Global Medical Insurance
Gold

Policy of Insurance

IMG™

Underwritten by LLOYD'S

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BENEFIT SUMMARY

Coverage Limit / Maximum Amount for Eligible Medical Expenses				
Period of Coverage	Maximum Limit: 365 days			
Area of Coverage	Area 2: Worldwide excluding United States, Canada, China, Hong Kong, Japan, Macau, Singapore and Taiwan. United States 30-day maximum per Period of Coverage for Emergency Illness or Accident only. Treatment in the United States must be received from a Physician, Hospital or other healthcare provider within the Preferred Provider Network (PPO).			
	Area 3: Worldwide			
Lifetime Maximum Limit	$5,000,000			
Medical Concierge • Non-emergency services only	The Medical Concierge Service is a proprietary service of IMG that helps an Insured Person navigate the United States Healthcare system to identify the highest quality, most cost-effective providers for scheduled Inpatient and certain Outpatient Treatments. Refer to the MEDICAL CONCIERGE provision for further details.			
Benefit Plan Features (Subject to Area of Coverage indicated on the Declaration)				
United States: Fifty (50) states and the District of Columbia International: United States territories and countries other than the United States	**United States** Medical Concierge	**United States** In-Network	**United States** Out-of-Network	**International** International
Deductible for Eligible Medical Expenses				
Deductible • Refer to Declaration for Deductible amount	50% reduction of Deductible or Maximum of $2,500	100% of Deductible	100% of Deductible	50% reduction of Deductible or Maximum of $2,500
Deductible Carry Forward	If the Deductible has not been met during the Period of Coverage, then Expenses incurred during the last 30 days will be applied toward satisfaction of the Deductible for the next Period of Coverage.			
Coinsurance for Eligible Medical Expenses				
Coinsurance • In addition to Deductible	Plan pays 100% Insured pays 0%	Plan pays 100% Insured pays 0%	Plan pays 80% Insured pays 20%	Plan pays 100% Insured pays 0%
Out of Pocket Maximum	$0	$0	$1,000	$0

Pre-certification
• Transplants: No coverage if Pre-certification requirements are not met. • Interfacility Ambulance Transfer: No coverage if Pre-certification requirements are not met. • Medical Evacuation: No coverage if Pre-certification requirements are not met. • All other Treatments & supplies: fifty percent (50%) reduction of Eligible Medical Expenses if Pre-certification requirements are not met. • Deductible is taken after reduction. • Coinsurance is applied to remainder of the reduced amount. • Refer to PRE-CERTIFICATION REQUIREMENTS provision for a complete list of services that require Pre-certification.

Pre-existing Conditions	
Known Disclosed Conditions	Covered the same as any other Illness or Injury unless excluded by a Rider
Non-disclosed Conditions	No Coverage
Unknown Conditions • After 24 months of Continuous Coverage	• Maximum Limit per Period of Coverage: $5,000 • Lifetime Maximum Limit: $50,000

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Eligible Medical Expenses	100%	100%	80%	100%
Outpatient Physician / Specialist Visit • Available through the first 36 months	Not Applicable	100%	80%	100%
Outpatient Physician / Specialist Visit • Available 37 months and after • Maximum Limit per Visit: $150				
Inpatient Physician Visits / Services	100%	100%	80%	100%
Urgent Care • Available through the first 36 months	Not Applicable	100%	80%	100%
Urgent Care • Available 37 months and after • Co-payment: $25				
Hospital Emergency Room: United States • Injury • Illness: Subject to a $250 Deductible for each Emergency Room visit for Treatment that does not result in a direct Hospital admission	Not Applicable	100%	80%	Not Applicable
Hospital Emergency Room: International	Not Applicable	Not Applicable	Not Applicable	100%
Hospitalization / Room & Board • Available through the first 36 months • Average semi-private room rate • Private room considered when no semi-private room available • Includes nursing, miscellaneous and Ancillary services	100%	100%	80%	100%
Hospitalization / Room & Board • Available 37 months and after • Maximum Limit per Day: $2,250 • Includes nursing, miscellaneous and Ancillary services				
Intensive Care • Available through the first 36 months	100%	100%	80%	100%
Intensive Care • Available 37 months and after • Maximum Limit per Day: $4,500				

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Outpatient Surgery / Hospital Facility • Available through the first 36 months	100%	100%	80%	100%
Outpatient Surgery / Hospital Facility • Available 37 months and after • Co-payment: $100 • In addition to Hospital Emergency Room Deductible if not admitted as an Inpatient				
Outpatient and Inpatient Laboratory / Radiology / X-ray • Available through the first 36 months	100%	100%	80%	100%
Outpatient Laboratory / Radiology / X-ray • Available 37 months and after • Maximum Limit: $5,000				
Inpatient Laboratory / Radiology / X-ray • Available 37 months and after				
Chemotherapy / Radiation Therapy • Available through the first 36 months	Not Applicable	100%	80%	100%
Chemotherapy / Radiation Therapy • Available 37 months and after • Combined Inpatient and Outpatient Maximum Limit: $10,000 • Combined Inpatient and Outpatient Lifetime Maximum Limit: $50,000				
Pre-admission Testing	Not Applicable	100%	80%	100%
Surgery	100%	100%	80%	100%
Reconstructive Surgery • Surgery is incidental to or follows Surgery that was covered under the Plan	100%	100%	80%	100%
Assistant Surgeon • 20% of the primary surgeon's eligible fee	Not Applicable	100%	80%	100%
Second Surgical Opinion • Payable at 100% if requested by the Company • 50% reduction of Eligible Medical Expenses for failure to obtain Second Surgical Opinion when required by the Company	Not Applicable	100%	80%	100%
Anesthesia	Not Applicable	100%	80%	100%
Durable Medical Equipment	Not Applicable	100%	80%	100%
Podiatry • Maximum Limit: $750	Not Applicable	100%	80%	100%

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Physical Therapy • Available through the first 36 months • Maximum Limit per Visit: $50 • Maximum Visits per Day: 1 • Medical order or Treatment plan required	Not Applicable	100%	80%	100%
Physical Therapy • Available 37 months and after • Maximum Limit per Visit: $50 • Maximum Visits per Day: 1 • Maximum Limit: $1,000 • Lifetime Maximum Limit: $10,000 • Medical order or Treatment plan required				
Extended Care Facility • Maximum Day Limit: 30 • Upon direct transfer from an acute care Facility	100%	100%	80%	100%
Home Nursing Care • Provided by a Home Health Care Agency • Upon direct transfer from an acute care Facility	100%	100%	80%	100%
Hospice • Maximum Day Limit: 30 • Terminally ill – 6 months to live • Inpatient Hospice Facility • Insured Person's home	100%	100%	80%	100%
Transplant • Available through the first 36 months • Lifetime Maximum: $1,000,000 • Transplant Maximum: 1 • Organ procurement & harvesting costs Lifetime Maximum: $10,000 • Travel & lodging Lifetime Maximum Expense: $5,000 • Covered Transplants: cornea, heart, heart/lung, lung, kidney, kidney/pancreas, liver, allogeneic or autologous bone marrow • Subject to the TRANSPLANT PRE-CERTIFICATION provision and only when Treatment is provided within the Company's approved independent Managed Transplant System Network	100%	100%	Not Applicable	100%

