GBG High-End Medical

Individual Member Guide

GBG

Insurance Without Borders℠

contents

1.0	**Quick Start Guide**	**01**
	Ways of using your medical benefits	01
	1.1 Provider Network	02
	1.2 Pre-Authorizations	03
2.0	**Value-Added Service**	**05**
	2.1 Professional Medical Second Opinion	05
3.0	**Benefits User Guide**	**06**
	3.1 Getting In-patient Treatment and/or Getting Maternity Treatment（Optional）	06
	3.2 Receiving Out-patient and/or Dental, Vision /Health Check-Ups Treatments	06
	3.2 Medical Emergency Services	07
4.0	**Claims Guidance**	**08**
	4.1 Getting Treatment and Submitting Claims	08
	4.2 Claims	08
	4.3 Claims Submission Time Frame	09
	4.4 Claims Submissions	09
	4.5 Medical Data Release and Verification	09
	4.6 Claim Appeal and Complaint Procedure	09
	4.7 Major Exclusions	10
5.0	**Insurance Benefits in Details**	**11**
	5.1 Policy Benefits Limits	11
	5.2 Area of Cover	11
	5.3 Medical Necessity and Customary Charges	12
	5.4 Eligibility and Enrolment	13
	5.5 Policy Valid Period, Renewal and Cancellation	14
	5.6 How to Change Your Policy	15
6.0	**Exclusions and Limitations**	**17**
7.0	**Additional Terms and Conditions**	**20**
	7.1 Applicable Law and Dispute Resolution	20
	7.2 Data Protection	20
	7.3 Force majeure	20
	7.4 Fraud	20
	7.4 Liability	20
	7.5 Making Contact With Dependents	21
	7.6 Benefits Third Party Liability and Subrogation	21
	7.7 What We Cover	21
8.0	**Deflinitions**	**22**

Introduction

This Individual Benefit Guide explains the terms and conditions contained in the Individual Health Insurance Contract. It is provided as reference for the insured person and describes the standard benefits and rules of your insurance policy. Please read this guide in conjunction with your Insurance Certificate and Schedule of Benefits.

Your Insurance ‘Schedule of Benefits’ details the plan(s) and geographical area of coverage that you have chosen for you and your dependents (if applicable) as well as the start date and renewal date of your coverage. This document will also state any endorsements or special conditions that apply to your coverage.

The Schedule of Benefits also shows the plan(s) selected, the associated benefits available to you, and specifies which benefits/treatments require submission of a ‘Pre-authorization Form’. It also confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply.

Information provided to us by, or on behalf of, the insured member(s) in the signed Application Form, Confirmation of Health Status Form or others (hereafter referred to collectively as the ‘relevant application form’) or other supporting medical information are confirmation to your health status and benefits, you should be responsible for any results because of unrevealed information.

Please note that we will send you a new Insurance Certificate if you request (and we accept) a change such as adding a dependent, or if we apply a change which we are entitled to make. Chines Yuan is the currency for your policy.

Please note that for the administration of your policy service, we are working in partnership with Taiping General Insurance, and GBG China is a branch office of GBG International Limited-- a specialist in offering global health care insurance. We are here to ensure you with a service that is fast, flexible and totally reliable.

01 Quick Start Guide

Ways of using your medical benefits:
(Detailed process description can be found in the related chapter)

We have directly contracted with a network of medical providers within Greater China to offer healthcare provider access and cashless settlement services, subject to the provisions of the Policy Benefits you have selected.

Direct billing is a service provided by GBG that allows you to enjoy cashless service. When you visit a provider in our direct billing network, the provider will submit the invoice directly to us after your treatment. Therefore, you will not need to pay upfront and seek reimbursement from GBG.

Please note:

- While direct billing is a time-saving feature, it does NOT guarantee full coverage.
- The specific coverage is still subject to your insurance benefits and limits listed in your Schedule of Benefits.
- Additionally, you may be required to make self-payments as a result of (but not limited to) deductibles, benefit overages, or treatments not covered.
- Unpaid self-payment balances may result in suspension of your direct billing privileges.
- The out-patient deductible will be waived, if the out-patient treatment was taken in the public hospitals (including VIP wings).

Contact Details

GBG 24 Hour Hotline: +86 400-816-9300 (Mainland China and HK, Macau and Taiwan)
1-866-914-5333 (in USA) / 1-905-669-4920 (out of USA)
Client Service Email: chinaservice@gbg.com
Address: Suite 2104, SCG Da Tang International Plaza, 868 Ying Hua Road, Shanghai 201204, PRC

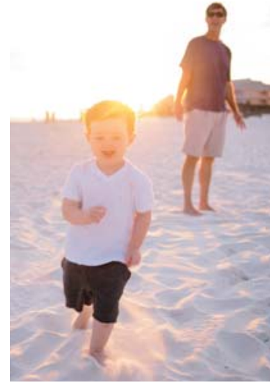
1.1 PROVIDER NETWORK

You can find our network provider via below three ways:

① Log into our website www.gbg.com, use “Provider Directory” search engine.
② Search by our WeChat official account “GBG Official Account”—“GBG Services”—“Medical Providers Map”
③ Call our hotline 400-816-9300 for details

1.1.1 Major Direct Billing Providers in Mainland China

- Peking Union Medical College Hospital International Medical Service
- China Japan Friendship Hospital
- Beijing Friendship Hospital
- Shanghai Huashan Worldwide Medical Center
- Shanghai Children's Medical Center VIP Clinic
- Shanghai 6th Hospital International Department
- The First People's Hospital of Shanghai
- Zhongshan Hospital Affiliated to Fudan University
- The University of Hong Kong-Shenzhen Hospital International Medical Center
- Nanfang Hospital Huiqiao Building(Foreign Medical Center)
- Peking University Shenzhen Hospital Priority Clinical Center
- Xiangya Hospital Central South University - International Medical Center



1.1.2 Provider Network

Direct Billing Providers within the USA

GBG utilizes one of the nation’ s largest networks of hospitals and outpatient care providers, helping to control medical insurance costs. The network’ s doctors and nurses continually evaluate the service they deliver to you, to their clients, and to health care professionals who participate in the network.

