

Standard GEO Plan #1: Group Medical Summary

| Schedule of Benefits | BENEFIT DESCRIPTION |
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| Coverage Area | Worldwide |
| Rate Guarantee | 12 Months |
| Maximum Lifetime Benefit Per Person | \$50,000 to \$8,000,000 |
| Deductible (Calendar Year) | \$0 to \$25,000 |
| Deductibles Per Family | 2 or 3 |
| Deductible when using PPO network inside the U.S. | Deductible is reduced by 50% |
| Coinsurance Percentages for eligible medical expenses | |
| Incurred outside the U.S. & Canada | 100% after deductible |
| Incurred in the U.S. and using the PPO network | 100% after deductible |
| Incurred in the U.S. and outside the PPO network | 80% up to \$5,000 after deductible – 100% thereafter |
| Incurred in Canada | 80% up to \$5,000 after deductible – 100% thereafter |
| Independent US Preferred Provider Network | The First Health Network |
| Physician Office Services: | |
| * Adult Wellness Benefit | Up to \$250 per Calendar Year |
| * Child Wellness Benefit | Up to \$150 per Calendar Year |
| Illness or Accident Benefit | Covered to Plan Maximum |
| Hospital Services: | |
| Inpatient & Outpatient | Covered to Plan Maximum |
| Emergency Room | Covered to Plan Maximum |
| Injury | Covered to Plan Maximum |
| Illness (if directly admitted to hospital) | Covered to Plan Maximum |
| Illness (if not admitted to hospital) | Additional \$250 Deductible - Covered to Plan Maximum |
| Maternity Coverage (not available until there has been 10 months of continuous coverage - Full takeover available) | |
| Pre-natal care - Delivery of Newborn - Post-Natal Care | Covered to Plan Maximum |
| Newborn Baby Care (Routine care for first 31 days of life) | Covered to Plan Maximum |
| Other Services: | |
| AIDS and related diseases | Covered to Plan Maximum |
| * Chiropractic Care | Up to \$25 per visit - maximum of 20 visits per policy period |
| Complementary Medicine | Acupuncture \$150 – Magnetic Therapy \$75 Herbal Therapy \$50 Massage Therapy \$150 - Aroma Therapy \$50 - Vitamin Therapy \$100 |
| Durable Medical Equipment | Covered to Plan Maximum |
| Eligible Medical Expenses | Covered to Plan Maximum |
| * Emergency Medical Evacuation | Covered to Plan Maximum |
| Emergency Reunion | Up to \$10,000 (Lifetime Maximum Benefit) |
| Human Organ Covered Transplants | Up to \$1,000,000 (Lifetime Maximum Benefit) |
| Local Ambulance | Covered to Plan Maximum |
| Physical Therapy | Up to \$50 Benefit per visit |
| Prescription Drugs: outside US and Canada | Covered to Plan Maximum |
| Prescription Drugs: in US and Canada | Paid at 80% after Deductible |
| * Return of mortal remains (return to home country) | Up to \$25,000 |
| Supplemental Accident Benefit | Up to \$300 per accident - Covered to Plan Maximum thereafter |
| Vision Benefit: | |
| Exams | Up to \$100 per 24 months |
| Materials (frames, lenses, contacts) | Up to \$150 per 24 months |
| Mental/Nervous Disorders, Alcohol/Substance Abuse: | Up to \$10,000 per policy period and \$20,000 Lifetime Maximum |
| (Not available until there has been 12 months of continuous coverage - Full takeover available) | |
| Group Life Insurance: | \$10,000 to \$500,000 |
| 2 - 20 employees: \$10,000 minimum required / 21 or more insured employees: Optional | |
| Guarantee Issue from \$10,000 - \$100,000 / Additional underwriting required from \$100,001 - \$250,000 | |
| Most benefits are subject to an Annual Deductible and any applicable coinsurance (see 'Coinsurance Percentages'). An asterisk (*) means that the benefit IS NOT subject to the Deductible and Coinsurance | |
| <i>This is a summary of benefits only and is subject to the specific terms and conditions of the plan concerning eligible benefits. Limitations, eligibility and exclusions there under. Please refer to the policy wording for a complete description, which is available upon request.</i> | |