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Transplant • Available 37 months and after • Lifetime Maximum: $500,000 • Transplant Maximum: 1 • Organ procurement & harvesting costs Lifetime Maximum: $10,000 • Travel & lodging Lifetime Maximum Expense: $5,000 • Covered Transplants: cornea, heart, heart/lung, lung, kidney, kidney/pancreas, liver, allogeneic or autologous bone marrow • Subject to the TRANSPLANT PRE-CERTIFICATION provision and only when Treatment is provided within the Company's approved independent Managed Transplant System Network	100%	100%	Not Applicable	100%
Prescriptions Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Outpatient Prescriptions • Available through the first 36 months • Dispensing Maximum per Prescription: 90 days	Not Applicable	100%	80%	100%
Outpatient Prescriptions • Available 37 months and after • Maximum Limit: $5,000 • Dispensing Maximum per Prescription: 90 days				
Preventative Care NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Adult Preventative Care • Ages 19 and older • After 12 months of Continuous Coverage • Maximum Limit: $250	Not Applicable	100%	100%	100%
Child Preventative Care • Ages 18 and younger • After 12 months of Continuous Coverage • Maximum Limit: $200	Not Applicable	100%	100%	100%

Mental or Nervous and Counseling Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Mental or Nervous Lifetime Maximum Limit: • Combined Inpatient and Outpatient • After 12 months of Continuous Coverage	$50,000			
Inpatient and Outpatient Mental or Nervous • Available through the first 36 months • After 12 months of Continuous Coverage • Maximum Limit: $10,000	Not Applicable	100%	80%	100%
Inpatient Mental or Nervous • Available 37 months and after • Combined Inpatient and Outpatient Maximum Limit: $2,500				
Outpatient Mental or Nervous • Available 37 months and after • Outpatient Maximum Limit per Visit: $75 • Combined Inpatient and Outpatient Maximum Limit: $2,500	Not Applicable	70%	70%	70%
Bereavement Counseling • Not Subject to Deductible and Coinsurance • Lifetime Maximum: $300 • Counseling 6 months before or after a Family member's death	Not Applicable	100%	100%	100%
Emergency Services NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Emergency Local Ambulance • Available through the first 36 months • Subject to Deductible and Coinsurance • Injury • Illness resulting in an Inpatient Hospital admission	Not Applicable	100%	80%	100%
Emergency Local Ambulance • Available 37 months and after • Injury • Illness Maximum Limit per event: $100 • Illness resulting in an Inpatient Hospital admission	Not Applicable	100%	100%	100%

Emergency Services NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Emergency Medical Evacuation • Available through the first 36 months • Up to the Lifetime Maximum Limit • Approved in advance and coordinated by the Company • Travel outside of the Insured Person's Home Country	Not Applicable	100%	100%	100%
Emergency Medical Evacuation • Available 37 months and after • Maximum Limit: $250,000 • Approved in advance and coordinated by the Company • Travel outside of the Insured Person's Home Country				
Emergency Reunion • Lifetime Maximum Limit: $10,000 • Maximum Day Limit: 15 • Meal Maximum Limit per Day: $25 • Reasonable and necessary travel costs and accommodations • Approved in advance by the Company	Not Applicable	100%	100%	100%
Interfacility Ambulance Transfer • Available through the first 36 months • Subject to Deductible and Coinsurance • United States only • Transfer from one licensed health care Facility to another licensed health care Facility	Not Applicable	100%	80%	Not Applicable
Interfacility Ambulance Transfer • Available 37 months and after • United States only • Illness Maximum Limit per event: $100 • Transfer from one licensed health care Facility to another licensed health care Facility	Not Applicable	100%	100%	Not Applicable

Emergency Services NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Return of Mortal Remains • Available through the first 36 months • Maximum Limit: $25,000 • Local Burial / Cremation Maximum Limit: $5,000 • Return of Insured Person's Mortal Remains to Country of Residence • Approved in advance by the Company	Not Applicable	100%	100%	100%
Return of Mortal Remains • Available 37 months and after • Maximum Limit: $15,000 • Local Burial / Cremation Maximum Limit: $5,000 • Return of Insured Person's Mortal Remains to Country of Residence • Approved in advance by the Company				
Other Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Complementary Medicine • Maximum Limit: $500 • Services include Acupuncture, Aromatherapy, Herbal Therapy, Magnetic Therapy, Massage Therapy and Vitamin Therapy	Not Applicable	100%	100%	100%
Dental Treatment • Available through the first 36 months • Maximum Limit: $100 (Treatment due to unexpected pain to sound natural teeth) • Maximum Limit: $500 (Non-emergency Treatment at a Dental Provider due to an Accident)	Not Applicable	100%	100%	100%
Dental Treatment • Available 37 months and after • Maximum Limit: $100 (Treatment due to unexpected pain to sound natural teeth) • Maximum Limit: $500 (Non-emergency Treatment at a Dental Provider due to an Accident)				

Other Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limits per Period of Coverage or if indicated, per Lifetime				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Traumatic Dental Injury • Available through the first 36 months • Up the Lifetime Maximum Limit • Treatment at a Hospital Facility due to an Accident • Additional Treatment for the same Injury rendered by a Dental Provider will be paid at 100%	Not Applicable	100%	80%	100%
Traumatic Dental Injury • Available 37 months and after • Maximum Limit: $5,000 • Treatment at a Hospital Facility due to an Accident • Additional Treatment for the same Injury rendered by a Dental Provider will be paid at 100%				
Hospital Indemnity • Not Subject to Deductible and Coinsurance • International Only	Private Hospital • Overnight Maximum: $400 • Maximum: $4,000 Public Hospital • Overnight Maximum: $500 • Maximum: $5,000 Eligible Medical Expenses are incurred at a state, government or charitable Hospital and no costs are incurred by the Insured or the Company for the Hospitalization and/or related Treatment while Hospitalized.			
Supplemental Accident • Not Subject to Deductible and Coinsurance • Maximum Limit per Accident: $300 • Charges will be subject to Deductible and Coinsurance and paid the same as any other Injury once the Maximum Limit has been satisfied	Not Applicable	100%	100%	100%

A. **BENEFIT SUMMARY**: The following benefits and coverage are available to the Insured Person, subject to the AGREEMENT provision, while the insurance plan shown in the Declaration is in effect.

B. **AGREEMENT**: Certain Underwriters at Lloyd's (publ) (the Company) promise and agree to provide the Insured Person with the benefits described in this Policy, as outlined herein and coverage for which is certified hereunder by the Company. The Company makes this promise and agreement in consideration of the accuracy and truthfulness of the Insured Person's Application and payment of Premium, and subject to all of the Terms of this Policy, including any Riders. This Policy is effective as of January 1, 2018 and shall remain in effect until terminated in accordance with the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF POLICY provision. This Policy shall be effective as of the Effective Date of Coverage shown on the Declaration and shall remain in effect until terminated in accordance with the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF COVERAGE FOR INSURED PERSONS provision. The insurance contract is this Policy, the Application, and any applicable Riders. This Policy is a description of and evidence of the Insured Person's rights and benefits under the contract. The Declaration likewise is evidence of the coverage under the contract and a statement of the Effective Date of Coverage, subject always to the Terms of coverage contained within this contract. The Company hereby recognizes International Medical Group®, Inc., as the Company's authorized representative, and as the Plan Administrator of this Policy. Subject to the Terms of the CONDITIONS AND GENERAL PROVISIONS, SERVICE OF SUIT; VENUE; CHOICE OF LAW; TRIAL BY COURT provision, all communications, notices and payments to the Company that are required or permitted under this Policy and/or as described in this Policy shall be transmitted through the Plan Administrator, and receipt of same by the Plan Administrator shall be considered receipt by the Company.