If you choose to take treatments with an In-Network providers, the result will be more cost effective for you. Since provider has agreed to accept a negotiated discount for services, GBG will pay a medical necessary and customary charges as per the provider agreement. However, utilizing providers that are Out-of-Network is a more costly option for you. The Insurer reimburses such providers up to a reasonable and customary amount as determined by the Insurer. The provider may bill the Insured the difference between the amounts reimbursed by the Insurer and the provider’ s billed charge. Additionally, the Insured will pay a coinsurance amount that is higher than if an In-Network provider were used.

All direct billing providers and other appointed medical facilities list can be found on www.gbg.com.

For non-emergency treatment within the United States, outside of the Preferred Provider Network, where an appropriate network provider is available, you may be reimbursed up to the GBG negotiated charges with the Preferred Provider Network or Reasonable and Customary amounts. Amounts in excess of these charges shall be the sole responsibility of the Insured. Amounts in excess of the Reasonable and Customary charges will not count toward the Out-of-Pocket Maximum, Deductibles or Plan Co-payments.

1.1.3 Luxury Hospitals and Public Hospitals

Public Hospitals: Public hospitals are those government owned and managed hospitals. Getting treatments in public hospitals (including VIP sections) which are outside of our provider networks for eligible benefits can be reimbursed through claims process.

Luxury Hospitals (Tier1 providers): Hospitals/clinics whose medical charges are greatly higher than the normal medical service providers. Please ensure that your policy benefits cover the below listed medical providers. For example,if your policy does not cover the Luxury hospitals, and you just get treatments in these medical providers, then, the medical cost won't be reimbursed from your insurance policy. Also, you won't get direct billing services at these providers. If your policy covers the Luxury hospitals with a co-payment, you will need to pay the co-payment amount in these providers after you take the treatments.

- United Family Hospitals and Clinics
- Parkway Health Clinics (Parkway Beijing Excluded)
- Institute for Western Surgery
- International SOS Clinics
- Klinoerth Therapy Clinic
- Shanghai East International Medical Center
- SinoUnited Health
- Guangzhou Can Am International Medical Center
- Beijing New Century Women's and Children's Hospitals*
- Shanghai Redleaf Women's Hospital
- Asia Medical Specialists / Sports physician (Sports performance) Ltd. (Hong Kong)
- Hong Kong Adventist Hospital (Hong Kong
- Hong Kong Sanatorium & Hospital (Hong s Kong)
- Matilda International Hospital (Hong Kong))
- Mount Elizabeth Hospital (Singapore)
- Gleneagles Hospital (Singapore)

We will adjust the list based on our review of the hospital charges

*Beijing New Century Harmony Pediatric Clinic/ Beijing New Century Women' s and Children' s Hospitals/New Century International Children' s Hospital/New Century Women' s and Children' s Hospital/Suzhou New Century Children's Hospital

1.2 Pre-Authorizations

1.2.1 What is pre-authorization?

Pre-authorization is a process by which an insured person obtains written approval for certain medical procedures or treatments from the insurer prior to the commencement of the proposed medical services. Your medical plan also states certain requirements on pre-authorizations.

1.2.2 What if I do not obtain pre-authorization?

Failure to obtain pre-authorization for certain treatments or procedures will result in a 40% of penalty co-payment in the normal benefits.

1.2.3 What are the benefits of pre-authorization?

The pre-authorization is an added service to the member and includes the following benefits:

- To ensure the member receives the maximum benefits available under the policy
- To ensure that the services being provided or being requested are medically appropriate for the condition/diagnosis and covered under your plan
- To ensure GBG will be billed directly for services, avoiding the need to pay-and-claim.

1.2.4 What services require pre-authorization?

- Hospitalization - Pre-Authorization is required for all locations. (Including Hospital stay for Maternity / Delivery)
- Outpatient Surgeries requiring general anesthesia
- Skilled or Private Duty Nursing - (When 4 or more visits are required)
- Organ, Bone Marrow, Stem Cell Transplants, and other similar procedures
- Air Ambulance service will be coordinated by Insurer's air ambulance provider; The Insurer will not take responsibility for reimbursement for members that fail to obtain pre-authorization prior to treatment

- Any condition, including cancer treatment or any chronic condition, which does not meet the above criteria, but are expected to accumulate over CNY60,000 of medical treatment per policy year
- Hospices
- Medication that will be in excess of $ 3,000 USD / CNY20,000 per refill
- Other conditions and treatment required pre-authorization in the proposal or policy

1.2.5 How long does pre-authorization take?

GBG China will send our decision to the Member/Network Provider within 2 working days of receiving the complete application. Complex cases or cases above CNY50,000 may require up to 5 working days.

1.2.6 What else is important to know about pre-authorization?

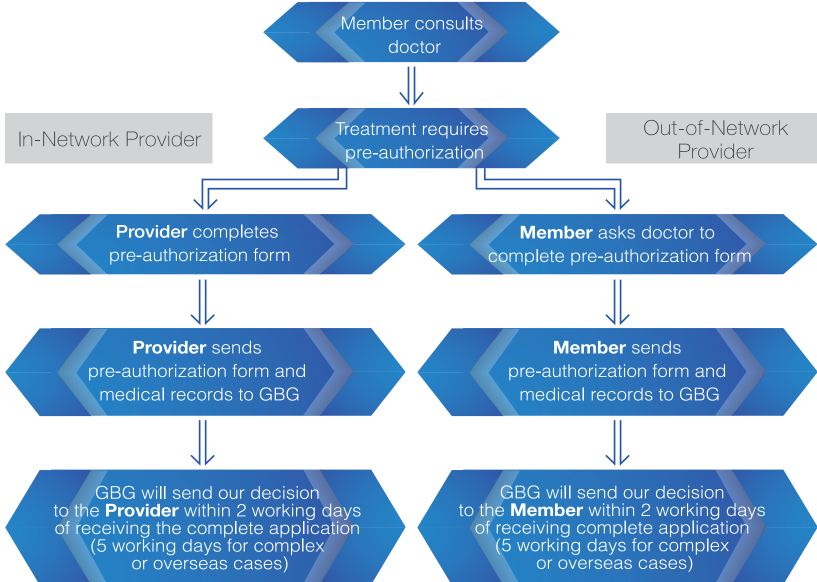
Pre-authorization does not guarantee full reimbursement. Health insurance policies are designed to reimburse only those claims that are “medically necessary” . For a treatment, service, or drug to be “medically necessary”, it must be complied with the following items:

- Be essential in treating the patient’s injury or illness
- Not to exceed the amount of care needed to provide safe and adequate treatment
- Be prescribed by a physician
- Not be Experimental or Investigative

1.2.7 How do I apply for pre-authorization?

The pre-authorization process is described in the below workflow. Initial clinical notes and diagnostic reports to support the medical necessity of the request are required. Depending on the complexity of the service being requested, additional information may be required as well, such as information on prior treatments etc. Failing to submit supplementary documents could result in delay of the authorization or rejection. The provider may decline to provide direct billing service with GBG.

