospital, in the country in which it is located. Illnesses/diseases of acute nature, as well as emergencies, can be treated in this facility. It must be under the constant supervision of a resident physician. A hospital is not a spa, hydro-clinic, sanitarium, rehabilitation institution, nursing home, or homes for the aged.

Identification Card - The document provided the individual member and his/her dependents, which outlines the policy benefits, name of the policyholder, insured persons, and endorsements, if any. On this card, members will find benefit

information, as well as contact information for submitting claims and emergency medical treatment. Members may in certain circumstances have two (2) identification cards.

Inpatient - An insured person who occupies a bed overnight in a hospital for the sole purpose of receiving treatment.

Insured person - A group member or an eligible dependent.

Maternity Care - The cost of prenatal care, childbirth and postnatal treatment subject to the specific limit. Any complications related to pregnancy including Cesarean section will be treated as maternity and will be subject to the specified limit.

Medical Emergency – This phrase is used under two different contexts in this policy. For complete definitions, please see page 6, number 10.

Medical Practitioner - A general medical practitioner is registered or recognized by the law of the country in which he/she practices and is recognized by the Company.

Medically Necessary - A treatment, service, supply, or drug, is medically necessary if it:

- is appropriate and essential to diagnose or treat the patient's Illness or Injury;
- does not exceed, in scope, duration, or intensity, the level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment;
- is prescribed by a Physician;
- is consistent with widely accepted professional standards of medical practice in the jurisdiction where treatment is rendered;
- is not primarily for the personal comfort or convenience of the patient, the family, *Physician*, or other provider of care;
- is not a part of or associated with the scholastic education or vocational training of the patient;
- is not Experimental or Investigative;
- in the case of inpatient care, cannot be provided safely on an outpatient basis;
- the regulations and guidelines authorized by the U.S. Department of Health & Human Services, Food & Drug Administration and Center for Devices & Radiological Health may be used to determine appropriateness of service and treatment provided.

Outpatient - An insured person who receives treatment at a hospital, specialist's consulting room, or other facility recognized by the Company, where the insured person does not remain overnight.

Physician - Is any person legally licensed to practice medicine in the country where treatment is provided and includes doctors of medicine, general practitioners, specialists and consultants and anyone who renders such treatment within the scope of their licensing and training.

Policy - Our contract of insurance with the policyholder, under which the Company provides the coverage described in the policy document and the agreement for group members and their eligible dependents. The Application, Certificate of Insurance, List of Contract Medical Providers and Hospitals (current at the relevant date) form part of the contract and must be read together with this policy document (as amended from time to time). A complete list of providers may be found at www.claimssite.com.

Policyholder - The employer or the insured person to whom the Certificate of Insurance is issued and who is responsible for the premium payment and for the reporting of additions and deletions.

Policy Effective Date - The date as shown in the Certificate of Insurance, when coverage under this policy commences.

Policy Period - The period of insurance coverage as stated in the Certificate of Insurance and any subsequent period for which the policyholder pays a premium that the Company accepts.

Pre-admission - Relates to admission to a hospital as an inpatient for the purpose of receiving predetermined medical treatment.

Pre-authorization - Certain procedures will require pre-authorization. Pre-authorization approval does not guarantee payment, and additional co-payments and out of pocket expenses may apply. Failure to comply with pre-authorization procedures will result in a 40% co-payment without any out of the pocket limit. Contact International Claims Services on the back of your I.D. Card.

- Benefits payable under the Policy are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Policy. *Pre-Authorization* does not guarantee or confirm benefits under the policy.
- In the event of an emergency that requires medical evacuation, contact MedAire Inc, the 24-hour Operations Center, in advance in order to approve and arrange such Emergency Medical Air Transportation. The Operations Center, on behalf of the insurer, retains the right to decide the medical facility to which the insured person shall be transported. MedAire's contact information can be located on the membership card. *(See medical transportation)*
- In the event of an emergency, pre-authorization is required for International Plus members who require treatment in a restricted area.

Pre-existing Conditions - Any known medical condition(s) that is a consequence of any previous illness that has been diagnosed or required hospitalization, medical treatment and/or medication prior to the first day of this insurance.

Preferred Provider Network – The Company maintains an international network of medical providers and facilities with which it has arranged direct billing procedures.

Please refer to your Identification card to locate Preferred Providers, or access a list of providers at www.claimssite.com.

As Preferred Providers are paid directly, use of a Network Provider eliminates the need for the member to file a claims form.

There is a 20% co-pay up to a maximum of $2,000 for use of a facility not within our network, unless a facility within our network is not available.

Special terms and conditions apply to the Preferred Provider Network in the United States for those members with Worldwide coverage. Please see page 13 for details.

Prescription Drugs - Prescription drugs are medications which are prescribed by a physician and which would not be available without such prescription. Certain treatments and medications, such as vitamins, herbs, aspirin, cold remedies, medicines, experimental or Investigative drugs, or medical supplies even when recommended by a physician, do not qualify as prescription drugs.

The regulations and guidelines authorized by the U.S. Department of Health & Human Services, Food & Drug Administration may be used to determine appropriateness of service and treatment provided.