C. **CONDITIONS AND GENERAL PROVISIONS**: The following Terms are conditions precedent to the Company's liability under the insurance provided to the Insured Person pursuant to and in accordance with the Terms of this Policy, as outlined by this Policy (such insurance being sometimes referred to herein as "this insurance" or "the plan"):

(1) **ENTIRE AGREEMENT**: This Policy, including the Application and any Riders, shall constitute the entire agreement among the Company, and the Insured Person.

(2) **PREMIUM**: Payment of required Premium shall be remitted to the Company:

(a) on or before the Due Date(s) specified on the Declaration

(b) on or before any renewal date subject to the CONDITIONS AND GENERAL PROVISIONS, RENEWAL; AMENDMENTS provision

(c) prior to any reinstatement under the CONDITIONS AND GENERAL PROVISIONS, REINSTATEMENT OF COVERAGE FOR INSURED PERSONS provision.

A grace period of ten (10) days (notwithstanding intervening Saturdays, Sundays or legal holidays) will be allowed for the payment of each installment of Premium, including Renewal Premium, except the first installment of the first Period of Coverage. If any Premium is unpaid at the end of the grace period, all insurance coverage and benefits under this insurance shall lapse and terminate with effect from the initial Due Date of the unpaid Premium, and the Company shall have no liability to the Insured Person for any claims incurred on or after such date. Premium is considered paid on the date the payment is actually received by the Company.

(3) **CLAIMS NOTIFICATION**: All claims and related claim information should be filed with the Company through the Plan Administrator at the contact information below, or online at www.imglobal.com/member as soon as possible:

International Medical Group

Attn: Claims Department

PO Box 88500

Indianapolis, IN 46208-0500

USA

Proof of Claim: When the Company receives notice of a claim for benefits under this insurance from or on behalf of an Insured Person, it will provide the Insured Person with a Claim Form & Authorization for filing Proof of Claim.

(a) All of the following items must be submitted by or on behalf of the Insured Person to be considered a complete Proof of Claim eligible for consideration of coverage under this insurance:

(i) a duly completed, timely submitted, and signed claim form and authorization for release of information

(ii) all original itemized bills and statements of services rendered from Physicians, Hospitals, and other healthcare or medical service providers involved with respect to the claim

(iii) all original receipts for any costs, fees or expenses that have been incurred or paid by or on behalf of the Insured Person with respect to the claim, including without limitation all original receipts for any cash and/or credit card payments. The provider of service's full name, address, telephone number (including area/country code), date of service, description of services (applicable procedure codes), and diagnosis code must be included on the receipts.

(b) The Insured Person and/or Physician, Hospital and other healthcare and medical service providers and suppliers shall have ninety (90) days from the date a claim is incurred to submit a complete Proof of Claim. The Company at its option may pend resolution and adjudication of submitted claims and/or may deny coverage due to either of the following:

(i) an incomplete Proof of Claim

(ii) failure to submit a Proof of Claim.

The Company at its option may waive the requirements regarding submission of a new claim form for subsequent claims incurred by an Insured Person relating to a continuing Illness, Injury or other medical condition for which a properly completed and signed Claim Form & Authorization has previously been submitted and received.

(4) **APPEALING A CLAIM**: In the event the Company denies all or part of a claim, the Insured Person shall have ninety (90) days from the date that the notice of denial was mailed to the Insured Person's last known residence or mailing address within which to appeal the determination. The Insured Person must file an appeal prior to bringing any legal action under the contract of insurance. The Insured Person should submit a written request for an appeal along with comments, all relevant, pertinent or related documents, medical records, and other information relating to the claim.

The appeal must be sent to:

International Medical Group

Attn: Benefit Review

2960 N. Meridian Street

Indianapolis, IN 46208

USA

The Company's review will take into account all comments, documents, records, and other information submitted by the Insured Person relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. Upon receipt of a written appeal, the Company shall have an opportunity for further reasonable investigation and/or review as set forth in the CONDITIONS AND GENERAL PROVISIONS, EXPLANATION OR VERIFICATION OF BENEFITS provision, and will respond in writing as soon as reasonably practicable, and in any event within ninety (90) days from receipt thereof.

If after an appeal is concluded the Insured Person is still not satisfied with the response, or has any other complaint, he or she should contact the Insurance Commission of the Bahamas at the following address:

The Insurance Commission of the Bahamas

3rd Floor, Charlotte House

Charlotte and Shirley Streets

P.O. Box N-4844

Nassau, N.P., The Bahamas

(5) **ASSIGNMENT, CHANGE OR WAIVER**: Notwithstanding any law, statute, judicial decision, or rule to the contrary which may be or may purport to be otherwise applicable within the jurisdiction, locale or forum state of any healthcare or medical service provider, no transfer or assignment of any of the Insured Person's rights, benefits or interests under this insurance shall be valid, binding on, or enforceable against the Company unless first expressly agreed and consented to in writing by the Company. Any such purported transfer or assignment not in compliance with the foregoing Terms shall be void *ab initio* and without effect as against the Company, and the Company shall have no liability of any kind under this insurance to any such purported transferee or assignee with respect thereto. The Terms of this Policy shall not be waived or modified except by the express written agreement of the Company.

(6) **SERVICE OF SUIT; VENUE; CHOICE OF LAW; TRIAL BY COURT**: No action at law or in equity can be brought by an Insured Person to recover on the contract of insurance prior to the later of (a) expiration of sixty (60) days after written Proof of Claim has been furnished in accordance with the contract of insurance or (b) exhaustion of one (1) appeal under the CONDITIONS AND GENERAL PROVISIONS, APPEALING A CLAIM provision above. No action at law or in equity can be brought after the expiration of three (3) years after the time written Proof of Claim is required to be furnished under the contract of insurance. The contract of insurance between the Insured Person and the Company, as represented by this Policy, shall be deemed issued, finalized and made in Nassau, Bahamas. Sole and exclusive jurisdiction and venue for any court action or administrative proceeding relating to this insurance shall be in Nassau, Bahamas, for which the Insured Person expressly consents. The subjects, risks and benefits of insurance covered by this Policy and evidenced by this Policy are not intended or considered by the Insured Person or the Company (or the Plan Administrator) to be resident, located, or performed in any particular State of the United States or other jurisdiction. Bahamas law shall govern all rights and claims raised under this Policy of Insurance.

In the event of the failure of the Company to provide benefits or pay or reimburse any amount claimed to be due under this insurance, the Company, at the request of the Insured Person and upon receipt of lawful process or summons, will submit to the jurisdiction of a court of competent subject matter jurisdiction located in Nassau, Bahamas, provided there exists an independent statutory and constitutional basis for *in personam* jurisdiction over the Company in said court and by said

forum. All trials regarding any dispute under this insurance shall be exclusively presented to and determined solely by the court as the trier of fact, without a jury. The Company reserves the right, acting by and through the Plan Administrator, to initiate and pursue actions for declaratory judgment and/or other appropriate relief with respect to the validity, binding effect, administration of and/or any dispute or controversy arising under this insurance. In any suit instituted by or against the Company pursuant to the Terms of this provision, the Company will abide by the final decision of such court or of any appellate court in the event of an appeal.

Nothing in this provision constitutes or should be deemed, considered or understood to constitute a waiver of the Company's rights to: (i) oppose venue, procedural and/or substantive choice of law, personal jurisdiction, or subject matter jurisdiction in any forum, (ii) commence an action in any court of competent jurisdiction in or outside of the United States, (iii) remove an action to a United States District Court, or (iv) seek transfer of a case to another court or forum as permitted by the laws of such forum or the laws of the United States or of any State in the United States, as applicable; all of which rights are expressly reserved and retained.