Pre-Authorization Workflow



*Please submit your pre-authorization application to GBG Customer Service Email.

02 Value-Added Service

2.1 Professional Medical Second Opinion

When a serious medical condition occurs, he or she may not know where to go for advice regarding treatment options or how best to comply with treatment recommendations. GBG gives all our members free access to a world-class service from independent service party that offers them a review of their diagnosis by an expert in the relevant field.

How to get a second opinion?

Any individual members can access as a value-added service provided by GBG

What we need to launch the service?

The completed relevant medical record/report is required.

Your details will be reviewed by one or more leading experts in the field, and a report is compiled which including your diagnosis and treatment plan in 10 working days after getting the completed medical documents via email.

03 Benefits User Guide

3.1 Getting In-patient Treatment and/or Getting Maternity Treatment (Optional)

Please refer to your "Schedule of Benefits" to confirm your plan covers the treatment you are seeking. If you require treatment that needs pre-authorization from GBG, please follow the Pre-Authorization procedure and contact us 5 working days prior to your scheduled treatments.

Failure to obtain pre-authorization for certain treatments or procedures will result in a 40% of penalty co-payment in the normal benefits.

3.2 Receiving Out-patient and/or Dental, Vision /Health Check-Ups Treatments

First, please check your "Schedule of Benefits" to ensure your plan covers the treatment you are seeking. It confirms which benefits are available to you; also, if any special conditions apply to your treatment, these will also be indicated on your "Schedule of Benefits". If you have any queries regarding your coverage, you can always call our hotline for further assistance.

3.3 Medical Emergency Services

When you are in need of the emergency medical evacuations and repatriations, please contact us immediately and refer to the below contents to obtain the related services.

What is Medical Emergency:

"Medical Emergency", is defined as a sudden or unexpected onset of a condition requiring medical or surgical care which the Insured Person secures after the onset of such condition (or as soon thereafter as care can be made available, but in any case, not any later than 24 hours after the onset) and in the absence of which care an Insured would be expected to suffer severe life-long injury or premature death.

Medical Emergency Pre-Authorizations must be received within **48 hours of the admission** or procedure. In instances of an emergency, you or the Insured should go to the nearest hospital or provider for assistance even if that hospital or provider is not part of GBG medical Network. Please directly Contact GBG Assist.

Emergency Ambulance Services

Benefits are provided for medically necessary emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care, and are payable in accordance with the current Schedule of Benefits.

Medical Evacuation

Utilization of the medical evacuation provision requires the prior approval of GBG Assist. In the event of an emergency that may require medical evacuation, contact **GBG Assist** in advance in order to approve and arrange such Emergency Medical Air Transportation. GBG Assist, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported and the means of transportation. Approved Medical Evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment.

Should treatment be available locally but the Insured Person chooses to be treated elsewhere, transportation expenses shall be the responsibility of the Insured Person. GBG Assist must be contacted in advance in order to approve and arrange such Emergency Medical Air Transportation. GBG Assist, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. If the person chooses not to be treated at the facility and location arranged by GBG Assist, then transportation expenses shall be the responsibility of the Insured Person. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

Emergency Air Ambulance Services

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

Repatriation of Mortal Remains

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

04 Claims Guidance

4.1 Getting Treatment and Submitting Claims

Prior to your claims submissions, please ensure you have checked with your Schedule of Benefits to confirm you have the related eligible benefits, if you have any questions regarding to your Schedule of Benefits, please contact our hotline +86 400-816-9300 for further assistance.

4.2 Claims

For any service received from a non-network provider or when the provider was unable to verify your benefits, you will need to pay the fees first and apply for reimbursement after your visit.
Our claims administrator recommends claims to be submitted within 180 days after first day of treatment to be eligible for reimbursement of covered expenses.

When submitting claims, please provide below documents for reimbursement:

Information Required for Claim						
Claim Documents	Outpatien	Inpatient	Maternity	Preventive Care	Denta	Vision
Claim Form (including member ID, name, DOB, email, phone No, bank information and wet signature	✓	✓	✓	✓	✓	✓
Original Fapiao	✓	✓	✓	✓	✓	✓
Itemized Invoice(including treatment and price, drug name and price)	✓	✓	✓		✓	✓
Medical report and prescription (including dosage and usage)	✓	✓	✓		✓	
Cover Sheet of Health Check-up Report				✓		
Discharge Summary		✓				
Eyeglass Prescription						✓
Maternity Questionnaire			✓			
Claim Division Sheet(only applicable if you get reimbursement from other insurer.)	✓	✓	✓	✓	✓	✓
Above documents are the routine claim documents, we may require further information if the documents are not sufficient to make a decision.						

Status of claims

The claim processing usually will be completed within 15 working days after receiving complete claim materials. If members request claim status or have questions about the reimbursement, please email the claim department at chinaservice@gbg.com.

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

4.3 Claims Submission Time Frame

All claims should be submitted within 180 days after the first treatment. And all claims history checking should be requested within 12 months after the treatments.