Special terms and conditions apply to the prescription drug Preferred Provider Network in the United States for those members with Worldwide coverage. Please see page 13 for details.

Qualified Physiotherapist or Chiropractor - A chartered or state-registered physiotherapist, or someone, who on professional advice the Company accepts, is of the equivalent professional status in the relevant country.

Relevant Date - The actual date when treatment was administered.

Renal Failure - End stage renal failure due to chronic irreversible failure of both kidneys to function. This must be evidenced by the insured undergoing regular renal dialysis or having had renal transplantation.

Renewal Date - The annual anniversary of the policy's effective date.

Repatriation or Local Burial - This is the expense of preparation and the air transportation of the mortal remains of the insured person from the place of death to their home country, or the preparation and local burial of the mortal remains of an insured person who dies outside his/her home country. This benefit is excluded where death occurs in their home country.

Residence - The following rules apply to the location and physical address of the insured member and dependents.

- The residence of primary insured and all dependents is assumed to be the location of the employer. If the residency of the spouse or dependents is otherwise, the Company must be notified in writing of their full-time residence immediately. Further, it is assumed that primary insured is residing in location of employer during the employment year. Any change must be immediately reported to the Company.

- If the spouse or dependent of an insured is living full-time in the specified restricted areas, the premiums will be adjusted according to the applicable surcharge.
- Residence of the primary insured, spouse and dependents under this policy is presumed to be at the location of employer during the employment year, any deviation must be reported immediately to the Company who reserves the right to change rates to reflect normal residency.

Restricted Area - Countries and/or facilities, where medical treatment may not be covered under certain policies, as defined by the Company. Consult www.claimssite.com for a complete list of restricted areas and facilities.

Skilled Nurse - A skilled nurse is one whose name is currently on any register or roll of nurses maintained by any statutory nursing registration body within the country in which they are resident.

TieCare International - All use of "TieCare" is intended to be the same as TieCare International/Global Benefits Group, Inc.

Treatment - Surgical or medical procedures that have the sole purpose of curing or relieving acute illnesses or injury.

Usual and Customary Charges - Benefits payable under this policy are limited to medically necessary services and treatments, and shall be limited to the reasonable, usual, and customary charges for hospital and medical services.

Utilization Review Measures – The Company retains the right to determine the medical necessity of a planned treatment. The appropriateness of care and the treatment plan will be reviewed in consultation with the attending physician and alternative care options may be recommended.

XI. HOW TO FILE A CLAIM

Claims Forms are downloadable from www.claimssite.com. **ICS** can also send Claims Forms by fax or e-mail, upon request. International Claims Services must **receive** completed forms within **180 days** of treatment to be eligible for reimbursement of covered expenses.

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

- Part 1 and Part 2 are completely filled out by the member.
- All claims forms must have itemized bills and receipts attached, and should include the following information:
  - Name of patient.
  - Printed invoice number.
  - Name and entity of medical practitioner or institution.
  - Description of services rendered.
  - Prescriptions must accompany all pharmacy bills.

Mail the Claim Form and documentation to:

International Claims Services
27092 Burbank
Foothill Ranch CA 92610
USA

Status of claims:

Members wishing to request the status of a claim or have a question about a reimbursement received, please submit the status request form via our website at www.claimssite.com or e-mail the customer service dept. at claims@claimssite.com.

Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.

XII. MEDICAL ASSISTANCE COMPANY

Claims Appeal:

If at anytime you do not agree with the outcome of a processed claim, you may submit a written appeal with attached documents to:

International Claims Services
Attention: Appeals Dept.
27092 Burbank
Foothill Ranch, CA 92610
USA

Appeals should be submitted within 60 days of receiving your processed claim.

Upon appeal, any fees associated with the request of medical records will be paid by the member.

The ICS appeals committee will review your information and provide a response within 45 business days of receipt.

Medlink by MedAire

- The Company contracts with a medical assistance company to provide medical assistance for its members.
- Medlink by MedAire has been selected as the medical assistance company.
- All members ***MUST*** receive Medlink by MedAire's approval prior to an emergency medical evacuation. Failure to do so will result in the evacuation costs not being covered.
- Additionally, International Plus members ***MUST*** receive pre-approval from Medlink by MedAire ***BEFORE*** receiving treatment in the restricted areas.
- A complete list of the restricted areas and facilities can be found at www.claimssite.com.

Contact Information

Inside of the United States	**+1 888 391 9099**
Outside of the United States	**+1 602 747 9099 (collect)** **+1 602 747 9633 (collect)**

XIII. COORDINATED CARE

Coordinated Care

- The Company contracts with a Coordinated Care Company to provide certain medical services described elsewhere in this policy.
- International Care Network (ICN) has been selected as the Coordinated Care Company.
- All members ***MUST*** receive ICN's approval prior to receiving certain treatment. Please see page 7 for complete details.
- Coordinated Care will ensure that the member minimizes out-of-pocket costs.

Coordinated Care Contact Information

Inside of the United States: 888-751-2407

Outside of the United States: 949-975-1898

Web access: www.claimssite.com

International Care Network