Further, subject to and without limiting, expanding, superseding, modifying or waiving any of the foregoing Terms contained in this Provision, pursuant to any statute of any jurisdiction which makes provision thereof, the Company hereby designates the Superintendent of the Insurance Commission of the Bahamas (or such other officer specified for that purpose in the statute), or her/his successor or successors in office, as its true and lawful attorney, under a special power of attorney, upon whom may be served any lawful process issued in connection with the initiation of any action, suit or proceeding instituted by or on behalf of the Insured Person arising out of this insurance, and hereby designates and appoints Higgs & Johnson, Ocean Centre, Montagu Foreshore East Bay Street, P.O. Box N-3247, Nassau, Bahamas, as its attorney-in-fact and agent for service of process to whom the said officer or Commissioner is authorized to mail or serve any such process or a true copy thereof.

(7) **MISREPRESENTATION**: Any false representation, incomplete information, misleading statement, misstatement, omission, concealment or fraud, whether or not innocently made, either in the Insured Person's Application which forms a part of this Policy, or in relation to any claim form, statement, certification or warranty made by the Insured Person or his/her representatives, agents or proxies, whether in writing or otherwise, to the Company or the Plan Administrator or their respective agents, employees or representatives, or in connection with the making of any claim under this insurance, shall render the Declaration and this Policy null and void and all claims and benefits under this insurance shall be forfeited and waived.

(8) **INSOLVENCY**: The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors or dissolution of any Insured Person shall not impose upon the Company any liability or obligation other than that specifically included in this insurance.

(9) **SUBROGATION CLAUSE**: The Insured Person shall undertake to pursue in his/her own name and stead, and to fully cooperate with the Company in the pursuit and prosecution of, any and all valid claims that the Insured Person may have against any third party who may be liable or responsible for any loss or damage arising out of any act, omission or occurrence which results or may result in a loss payment, provision of benefits, or coverage of claim by the Company under this insurance, and to fully account to the Company for any amounts recovered or recoverable in connection therewith, on the basis that the Company shall be reimbursed and entitled to recover first in full for any sums paid or to be paid by it before the Insured Person shares in any amount so recovered.

The Insured Person further agrees and understands that the Company requires the Insured Person to complete a subrogation questionnaire, sign an acknowledgment of the Company's subrogation rights and sign an agreement before the Company considers paying, or continues to pay, any claims. Should the Insured Person fail to so cooperate, account, or to prosecute any valid claims against any such third party or parties, and the Company thereupon or otherwise becomes liable or otherwise obligated to make payment under the Terms of this insurance, then the Company shall be fully subrogated to all rights and interests of the Insured Person with respect thereto and may prosecute such claims in its own name as subrogee.

The Insured Person’s submission of Proof of Claim or acceptance of coverage or benefits under this insurance shall be deemed to constitute an authorization, consent and assignment of such subrogation rights by the Insured Person to the Company. The Insured Person agrees the Company has a secured proprietary interest in any settlement proceeds the Insured Person receives or may be entitled to receive.

The Insured Person understands and agrees the Company is entitled to a constructive trust interest in the proceeds of any settlement or recovery. The Insured Person agrees to include the Company as a co-payee on any settlement check or check from any third party or insurer. The Insured Person agrees he/she will not release any party or their insured without prior written approval from the Company, and will take no action which prejudices the Company's rights.

The Insured Person is obligated to inform their legal representative of the Company’s rights and lien and to make no distributions from any settlement or judgment which will in any way result in the Company receiving less than the full amount of its lien without the written approval of the Company. Any amount recovered by the Company in accordance with the foregoing shall first be used to pay in full the costs and expenses of collection incurred by the Company, including reasonable attorneys’ fees, and for reimbursement to the Company for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts recovered shall be paid to the Insured Person or other persons lawfully entitled thereto, as applicable. In the event that the Insured Person receives any form or type of settlement and either fails or refuses to abide by the Terms of this insurance contract, in addition to any other remedies the Company may have, the Company retains a right of equitable offset against future claims.

(10) OTHER INSURANCE: The Company shall not be liable or obligated to provide any coverage or benefits or to pay or reimburse any claim under this insurance if there is any other insurance, membership benefit, workers' or workplace compensation coverage program or other government program, reimbursement or indemnification coverage, right of contribution, recoupment or recovery, contract, or any other third-party obligation or liability for provision of benefits ("Other Coverage") which would, or would but for the existence of this insurance, be available or obligated to provide such benefit or to pay or reimburse or provide indemnity for such claim, except in respect of any excess beyond the amount payable or provided under such Other Coverage had this insurance not been effected. Notwithstanding the foregoing, the Company shall not be liable or obligated to provide any benefit or to pay or reimburse any claim for any Insured Person in respect to Treatment or supplies furnished by any program or agency funded by any government or governmental authority.

(11) CANCELLATION BY INSURED PERSON: The Insured Person shall have fifteen (15) days from the Initial Effective Date of Coverage (the "Review Period") to review the benefits, conditions, limitations, exclusions and all other Terms of this Policy as evidenced and outlined by this Policy. If not completely satisfied, the Insured Person may request cancellation of this insurance retroactive to the Initial Effective Date of Coverage by sending a written request to the Company by email, mail or fax and received by the Company within the Review Period, thereby qualifying to receive a full refund of Premium paid. Upon effectuation of such cancellation and refund, neither the Company nor the Insured Person shall have any further rights, liabilities or obligations under this insurance.

After the Review Period, the Insured Person may request cancellation of the Declaration and this Policy by giving the Company not less than five (5) days advance written request. Cancellation is at the sole option of the Company, except as provided in the CONDITIONS AND GENERAL PROVISIONS, RENEWAL; AMENDMENTS provision, and the Company may request and/or require the Insured Person to execute a release of claims as a condition to and/or in consideration of granting such cancellation. If the Company grants cancellation, coverage for the Insured Person under this insurance shall terminate with effect from the cancellation date specified by the Company. The Company shall calculate the amount of Premium earned upon the Declaration and Policy through the requested date of cancellation (Short Rate Earned Premium) in accordance with the Short Rate Cancellation Table in effect as of the date of the request for cancellation. If the Insured Person has paid more than the Short Rate Earned Premium, the Company shall refund the difference between the amount actually paid and the Short Rate Earned Premium. If the Insured Person has paid less than the Short Rate Earned Premium, the Insured Person shall remit to the Company the difference between the Short Rate Earned Premium and the amount actually paid as a condition to cancellation as of such requested date, or the cancellation date will be established retroactive to the date through which and for which Premiums have actually been paid.

(12) APPLICABLE CURRENCY: All benefit amounts, coverage, monetary limits and sub-limits, and other amounts stated in this Policy, the Application, the Declaration, and in any Riders, including Premium, are in USD (United States Dollars).

(13) COOPERATION: The Insured Person and his/her Physicians, Hospitals and other healthcare and medical service providers and suppliers shall undertake to cooperate fully with the Company and the Plan Administrator in reviewing, investigating, adjudicating, considering an appeal of, and/or administering any claim for benefits under this insurance, including granting full right of access to all relevant, pertinent or related records, medical documentation, medical histories, reports, lab or test results, x-rays, and all other available evidence relating to or affecting the review, investigation, adjudication or administration of the claim. The Company at its own expense shall have the right and opportunity to examine all evidence related to a claim when and as often as it may reasonably require during the pendency of a claim hereunder. The Company at its option may suspend or pend adjudication of a claim and/or may deny benefits and/or coverage for a claim when any of the following has occurred:

(a) a refusal to so cooperate

(b) an unreasonable delay in such cooperation

(c) any other act or omission on the part of the Insured Person and/or his/her healthcare providers which hinders, delays, impairs or otherwise prejudices the performance of the Company's obligations under this insurance.