4.4 Claims Submissions

Two ways of submission for your own choice

① Offline Claims Submission by Mail	② Submit Through GBG WeChat Official Account

How to submit a claim to GBG

1st Step You can use the claim form in your member pack or downloads it from www.gbg.com

2nd Step Complete and sign the claim form

3rd Step Mail the completed the Claim form and all the above mentioned documentation to GBG

How to submit claims through WeChat

1st Step Please scan the QR code to add GBG official account and enter "GBG Services"-"Claims Guide"

2nd Step Please complete the form, upload all the necessary documents and sign at last to submit the claim

3rd Step If the claims amount reaches above CNY 3,000, please send the original fapiao to us (address same as above mentioned)

4.5 Medical Data Release and Verification

In order for us to process your claims, and based on the data protection legislations in China mainland, you have the responsibility to provide all your claims related medical records to GBG by yourself or by your treating doctor. Any confidential personal data could be sent to us by encrypted file. Meanwhile, we also have the authority to appoint a doctor to review your claim (at our cost), and you can also appoint your own doctor to review with us together (at your cost). Please be noted if yourself and any of your dependents (if any) refuse to release the above mentioned medical information related to the claims submitted, GBG has the right to decline the claim case.

4.6 Claim Appeal and Complaint Procedure

If at any time you do not agree with the claim result, you may submit an appeal/grievance, you can send a completed Appeal/Grievance Form (available at www.gbg.com) along with all the supporting documents to GBG China office.

Appeals Procedure

GBG has a two-step appeal/grievance procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal/grievance in writing within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal or grievance should be approved and include any information supporting your appeal/grievance. You may send it to GBG China office.

Request for Reproduction of Records

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

4.7 Major Exclusions

Please read carefully below items only if stated in your policy riders, all the below mentioned items are excluded from your coverage: （A detailed Exclusion list can be found in chapter 6.0 "Exclusion" ）

1. Vitamins, minerals, nutriments, etc. (excluding vitamins and calcium supplements prescribed by doctors during pregnancy)
2. Pre-existing conditions non-disclosure in the application.
3. Injuries resulting from the abuse of drugs or alcohol consumption
4. Allergen test and desensitization
5. Any reproductive treatments, including abortion, contraception, infertility, sterilization,sterilization recoverage surgery, sexual dysfunction and post/prenatal classes, assisted reproductive, sex change operations and related treatments
6. Congenital conditions and birth anomalies (except baby born with the maternity benefits)
7. Injuries resulting from War and Terrorism, or medical conditions come from chemical, biological, or nuclear pollution.
8. Cosmetic surgery and self-inflicted injuries treatment to change the refraction of one or both eyes (laser eye correction)
9. Developmental problems, such as learning ability, language ability and behavior, growth hormone treatment fees.
10. Dietetic disorder and body weight related diseases
11. Any experimental treatment, any non-prescription drugs
12. Hearing aids related costs, treatment costs associated with hair loss.
13. Menopause, puberty, aging and similar physical changes.
14. Complication of maternity (except covered with maternity benefits)
15. Injuries resulting from engaging in professional sports, or activities related to the use of a weapon or firearm
16. Searching or rescue campaign
17. Self mutilation, suicide and / or willful exposure to unnecessary dangers.
18. Sleep disorders, anxiety disorders, depression, behavioral or learning disabilities, eating disorders

05 Insurance Benefits in Details

5.1 Policy Benefits Limits

There are two kinds of benefit limits shown in your Schedule of Benefits.

The maximum plan benefit, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan, e.g. the outpatient plan maximum limit is CNY100,000.

Some benefits also have **a specific benefit limit**, which may be provided on a "per Insurance Year" basis, a "per lifetime" basis or on a "per event" basis, such as, per visit or per pregnancy.

In some instances, we will pay a percentage of the costs for the specific benefit, e.g. “80% refund, up to CNY10,000”. Where a specific benefit limit applies or where the term "Full refund" appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Year, unless otherwise stated in your schedule of Benefits.

If you are covered for maternity benefits, these will be stated in your Table of Benefits along with any benefit limit and/or waiting period which applies. Benefit limits for “Routine maternity” and “Complications of childbirth” are payable on a “per pregnancy” basis. If a pregnancy spans two Insurance Years, please note that if a change is applied to the benefit limit at policy renewal, the following will apply:

All eligible expenses incurred in the first year will be subject to the benefit limit that applies in year one.

All eligible expenses incurred in the second year will be subject to the updated benefit limit that applies in year two, less the total benefit amount reimbursed in year one.

In the event that the benefit limit decreases in year two and this updated amount has been reached or exceeded by eligible costs incurred in year one, no additional benefit amount will be payable.

5.2 Area of Cover

GBG has three areas of cover which are listed below:

Worldwide

Worldwide Excluding USA

Greater China

Emergency Treatment Outside of Area of Cover

Emergency treatment outside area of cover is treatment for medical emergencies which occur during business or holiday trips outside your area of cover. Cover is provided up to a maximum period of six weeks per trip within the maximum benefit amount and includes treatment required in the event of an accident, or the sudden beginning or worsening of a severe illness which presents an immediate threat to your health. Treatment by a physician, medical practitioner or specialist must commence within 24 hours of the emergency event. All the other benefits in your policy will be replaced by this benefits cover and all the deductibles, copayment and any other special riders will remain the same. Please advise us if you are moving outside your area of cover for more than six weeks.

If you submit such claims, we will communicate with your treating doctor. GBG reserves the right to decide if it is a reasonable and customary charge, meanwhile we need to confirm that the emergency treatment outside of cover of area cannot be delayed after you return back to your normal cover of area.

Exclusions for Emergency Treatment Outside of Area of Cover

Emergency Treatment outside of cover area is for treatment by a physician, medical practitioner or specialist must commence within 24 hours of the emergency event. The followings are excluded from this benefits cover:

1. Existing conditions when you travel to the region outside of area of cover
2. Normal medical conditions
3. Medical conditions which are not with emergency and can be delayed when the member
4. travels back to their country of residence.
5. Any planned medical conditions
6. Any medical conditions should be known to the members and/or their dependents
   Maternity/complication of pregnancy and all the related conditions

5.3 Medical Necessity and Customary Charges

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

1. Consistent with the symptom, or diagnosis and treatment of condition, disease or injury;
2. Appropriate with regard to standards of accepted professional practice;
3. Not solely for the Insured Person's convenience, the Physician's convenience or any other provider's convenience;
4. The most appropriate supply or level of service, which can be provided. When applied to an inpatient, it further means that the medical symptoms or conditions require that the services or supplies cannot be safely provided as an outpatient;
5. Is not a part of or associated with the scholastic education or vocational training of the patient;
6. Is not Experimental or Investigative;

Reasonable and Customary Charge:

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

The **Reasonable and Customary Charge** for a treatment, service, or supply that is unusual, or not often provided in the area, or that is provided by only a small number of providers in the area, will be determined by the Insurer. The Insurer will consider such factors as (1) complexity, (2) degree of skill needed, (3) type of specialist required, (4) range of services or supplies provided by a facility, and (5) the prevailing charge in other areas. The term "area" refers to a city, county, or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment, based upon United States standards.

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

5.4 Eligibility and Enrolment

5.4.1 Eligibility

GBG-Taiping Medical insurance is applicable to all the individuals and their family members. Details can be found in your policy details.

5.4.2 Pre-existing Conditions

Applicants needs to honestly fill the health declaration part of the application form to declare all the pre-existing and any other medical conditions with completed information. GBG will state in the underwriting notice to confirm if we could cover or not cover any of the conditions declare in the health declaration form.

Any medical conditions which are not disclosed in the health declaration form will not be covered under the plan.

Meanwhile， please ensure all the information disclosed in the health declaration form are accurate and no errors/ misunderstandings, otherwise may result in your policy to be invalid.

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

5.4.3 Age Limitation

Maximum Enrollment Age: 64, Max. Renewal age 71. Unlimited if you enrolled at age 59 or before. Age 50 and above needs to submit health check-up report for new applications.

5.4.4 Dependents

Dependent is your **spouse** (age from 18 to 64 inclusive) and/or unmarried **children** (including any step, foster or adopted child) financially dependent on the policyholder up to the day before their 18th birthday; or up to the day before their 24th birthday if in full time education, and also named in your Insurance policy as one of your dependents.

5.4.5 Policy Effective

After we have accepted your applications, we will issue a policy to you, a confirmed policy effective date will be stated on your policy certificate.

5.5 Policy Valid Period, Renewal and Cancellation

5.5.1 Policy Period and How to Renew Your Policy

Your policy will be valid for continuous 12 months, which will be stated in your policy. (The policy expiry time should be at 24:00 Beijing Time, otherwise it will be stated in your policy riders)

30 days prior to the end of your policy period, we will send out a renewal notice to you and process your policy renewal upon your confirmation with us. The terms and conditions as well as the rates may be also renewed and applied to your renewal policy and any premium adjustment will be notified in your renewal notice.

5.5.2 Cancellation

After you have settled the full premium to the insurer, and your policy is effective, if you want to cancel all the policy or delete one of the insured person, please send us a notification through email and please be careful for such an action, because if you have any kind of claims reimbursed from the insurer, we will cancel your policy without premium reimbursement.

The insured should submit or return the following documentations to us for policy cancellation:

（1）Insurance policy cancellation notification letter
（2）Original copy of the insurance policy
（3）Premium payment slip
（4）ID card of the policy holder
（5）Insurance Card(s)
（6）Original Fapiao
（7）Any other does requested by the insurer

The policyholder will receive a policy cancelation confirmation issued by the insurer, the policy will be cancelled as of the cancellation notification letter submission date, and the insurer will reimburse any eligible pro-rata net premium within 30 days.

5.5.3 Cover for dependents when the policyholder in case of death

If the dependents meet the following criteria, he/she could become the new policyholder of the existing policy, when the original policyholder has died.

（1）When the dependents meet the eligible criteria of the policy holder listed in this membership guide.
（2）The dependent spouse/child needs to fill a new application form to apply for new policyholder (health declaration part can be skipped)

If all the dependents do not meet the above-mentioned criteria, the original policy will expire at the next renewal date.

5.6 How to Change Your Policy

5.6.1 Addition of a Dependent to Your Policy

During the policy effective period, it' s allowable for the policyholder to add eligible dependents (spouse or child) to his/her policy. And the insurer or the broker agents needs to be notified. New dependents need to submit a new application form and its coverage will be decided by the insurer' s underwriting results. If the underwriter approves the addition, the dependent can be added into the policy and obtain limited or the same full cover with the policyholder (any policy waiting period will also apply). If the policyholder' s marital status has changed to add his/her new spouse into the policy, then the additions request needs to be submitted to the insurer within 30 days.

If the addition of dependents is not notified to the insurer within notification period, the dependent will be deemed as a late enrollee. All the late enrollees will be requested to submit a health declaration form, and the coverage is subjective to health underwriting result and is not guaranteed or the dependent will only be added at policy next renewal.

5.6.2 Addition of a New Born Child

When a child was born under a policy with maternity benefits (already passed the waiting period) : the new born child (multiple birth, adopted child excluded) can be added into the policy without medical underwriting if the insurer is notified within 14 days. All the policy deductibles and copayment will apply, the insured needs to process as below steps:

- ✓ Notify the addition to the insurer within 14 days, provide the adoption certificate if the child is adopted
- ✓ New born child's coverage should be the same with the policyholder

Any addition requests submitted out of 14 days notification period, the insurance cover will be effective as of the notification date. If the child was not born under the maternity benefits of an existing policyholder or born under a policy with maternity benefits (during the waiting period), a health declaration form should be submitted for medical underwriting as well.

All legally adopted child after the birth can be added to the insurance policy if meet the below requirements:

- ✓ Child should be under 18 years old
- ✓ The policy holder should submit the legal adoption certificate
- ✓ Submit the health declaration form and lists all the pre-existing conditions

The insurance cover and its effective date should be subjected to the medical underwriting result, and

- ✓ If the addition request is submitted out of the 14 days notification period, the policy effective date will be the next day of the notification date
- ✓ All the pre-existing conditions cover will be subjected to medical underwing result

5.6.3 How to Change Your Policy Benefits

GBG-Taiping insurance policy allows benefits upgrade or downgrade, which should be requested at every policy renewal date and needs to be approved by the insurer. Any benefit upgrade needs to submit a new medical declaration form and approved by our medical underwriting team; benefits downgrade can be requested without a medical declaration form.

You can also upgrade your policy deductible/copayment amount at every policy renewal date. Please note any downgrade of the deductible/copayment amount needs a medical declaration form to be submitted, also all the benefits changes should be lasted for a whole policy year, all the mid-term policy changes won't be approved.