(14) CLAIM SETTLEMENT: Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have previously been paid by or on behalf of the Insured Person at the time of the Company's favorable adjudication thereof will be reimbursed by the Company directly to the Insured Person, by check, at his/her last known residence or mailing address. While this insurance is in effect, in order to effectuate proper administration, the Insured Person shall undertake to promptly notify the Company of any change in such addresses. Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have not been paid by or on behalf of the Insured Person at the time of adjudication will be paid by the Company by check or electronic funds transfer to the Insured Person at his/her last known residence or mailing address, or, at the sole option and discretion of the Company (but without obligation to do so), and as an accommodation to the Insured Person, directly to the provider(s), as applicable. All claim settlements, payments and reimbursements are subject to the insurance plan shown in the Declaration and all other Terms of this insurance. No healthcare or medical service provider or supplier, or any other third-party, shall have any direct or indirect interest, claim or right of action against the Company under this Policy, or the Declaration, whether by purported assignment of benefits, subrogation of interests or otherwise, unless first expressly agreed and consented to in writing by the Company, and notwithstanding the Company's exercise or failure to exercise any option or discretion under this provision regarding the method of claim payment. No such provider, supplier or other third-party is intended to have or shall have any rights as a third-party beneficiary under this Policy, or the Declaration.

(15) FRAUDULENT CLAIMS: A person who knowingly and with intent to defraud the Company files a statement of claim containing any false, incomplete, or misleading information commits a felony. If any claim or request for benefits under this

insurance shall knowingly be in any respect false, incomplete, misleading, concealing, fraudulent or deceitful, or if the Insured Person or anyone acting for or on his/her behalf under this insurance knowingly uses any false, incomplete, misleading, concealing, fraudulent or deceitful statements regarding the Insured Person, the insurance contract and all coverage thereunder may be cancelled, voided, rescinded and terminated by the Company in its sole and absolute discretion, and the Company shall have no obligation or liability for any such benefits, coverage or claims.

(16) **ARBITRATION**: No claim for benefits for which liability, eligibility, or coverage under this insurance has been denied in whole or in part by the Company nor any other dispute or controversy arising under or related to this insurance shall be arbitrable or subject to arbitration under any circumstances or for any reason.

(17) **TERMINATION OF POLICY**: This Policy can be terminated at any time by the Company by giving at least thirty (30) days written notice to the other and to the Insured Person. Such termination will have no effect on this Policy prior to the date of the termination, or on eligible coverage or benefits under this insurance accrued prior thereto.

(18) **TERMINATION OF COVERAGE FOR INSURED PERSONS**: Coverage and benefits for the Insured Person under this insurance will terminate effective at 12:01 AM EST on the earliest of the following dates:

(a) the next day following the end of the coverage period for which Premium has been fully and timely paid

(b) the termination date as shown on the Declaration for this Policy

(c) the date this Policy is terminated pursuant to the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF POLICY provision

(d) the date the Insured Person becomes a resident alien under IRS regulations or first fails to meet or no longer meets the eligibility requirements for this insurance as outlined in this Policy

(e) the 30th day after the Effective Date of this Policy, if the Insured Person is not a citizen of the United States but is located in the United States at the time of Application and has not departed the United States prior to such 30th day, unless the Insured Person is not eligible for any other medical insurance plan which is available to individuals similarly situated and located in the United States and has provided the Company an Affidavit of Eligibility

(f) the date the Company, at its sole option, elects to cancel from this plan all insured persons of the same sex, age, class or geographic location as the Insured Person, provided the Company gives no less than thirty (30) days advance written notice by mail to the Insured Person's last known residence or mailing address of its intent to exercise such option

(g) the cancellation date specified by the Company pursuant to the CONDITIONS AND GENERAL PROVISIONS, CANCELLATION BY INSURED PERSON provision

(h) the cancellation date specified by the Insured Person pursuant to the CONDITIONS AND GENERAL PROVISIONS, RENEWAL; AMENDMENTS provision

(i) the date specified by the Company in any notice of cancellation, forfeiture or rescission issued pursuant to or as a result of the circumstances described in the MISREPRESENTATION, FRAUDULENT CLAIMS and RIGHT OF RECOVERY subparagraphs of the CONDITIONS AND GENERAL PROVISIONS, or as otherwise permitted by the Terms of this insurance.

Coverage for the Insured Person shall remain in full force and effect unless terminated pursuant to this provision, except as otherwise provided in the Declaration, or this Policy.

(19) **REINSTATEMENT OF COVERAGE FOR INSURED PERSONS**: In the event coverage under this insurance lapses or is terminated in accordance with the PREMIUM and/or TERMINATION OF COVERAGE FOR INSURED PERSONS subparagraphs of the CONDITIONS AND GENERAL PROVISIONS for failure to pay Premium, the Insured Person may apply to the Company for reinstatement ("Reinstatement"). Reinstatement is at the sole option of the Company, and shall be subject to the Company's retained right, without obligation or liability of any kind, to reassess and make determination of acceptable risk in its sole and absolute discretion. In order to be considered for Reinstatement, the Insured Person must submit all of the following to the Company:

(a) a written request for Reinstatement

(b) a newly completed Reinstatement Application, which shall become a part of any reinstated Policy

(c) a written statement giving full details, as requested by the Company, of any claims incurred, diagnoses made, manifestations of symptoms or health conditions experienced, and/or Treatment or supplies received by the Insured Person since the Initial Effective Date under this insurance plan

(d) a written statement giving full details of the reason for the previous failure to pay Premium when due

(e) payment of all Premium due.

If the Company grants Reinstatement, it will promptly notify the Insured Person, and Reinstatement shall be effective as of 12:01 AM, EST, on the date stated in the notice. If the Company does not grant Reinstatement, the Company's sole obligation and liability shall be to return any paid and unearned Premium to the Insured Person.

(20) **PATIENT ADVOCACY**: Neither the Company nor the Plan Administrator shall have any right, obligation, or authority of any kind to ultimately select Physicians, Hospitals, or other healthcare or health service providers for the Insured Person or

to make any medical Treatment decisions for or on behalf of the Insured Person, and all such decisions shall be made solely and exclusively by the Insured Person and/or his/her guardians, Relatives, treating Physicians and other healthcare providers. Subject to the foregoing, the Company may determine that a particular claim, benefit, Treatment or diagnosis occurring under or relating to this insurance may be placed under the Company's "Patient Advocacy" program to ensure that Medically Necessary Treatment and supplies are provided in the most cost-effective manner. In the event the Company determines that a claim, benefit, Treatment, or diagnosis meets the Company's Patient Advocacy program guidelines, the Company will notify the Insured Person as soon as reasonably practicable, and a Patient Advocate will be assigned to the Insured Person. Thereafter, the Company's Patient Advocate may make evaluations and/or recommendations of Treatment settings, procedures and/or supplies that may be more cost effective for the Company and/or the Insured Person. Such recommendations will be made with input from the Insured Person and/or the Insured Person's guardians, Relatives, treating Physicians and/or other healthcare providers, and will be made only when it can be reasonably demonstrated that the Medically Necessary Treatment and/or supplies can be provided in a more cost-effective manner to the Company and/or the Insured Person. The Company will use its best efforts to evaluate and recommend Treatment settings and/or procedures and/or supplies that can reasonably be expected to result in the same or better care of the Insured Person. The Insured Person is under no obligation to accept or follow any of the Company's recommendations. However, if the Insured Person accepts and follows any of the Company's recommendations, the Insured Person agrees to hold the Company and the Company's agents and representatives, including the Patient Advocate, harmless from same, and the Company shall not be held liable or otherwise responsible for any Treatment or supply provided to the Insured Person except for the payment of claims and benefits eligible for coverage under the Terms of this insurance. After the Insured Person has been notified that the claim, Treatment, benefit or diagnosis meets the Company's Patient Advocacy program guidelines, the Company reserves the right, at its option and in its sole discretion without liability:

(a) to make payment for Treatment and/or supplies which, although not expressly covered under this insurance, may be beneficial to the Insured Person and cost effective to the Company; and/or

(b) to deny coverage and/or benefits for any Charges, including Eligible Medical Expenses otherwise eligible for coverage but for the Terms of this provision, which exceed the amount the Company would have covered had the Insured Person accepted and followed the recommendations of the Patient Advocacy program.

(21) RIGHT OF RECOVERY: In the event of overpayment by the Company of any claim for benefits under this insurance, for any reason, including without limitation because of any of the following:

(a) all or part of the claim was not incurred by or paid by or on behalf of the Insured Person

(b) the Insured Person or any of the Insured Person's Relatives, whether or not the Relative is or was an Insured Person under this insurance plan, is repaid or is entitled to be repaid for all or part of the claim in accordance with the CONDITIONS AND GENERAL PROVISIONS, OTHER INSURANCE provision, for defective equipment or medical devices covered under a warranty, or by or from a source other than the Company

(c) all or part of the claim was not eligible for payment or coverage under the Terms of this insurance

(d) all or part of the claim was paid or reimbursed based on an incorrect or mistaken application of benefits under this insurance

(e) all or part of the claim has been excused, waived, abandoned, forfeited, discounted or released by the provider

(f) the Insured Person is not liable or responsible as a matter of law for all or part of a claim.

The Company shall have the right to receive a refund and to recover the amount of overpayment from the Insured Person and/or the Hospital, Physician and/or other provider of services or supplies (as the case may be). The amount of the refund and recovery for overpayment of claims shall be the difference between: the amount actually paid by the Company; and the amount, if any, that should have been paid by the Company under the Terms of this insurance.

For all other overpayments, the amount of the refund and recovery shall be the amount overpaid.

If the Insured Person, Hospital, Physician, or other provider of services or supplies does not promptly make any such refund to the Company, the Company may, in addition to any other rights or remedies available to it (all of which are reserved):

(i) reduce or deduct from the amount of any future claim that is otherwise eligible for coverage or payment under this insurance, to the full extent of the refund due to the Company; and/or

(ii) cancel this Policy and all further coverage of the Insured Person under this Policy by giving thirty (30) days advance written notice by mail to the Insured Person at his/her last known residence or mailing address, and offset against the amount of any refund of Premium due the Insured Person to the full extent of the refund due to the Company.

(22) RENEWAL; AMENDMENTS: Subject to the Terms of the TERMINATION OF MASTER POLICY, TERMINATION OF COVERAGE FOR INSURED PERSONS, and REINSTATEMENT OF COVERAGE FOR INSURED PERSONS subparagraphs of the CONDITIONS AND GENERAL PROVISIONS, coverage under the insurance plan will be automatically renewed on each anniversary of the Insured Person's first day of coverage for an additional duration identical to the original Period of Coverage or twelve (12) months, whichever is shorter. Renewal is subject to the Terms of the plan then in effect (including the Terms of the then applicable Policy) and so long as renewal Premium is paid when due or within the allowable grace period and the Insured Person otherwise continues to meet the applicable eligibility requirements of the plan. Coverage under the insurance plan will not automatically renew if and only if:

(a) the Company provides thirty (30) days written notice to the Insured Person prior to the expiration date of the then existing Period of Coverage; or

(b) the Insured Person has cancelled the policy in accordance with the CONDITIONS AND GENERAL PROVISIONS, CANCELLATION BY INSURED PERSON provision.

The Company reserves the right in its sole discretion to make changes, additions and/or deletions to the Terms of this Policy, renewals or replacements of either, and/or to the insurance plan (including the issuance of Riders to effectuate same) at any time or from time to time after the Effective Date of Coverage of this Policy, upon no less than thirty (30) days prior written notice to the Insured Person ("Notice of Amendment"). The Notice of Amendment shall include a complete description of the changes, additions and/or deletions to be made, the effective date thereof (the "Change Date"), and notice of the Insured Person's cancellation rights as set forth below, and shall be sent electronically or first class mail, postage pre-paid, to the last known residence or mailing address of the Insured Person. Upon issuance of the Notice of Amendment, the Insured Person shall have the right to request cancellation of this Policy above, at any time prior to the Change Date; provided, however that cancellation under this provision shall be at the option of the Insured Person, and coverage under this insurance shall terminate with effect from the cancellation date specified by the Insured Person (subject to the provisions of the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF COVERAGE FOR INSURED PERSONS). If the Insured Person does not elect to cancel this Policy in accordance with the foregoing, the changes, additions and/or deletions as made by the Company and specified in said Notice of Amendment shall take effect as of the Change Date specified in the Company's Notice, and this insurance shall thereafter continue in effect in accordance with its Terms, as so amended and modified.

(23) **EXPLANATION OR VERIFICATION OF BENEFITS**: In the event of any verbal or telephone inquiry, every attempt will be made to help the Insured Person and his/her healthcare providers and suppliers understand the status, scope and extent of available benefits and coverage under this insurance; provided, however, that no statement made by any agent, employee or representative of the Company or the Plan Administrator will be deemed or construed as an actionable representation, promise, or an estoppel, or will create any liability against the Company or the Plan Administrator or be deemed or construed to bind the Company or to modify, replace, waive, extend or amend any of the Terms of this Policy, unless expressly set forth in writing and signed by an authorized agent or representative of the Company. Actual eligibility determinations, benefit verifications, final coverage decisions, claim adjudications, final payments, reimbursements of benefits, or claims shall be determined and adjudicated only after or at the time a proper and complete Application and/or Proof of Claim is submitted (as the case may be), an opportunity for reasonable investigation and/or review is provided, cooperation required hereunder received, and all facts and supporting information, including relevant data, information and medical records when deemed necessary or appropriate by the Company, are presented in writing. Appealed claims may be further investigated and/or reviewed. The Terms of this Policy govern all available coverage and payments made or to be made. If a definite answer to a specific benefits or coverage question is required for any reason, the Insured Person or his/her healthcare providers may submit a written request to the Company, including all pertinent medical information and a statement from the attending Physician (if applicable), and a written reply will be sent by the Company and kept on file. If the Company elects to verify generally and/or preliminarily to a provider or the Insured Person that an Injury, Illness, diagnosis or proposed Treatment is or may be covered under this insurance, or that benefits for same are or may be available as outlined in this Policy, any such verification of benefits does not guaranty either payment of benefits or the amount or eligibility of benefits. Final eligibility determinations, coverage decisions, claim appeals, and actual reimbursement or payment of claims or benefits are subject to all Terms of this insurance, including without limitation filing a proper and complete Proof of Claim and complying with the CONDITIONS AND GENERAL PROVISIONS, COOPERATION provision.