5.6.4 The Possible Reasons for Your Policy Cancellation or Modification

If any of the following listed items are violated by any reasons, the insurer has the right to suspend or cancel the insurance policy:

- ✓ Any kinds of fraud including but not limited to, the information declared on the relevant application form, which may affect the insurer's assessment of the risk
- ✓ Claim submission due to any reasons other than the eligible benefits
- ✓ Illegally obtain any benefits from the insurer in the help of any other third party
- ✓ Any kind of violation of the insurance terms and conditions or dishonesty
- ✓ The policy holder or the dependents are no longer meet the eligibility criteria, eg: the policyholder has moved outside of the China mainland

5.6.4 How to maintain coverage after leaving China mainland

Leaving your country of residence

Your benefits will be eligible for reimbursement if you stay in China for more than 180 days during one policy year.

You can notify us the date through email if you will be moving out of the China mainland on that date so that we will cancel your policy as of the date and ask our oversea branch offices to see if possible to arrange a new policy for you and your family members (if any).

06 Exclusions and Limitations

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

1 Charges in excess of reasonable and customary allowable charges for any covered procedure.
2 Services obtained in a Restricted Area or in a sanctioned country may be excluded.
3 Claims and costs for medical treatment, occurring before the effective date of coverage (including waiting periods) or after the expiration date of the policy. This includes any portion of a covered prescription to be used after the expiration of the current policy year.
4 Services, supplies, or treatment including drugs and/or emergency services that are provided by or payment is available from:
   a. Workers' Compensation law, Occupational Disease law or similar law concerning job related conditions of any country;
   b. The Insured Person, a family member or any enterprise owned partially or completely by the aforementioned persons;
   c. Another insurance company or government; or
   d. Under the direction of public authorities related to epidemics.
5 Exceptional Risks: Under "War and Terrorism", the Policy does not provide benefits if the Insured Person is an active participant, or in training, for activities described under the War and Terrorism section of this Policy. Additionally, benefits are not provided if nuclear, chemical, or biological weapons are used, regardless of the participation status of the Insured Person.
6 Services, supplies or treatments, including drugs, which are deemed to be experimental or investigational.
7 Any services, supplies, treatments including drugs and/or emergency air services:
   a. Not ordered by a Physician;
   b. Not medically necessary, not recommended or approved by a physician;
   c. Not rendered under the scope of the Physician's licensing; or
   d. Medical and dental services that do not meet professionally recognized standards or are determined by Insurer to be unnecessary for proper treatment.
8 Telephonic consultations, missed appointments, and after-hours expenses.
9 Personal comfort and convenience items including but not limited to: television, private rooms, housekeeping services, guest meals and accommodations, special diets, telephone charges, take home supplies, ambulance services (other than those provided by this Policy), and all other services and supplies that are not medically necessary including expenses related to travel and hotel costs incurred for medical or dental care.
10 Health check-ups, inoculations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.), other than provided for under the optional preventive care benefit.
11 Immunizations, other than provided for under well baby coverage, or optional Preventive Care benefit.
12 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.
13 Services and supplies related to visual therapy, Radial Keratotomy procedures, Lasik, or eye surgery to correct refractive error or deficiencies, including myopia or presbyopia.
14 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.

15 Elective and or cosmetic surgery, procedures, treatments, technologies, drugs, devices, items and supplies that are not medically necessary treatments.

16 Services or supplies for aesthetic treatment and cosmetic surgery, unless required because of a non-occupational injury that occurs while covered under the Policy.

17 Treatment for hair loss including but not limited to Hairplasty for male pattern alopecia or any alopecia; hair transplants to correct permanent hair loss that is caused by disease or injury; for male pattern baldness or age related thinning in women; the temporary removal of hair by laser; electrolysis; waxing; or any other means. Charges or treatment for breast reduction or augmentation; treatment of superficial, non-cystic or non-pustular acne or rosacea; treatment or removal of benign skin lesions not demonstrating evidence of suspicious cellular activity, or recent changes in size, shape, and color.

18 Any medical complications arising directly or indirectly as a result of a non-authorized elective or cosmetic procedure.

19 Sleep studies and other treatments relating to sleep apnea, except as described under Sleep Studies or testing section, and as Pre-Authorized by GBG Assist.

20 Smoking cessation treatments whether or not recommended by a Physician.

21 Weight Reduction and the cost of all treatments, supplies, services or drugs for weight reduction or weight reduction programs. Medical fast diets, weight loss programs, and educational dietary counseling related to weight loss efforts.

22 Health care services and associated expenses related to or associated with treatment of morbid or non-morbid obesity, including, but not limited to, gastric bypass, gastric balloons, gastric stapling, jejunal ileal bypass, and any other procedures or complications arising there from.

23 Organ transplants and related procedures except as specified in the Transplant Services section of this Policy including but not limited to the following:

a. All donor expense is excluded

b. services are not automatically covered and must be approved and managed by GBG Assist

c. All expenses of cryopreservation and the implantation of living supportive cells on a deceased person or in conjunction with infertility or reproductive treatments

d. Medically necessary organ, blood, or cell transplants may be covered on a case by case basis when Pre-Authorized and managed by GBG Assist

24 Fertility/infertility services, treatments, and/or procedures of any kind, including, but not limited to, fertility/infertility drugs, including drugs to regulate the menstrual cycle/ovulation for family planning purposes, artificial inseminations, in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), surrogate mother, and all other procedures and services related to fertility and infertility. Any pregnancy resulting from such treatments, complications of that pregnancy, delivery and postpartum care are also excluded.

25 Genetic counseling, screening, testing, or treatment.

26 Elective abortions and complications thereof, except for emergencies.

27 Reproductive treatments including but not limited to male and female birth control, vasectomies and sterilization, any expenses for male or female reversal of sterilization. Treatments for sex change or implantation or treatments for sexual transformation, sexual dysfunctions or inadequacies.

28 Viagra" or other sexual enhancement drugs and their respective generic equivalents will not be covered for any purpose.