D. **ELIGIBILITY**: If an Insured Person is not eligible, this Policy is void *ab initio* and all premium paid will be refunded. In order to be eligible and qualified for coverage under this insurance, a person must meet all of the following requirements:

(1) complete and sign an Application as the Insured Person (or be listed thereon by proxy as an applicant and proposed Insured Person), and/or as the Insured Person's spouse and/or Child

(2) pay the required Premium on or before the Effective Date of Coverage

(3) receive written acceptance of his/her Application or renewal from the Company

(4) be at least fourteen (14) days old but not yet seventy-five (75) years old

(5) not be Pregnant, Hospitalized or Disabled on the Initial Effective Date

(6) not be HIV+ on the Initial Effective Date

(7) United States citizens: must be residing outside of the United States as of the Effective Date (or renewal date) and plan to reside outside of the United States for at least six (6) of the next twelve (12) months thereafter

(8) Non-United States citizens:

(a) must reside outside the United States at time of Application (or renewal);

(b) must plan to reside outside of the United States continuously for at least six (6) months during the Period of Coverage with required departure from the United States not more than thirty (30) days after the Initial Effective Date or renewal Effective Date; or

(c) if located inside the United States at the time of Application (or renewal), must not be eligible for any other medical insurance plan which is available to individuals similarly situated and located in the United States and must provide the Company an Affidavit of Eligibility.

E. **PRE-CERTIFICATION REQUIREMENTS**: Pre-certification is a general determination of Medical Necessity, only, and all such determinations are made by the Company (acting through its authorized agents and representatives) in reliance and based upon the completeness and accuracy of the information provided by the Insured Person and/or his/her Relatives, guardians and/or healthcare providers at the time of Pre-certification. The Company reserves the right to challenge, dispute and/or revoke a prior determination of Medical Necessity based upon subsequent information obtained. Pre-certification is not an assurance, authorization, preauthorization, or verification of Treatment or coverage, a verification of benefits, or a guarantee of payment. The fact that Treatment or supplies are Pre-certified by the Company does not guarantee the payment of benefits, the availability of coverage, or the amount of or eligibility for benefits. The Company's consideration and determination of a Pre-certification request, as well as any subsequent review or adjudication of all medical claims submitted in connection therewith, shall remain subject to all of the Terms of this Policy, including exclusions for Pre-existing Conditions and other designated exclusions, benefit limitations and sub-limitations, and the requirement that claims be Usual, Reasonable and Customary. Any consideration or determination of a Pre-certification request shall not be deemed or considered as the Company's approval, authorization or ratification of, recommendation for, or consent to any diagnosis or proposed course of Treatment. Neither the Company nor the Plan Administrator (nor anyone acting on their respective behalves) has any authority or obligation to select Physicians, Hospitals, or other healthcare providers for the Insured Person, or to make any diagnosis or medical Treatment decisions on behalf of the Insured Person, and all such decisions must be made solely and exclusively by the Insured Person and/or his/her family members or guardians, treating Physicians and other healthcare providers. If the Insured Person and his/her healthcare providers comply with the Pre-certification requirements of this Policy, and the Treatment or supplies are Pre-certified as Medically Necessary, the Company will reimburse the Insured Person for Eligible Medical Expenses up to the amount shown in the BENEFIT SUMMARY incurred in relation thereto, subject to all Terms of this insurance and the insurance plan shown in the Declaration. Eligibility for and payment of benefits are subject to all of the Terms of this insurance and the insurance plan shown in the Declaration.

(1) **SPECIFIC REQUIREMENTS**: The following must always be Pre-certified for Medical Necessity by the Company through the Plan Administrator before admission or receiving the Treatments and/or supplies:

(a) Chemotherapy

(b) Extended Care Facility

(c) Home Nursing Care

(d) Hospice Care

(e) Inpatient Hospitalization

(f) Interfacility Ambulance Transfer

(g) Radiation Therapy

(h) Surgery or Surgical procedure

(i) Transplant.

(2) **GENERAL REQUIREMENTS**: To comply with the Pre-certification requirements of this insurance for the Treatments and/or supplies or services listed in the SPECIFIC REQUIREMENTS provision, above, the Insured Person or his/her Physician or healthcare provider must perform all of the following:

(a) contact the Company through the Plan Administrator at the telephone numbers printed on the Insured Person's ID card (contact information below), as soon as possible and before the Treatment or supply is to be obtained.

Inside the United States: +1.800.628.4664

Outside the United States: +1.317.655.4500 (Collect if necessary)

E-mail: acm@imglobal.com

Website: www.imglobal.com/member/precertification

(b) comply with the instructions of the Company and submit any information or documents required by the Company

(c) notify all Physicians, Hospitals and other healthcare providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company.

(3) **TRANSPLANT PRE-CERTIFICATION REQUIREMENTS**: To comply with the Transplant Pre-certification Requirements, the Insured Person must contact the Company through the Plan Administrator as soon as possible but always within seventy-two (72) hours of becoming a candidate for a Covered Transplant; comply with the instructions of the Company and submit any information or documents required by the Company; and notify all Physicians, Hospitals and other healthcare providers that this insurance contains Pre-certification requirements and ask them to cooperate fully with the Company.

(4) **LOSS OF COVERAGE / BENEFITS FOR NON-COMPLIANCE OF PRE-CERTIFICATION REQUIREMENTS**: If the Insured Person or his/her healthcare providers do not comply with the Pre-certification requirements for the Treatment or supplies identified in the SPECIFIC REQUIREMENTS subparagraphs above, other than Covered Transplant Treatment, or if such Treatment or supplies are not Pre-certified:

(a) Eligible Medical Expenses incurred with respect to said Treatment and/or supplies will be reduced by the amount shown in the BENEFIT SUMMARY

(b) the Deductible will be subtracted from the remaining amount

(c) Coinsurance will be applied.

If the Insured Person or his/her healthcare providers do not comply with the Pre-certification requirements for Treatment or supplies related to Covered Transplant Treatment, or if such Treatment and/or supplies are not Pre-certified, all Transplant Expense benefits shall be forfeited and waived.

(5) **EMERGENCY PRE-CERTIFICATION**: In the event of an Emergency Hospital admission, Pre-certification must be completed within forty-eight (48) hours after the admission, or as soon as is reasonably possible.

(6) **CONCURRENT REVIEW**: For Inpatient Treatment of any kind, the Company will Pre-certify a limited number of days of confinement based upon the disclosed medical condition. Thereafter, Pre-certification must again be requested and approved if additional days of Inpatient Treatment are necessary.

(7) **APPEAL PROCESS**: If the Insured Person disagrees with a Pre-certification decision of the Company, the Insured Person may in writing ask the Company to reconsider the decision and may supply additional documentation to support the appeal. The Company may reconsider its decision based on review of the additional documentation and facts, if any. The Company will advise the Insured Person of its decision within a reasonable time frame following receipt of additional documentation and facts.

The appeal must be sent to AkesoCare:

Phone: +1.317.655.4500, Option #2

Fax: +1.317.655.4505; ATTN: AkesoCare - Appeals

Email: ACM@akesocare.com

F. **UNITED STATES PREFERRED PROVIDER ORGANIZATION (PPO)**:

(1) **SPECIAL BENEFITS**: If Treatment or supplies eligible for coverage under this insurance are received directly from the Company's approved list of independent Preferred Provider Organization (PPO) providers while the Insured Person is in the United States, the Company will adjust the Deductible and/or Coinsurance applicable to such claims according to the amount shown in the BENEFIT SUMMARY. However, all claims for Treatment or supplies received in the United States from a non-PPO provider will remain subject to the applicable Deductible and Coinsurance, whether or not the Insured Person may be eligible for the foregoing special benefit relating to Treatment or supplies received from PPO providers.