29 Pregnancy and related conditions for a dependent child.

30 Maternity/Delivery Preparation Classes; Elective C-sections.

31 Circumcisions, unless medically necessary, and Pre-Authorized by GBG Assist.

32 Rehabilitative treatment for alcoholism, solvent abuse, drug abuse, or addictive conditions of any kind is limited to the benefit shown in the Schedule of Benefits. Treatment of any illness arising directly or indirectly from alcohol or drug abuse or addiction is excluded from

coverage. This includes but is not limited to treatment for any injuries caused by, contributed to or resulting from the Insured's use of alcohol, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the intended purpose prescribed by the Insured's Doctor.

33 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.

34 Injuries and/or illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law by an Insured Person.

35 Eyeglasses, contact lenses, or sunglasses unless the Optional Vision coverage has been purchased and they are included as a covered benefit.

36 Dental care is limited to accidental injury of sound, natural teeth sustained while covered under this plan, unless the Optional Dental coverage has been purchased. Accidental injury does not include damage to teeth incurred while chewing food or foreign objects. Dental Services at a hospital, including general anesthesia are not covered under the medical plan.

37 Treatment for (TMJD) or Malocclusion Temporomandibular Joint Disorders.

38 Prosthesis and corrective devices which are not medically required intra-operatively or equivalent appliances, except prosthesis or durable medical equipment used as an integral part of treatment prescribed by a physician, meeting the covered categories of durable medical equipment or prosthesis and approved in advance by GBG Assist.

39 Durable Medical Equipment does not include the following: 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 devices. The customizing of any vehicle, bathroom facility, or residential facility is also excluded.

40 Routine podiatry or other foot treatment not resulting from an illness or injury. Orthopedic shoes or other supportive devices for the feet, such as, but not limited to, arch supports and orthotic devices or any other preventative services and supplies; any devices resulting from the diagnosis of weak, strained, unstable or flat feet or fallen arches; or any tarsalgaia, metatarsalgia; or specified lesions of the feet, such as corns, calluses, and hyperkeratosis, toenails or bunions.

41 Growth Hormones, unless medically necessary and preauthorized by GBG Assist.

42 When a Health care provider advises against travel, heath care services incurred during such period of travel will not be covered.

43 Hearing Aids, Hearing Devices and Bone Anchored Hearing Aids.

44 Exceptional Risks

   a. Treatment as a consequence of injury sustained while participating in a hazardous activity or training for any professional sport;
   b. Treatment as a consequence of injury sustained while participating in, or training for, or as a consequence of: war (declared or not), acts of terrorism (see Policy for definition);
   c. Chemical contamination;
   d. Contamination by radioactivity from any nuclear material or from the combustion of nuclear fuel;
   e. Treatment for any loss or expense of nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily injury, except in an endeavor to save human life.

45 Treatment of sexually transmitted diseases including Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the HIV Virus, if defined as a pre-existing condition.

07 Additional Terms and Conditions

7.1 Applicable Law and Dispute Resolution

The insurance cover and your membership is governed by Chinese law, any differences in respect of medical opinion in connection with the results of a medical condition must be notified to us within one month of the decision. Such differences will be settled between two medical experts appointed by you and us in writing. Any dispute that cannot otherwise be resolved will be dealt with by courts in China or by a mutually agreed arbitration commission. Please note that there will be two years litigation validation period start from the medical treatment and cost.

7.2 Data Protection

Taiping General Insurance Co,.LTD is a Chinese authorized insurance company. We obtain and process personal information for the purposes of preparing quotations, underwriting policies, collecting premium, paying claims and for any other purpose which is directly related to administering policies in accordance with the insurance contract. Your information and information relating to your dependents may be disclosed to GBG and Taiping for the purposes of administration of your policy. The confidentiality of patient and member information is of paramount concern to both GBG and Taiping. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date. We will not retain your data for longer than is necessary for the purposes for which it was obtained.

7.3 Force Majeure

We shall not be liable for any failure or delay in the performance of our obligations under the terms of this policy, caused by, or resulting from, force majeure which shall include, but is not limited to: events which are unpredictable, unforeseeable or unavoidable, such as extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labor unrest, civil disturbances, sabotage, expropriation by governmental authorities and any other act or event that is outside of our reasonable control.

7.4 Fraud

Any material facts including, but not limited to, the information declared on the relevant application form, which may affect our assessment of the risk must be disclosed upon our request. The contract and/or your cover may be rendered null and void from the commencement date within 30 days after learning that

a) the applicant and/or the insured person intentionally failed to make any required disclosure; or the contract and/or your cover may be terminated/cancelled by us if

b) the applicant and/or the insured person failed to make any disclosure or made an incorrect disclosure due to material negligence.

If the applicant/insured person is not sure whether something is material, the applicant/insured person is obliged to inform us.

If the contract and/or the insured person' s cover is rendered null and void because of a) above, we will not refund the premium and shall not pay any claims relating to the contract and/or the insured person' s cover. Any claim payments made before the termination/ cancellation of the contract and/or the insured person's cover will become immediately due and owing to us.

If the contract and/or the insured person' s cover is terminated/cancelled because of b) above, and if the non-disclosed facts and/or incorrectly-disclosed facts have a material impact on the claims, we will refund the premium paid to date minus the cost of any claims paid by us relating to the contract and/or the insured person' s cover. If the cost of claims payments made by us before the termination/cancellation of the contract and/or the insured person' s cover exceeds the balance of the premium amount, we will be entitled to the reimbursement of this amount.

If you or your dependents or anyone acting on your or their behalf claims for treatment that never took place, we shall not pay any benefits for that claim and we shall be entitled to terminate your and/or your dependents' cover with effect from the date of our discovery of the fraudulent event. If any false, fraudulent, forged proof/means/devices are used to exaggerate the loss for more than entitled, we will not pay for the exaggerated/false portion. If it transpires that any claim paid by us is not eligible to be reimbursed, any amount paid will become immediately due and owing to us.

7.5 Liability

Our liability to you is limited to the amounts indicated in the Schedule of Benefits and any subsequent policy endorsements. In no event will the amount of reimbursement, whether under this policy, public medical schemes and any other insurance, exceed the amount of the invoice.

7.6 Making Contact With Dependents

In order to administer your policy in accordance with the insurance contract, there may be circumstances when we will need to request further information. If we need to make contact in relation to a dependent on a policy (e.g. where further information is required to process a claim), the policyholder (i.e. the principal member), acting for and on behalf of the dependent, may be contacted by us and asked to provide the relevant information. Similarly, all information in relation to any person covered by the insurance policy, for the purposes of administering claims, may be sent directly to the policyholder (i.e. the principal member).

7.7 Benefits Third Party Liability and Subrogation

If you or any of your dependents are eligible to claim benefits under a public scheme or any other insurance policy which pertains to a claim submitted to us, we reserve the right to decline to double pay benefits. You must inform us and provide all necessary information if and when you are entitled to a claim from a third party. You and the third party may not agree any final settlement or waive our right to recover outlays without our prior written agreement. Otherwise, we are entitled to recover the amounts paid from you and to cancel the policy. We have full rights of subrogation and may institute proceedings at our expense, to recover, for our benefit, the amount of any payment made under another policy.

If any of the treatments are taken because of a third-party liability, we would advise you to take necessary actions to claim the medical cost from the third-party, and if the third party has reimbursed related medical cost, the insurer reserves the right not to reimburse the paid medical cost.

7.8 What We Cover

The extent of your cover is determined by your Schedule of Benefits, any policy endorsements, these policy terms and conditions, as well as any other legal requirements. We will reimburse, in accordance with your Schedule of Benefits and individual terms and conditions, medical costs arising from the occurrence or worsening of a medical condition.

Treatments and procedures are only covered if they have a palliative, curative and/or diagnostic purpose, are medically necessary, appropriate and performed by a licensed physician, dentist or therapist. Claims/costs will be paid/reimbursed if the medical diagnosis and/or prescribed treatment are in accordance with generally accepted medical procedures.

This policy may not provide any cover or benefit to the extent that either the cover or benefit would violate any applicable sanction, law or regulations of China, the United Nations, the European Union or any other applicable economic or trade sanction, law or regulations.

The insurer will only be liable for medical costs that are eligible according to the terms and conditions of this policy. Insured persons are liable to pay their medical provider for treatments that are not eligible under their policy, as they are not entitled to payment of such non-eligible costs by the insurer. In the event that we receive a claim from a medical provider in relation to costs incurred by you (or your insured dependants) that you have not paid for and that are not covered for under your policy with us, we may settle the claim with the medical provider and then seek a refund from the policyholder (i.e. the principal member). We will contact the principal member with respect to these non-eligible claims and request that the principal member arranges full payment of the amount due within 14 days. Failure to refund this amount within a maximum of 21 days may result in the suspension of cover for all members covered under the policy During the suspension period, no claims will be paid. Furthermore, if the outstanding amount is not settled by the expiration date of the suspension period (7 days), the contract may be terminated in writing with immediate effect and we shall thereby be exempt to pay benefits to you. In these circumstances we will refund the premium amount(s) paid in respect of the period after the termination date minus the cost of any ineligible medical claims already paid and minus any amounts owing to us under the terms described in this paragraph. If the cost of claims paid for the relevant Insurance Year exceeds the amount of premium received and retained by us for that period, we will seek reimbursement of this amount from you.

08 Definitions

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

Allowable Charge
The fee or price Insurer determines to be the **Reasonable and Customary Charge** for health care services provided to Insured Persons that are covered under the Policy. The Insured Person is responsible for the payment of any balance over the Allowable Charge (except in the U.S. when a Preferred Provider has delivered the service, then there is no balance due) All services must be medically necessary. Once an allowable charge is established then the deductible, coinsurance, co-payments and any excess charges must be paid by the Insured.

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

- Once the Policy Year Coinsurance Maximum set forth in the Schedule of Benefits is reached, the Insurer shall pay 100% of eligible covered expenses for the remainder of the Policy Year.
- The out-of-pocket expenses apply to the first CNY70,000/USD10,000 or any amount agreed to between the Policyholder and the Company of covered treatment.
- The Policyholder may change the coinsurance level at the time of the policy renewal.
- In addition to basic coinsurance requirements, there may be additional co-payments associated with specific benefits, such as prescription drug coverage and/or physician office visits.
- The Coinsurance Maximum does not include any of the expenses covered under the optional Dental or Vision benefits.

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

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

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

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

Hazardous Activity
Activities that might heighten the risk of disease or death to an individual. These may include but are not limited to mountain or rock climbing, scuba diving, or race car driving.

Primary Insured
The person who is actively at work and lives normally, resides within the People's Republic of China, and are less than 65 years of age at time of enrollment (renewal max. age can be extended to 71 years old), as agreed to the Insurer.

Insured Dependent
Refers to member of the Insured's family (including spouse and/or child) who is enrolled under the Policy.

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

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

Maximum Benefit
The payment specified in the Schedule of Benefits, for specific services, which is the maximum amount payable by Insurer per person, per Policy year (unless otherwise noted) regardless of the actual or allowable charge. This is after the insured has met his obligations of deductible, coinsurance, co-payments and any other applicable costs.

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

- Consistent with the symptom, or diagnosis and treatment of condition, disease or injury;
- Appropriate with regard to standards of accepted professional practice;
- Not solely for the Insured Person's convenience, the Physician's convenience or any other provider's convenience;
- The most appropriate supply or level of service, which can be provided. When applied to an inpatient, it further means that the medical symptoms or conditions require that the services or supplies cannot be safely provided as an outpatient;
- Is not a part of or associated with the scholastic education or vocational training of the patient;
- Is not Experimental or Investigative;

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

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

Reasonable and Customary Charge
The lower of: a) the Provider's usual charge for furnishing the treatment, service or supply; or b) the charge determined by GBG to be the general rate charged by the others who render or furnish such treatments, services or supplies to persons (1) who reside in the same area (zip code) and (2) whose Injury or Illness is comparable in nature and severity.

The Reasonable and Customary Charge
for a treatment, service, or supply that is unusual, or not often provided in the area, or that is provided by only a small number of providers in the area, will be determined by the Insurer. The Insurer will consider such factors as (1) complexity, (2) degree of skill needed, (3) type of specialist required, (4) range of services or supplies provided by a facility, and (5) the prevailing charge in other areas. The term "area" refers to a city, county, or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment, based upon United States standards.

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