(2) **PPO INFORMATION**: The Company, through the Plan Administrator, endeavors to maintain a contractual arrangement with one (1) or more independent Preferred Provider Organizations (PPO) that has established and maintains a network of United States-based Physicians, Hospitals and other healthcare and health service providers who are contracted separately and directly with the PPO and who may provide re-pricings, discounts or reduced Charges for Treatment or supplies provided to the Insured Person. Neither the Company nor the Plan Administrator has any authority or control over the operations or business of the PPO, or over the operations or business of any provider within the independent PPO network. Neither the PPO nor provider within the PPO network, nor any of their respective agents, employees or representatives has or shall have any power or authority whatsoever to act for or on behalf of the Company or the Plan Administrator in any respect, including without limitation no power or authority to perform any of the following:

(a) approve Applications or enrollments for initial, renewal or reinstated coverage under this insurance plan or to accept Premium payments

(b) accept risks for or on behalf of the Company

(c) act for, speak for or bind the Company or the Plan Administrator in any way

(d) waive, alter or amend any of the Terms of this Policy or waive, release, compromise or settle any of the Company's rights, remedies, or interests thereunder or hereunder

(e) determine Pre-certification, coverage eligibility or verification of benefits, or make any coverage, benefit or claim adjudications or decisions of any kind.

It is not a requirement of this insurance that the Insured Person seek Treatment or supplies exclusively from a provider within the independent PPO network. However, the Insured Person's use or non-use of the PPO network may affect the scope and extent of benefits available under this insurance, including without limitation any applicable Deductible, Coinsurance and benefit reduction, as set forth above.

An Insured Person may contact the Company through the Plan Administrator and request a PPO directory for the area where the Insured Person will be receiving consultation or Treatment (therein listing the Physicians, Hospitals and other

healthcare providers within the PPO network by location and specialty), or an Insured Person may visit the Plan Administrator's website at www.imglobal.com/member to obtain such information.

G. **SECOND SURGICAL OPINION**: Except in the case of an Emergency, if a Physician recommends a Surgery or Covered Transplant, the Company may require, as a condition to becoming eligible for benefits under this insurance, that the Insured Person consult with another independent Physician for a second opinion as to the Medical Necessity of the Surgery ("Second Surgical Opinion").

The Insured Person must notify the Company immediately in the event a non-emergency Surgery or Covered Transplant is recommended by a Physician. The Company will promptly advise the Insured Person whether or not it will require a second opinion. Upon receipt of a second opinion that differs from the recommending Physician, the Company will promptly advise the Insured Person whether or not it will require a third opinion.

(1) The Company will notify the Insured Person if a Second Surgical Opinion is required as soon as is reasonably possible after the Insured Person Pre-certifies such Surgery in accordance with the PRE-CERTIFICATION REQUIREMENTS set forth in this Policy.

(2) The Physician providing the second opinion must meet all of the following criteria:

(a) not be a Relative of the Insured Person or the first recommending Physician

(b) not be financially or professionally or in any other way associated with the first recommending Physician

(c) provide the Company with a written opinion and any and all documents and records reasonably requested by the Company in support of such opinion.

If the Company does not require a second opinion, the Company will reimburse the Insured Person for Eligible Medical Expenses incurred in accordance with the Terms of this insurance.

If the second opinion is required by the Company, the Company will reimburse the Insured Person for Eligible Medical Expenses incurred for the consultation, including any required diagnostic tests or procedures which were not carried out by the first recommending Physician, without application of any Deductible or Coinsurance. If the second opinion concurs with the recommending Physician, then the Company will reimburse the Insured Person for Eligible Medical Expenses in accordance with the Terms of this insurance.

If the second opinion differs from the recommending Physician, the Insured Person may be required to consult with another Physician for a third opinion as to the Medical Necessity of the Surgery. The third Physician must also meet the requirements of subparagraphs (a) through (c) immediately above.

If the third opinion is required by the Company, the Company will reimburse the Insured Person for Eligible Medical Expenses incurred for the consultation, including any required diagnostic tests or procedures which were not carried out by the first or second Physicians, without application of any Deductible or Coinsurance.

If the Insured Person is requested or required to obtain a second or third opinion and does not, all benefits otherwise available under this insurance for reimbursement of Eligible Medical Expenses that are directly or indirectly related to or arise as a consequence of the Surgery shall be reduced by fifty percent (50%).

If the Insured Person obtains three (3) opinions, the Company will reimburse the Insured Person for Eligible Medical Expenses incurred in accordance with the Terms of this insurance based on the concurring recommendations of two (2) of the three (3) Physicians' opinions. If the Insured Person elects not to follow the recommendations of the two (2) concurring Physicians, all benefits otherwise available under this insurance for reimbursement of Eligible Medical Expenses which are directly or indirectly related to or arise as a consequence of the Surgery, or which are directly or indirectly related to or arise as a consequence of the Insured Person's refusal to undergo the recommended Surgery, shall be reduced by fifty percent (50%).

H. **MEDICAL CONCIERGE SERVICE**: The Medical Concierge Service is a proprietary service of IMG that helps an Insured Person navigate the United States health care system to identify the highest quality providers for scheduled, non-emergency inpatient and certain outpatient treatments.

With Medical Concierge Service, an Insured Person scheduling Inpatient or Outpatient Treatment receives important information to help them choose their medical provider of eligible medical conditions, including information on the cost and quality of hospitals, thereby maximizing the benefits provided under the insurance plan.

For non-emergency, Inpatient treatment incurred within the United States, use of the Medical Concierge Service will provide you with a list of qualified providers within the geographical area where you are located when treatment is medically necessary.

Special Benefit when using the Medical Concierge Service: When you obtain Treatment and incur Eligible Medical Expenses under the insurance plan shown in the Declaration page from a Physician, other health care provider or Hospital chosen by the Insured Person through use of our Medical Concierge Service, irrespective of whether the provider is within the United States preferred provider network (PPO), the Company will adjust the Coinsurance and out-of-pocket expenses to the amount shown in the BENEFIT SUMMARY.

To qualify for these benefits, the Insured Person must contact the Company immediately upon the recommendation by a health care provider that the Insured Person be admitted or receive any of the following:

(1) Colonoscopy

(2) Computerized Axial Tomography (CAT scans)

(3) Cystoscopy

(4) Echocardiography

(5) Endoscopy

(6) Gastroscopy

(7) Home nursing care

(8) Inpatient Care in an Extended Care Facility or rehabilitation Facility

(9) Inpatient status on non-emergency Treatment or Surgery

(10) Magnetic Resonance Imaging (MRI)

(11) Outpatient Surgery

(12) Receiving Covered Transplant Treatment or supplies.

Contact the Company as soon as possible PRIOR to the scheduling of Treatment as follows:

Inside the United States: +1.877.654.6229

Email: mcs@akesocare.com

Outside the United States: +1.317.655.4500 (Collect if necessary)

Website: www.imglobal.com/member

I. **ELIGIBLE MEDICAL EXPENSES**: Subject to the Terms of this insurance and the insurance plan shown in the Declaration, the Company will reimburse the Insured Person up to the amount shown in the BENEFIT SUMMARY for the following costs, Charges and expenses incurred by the Insured Person during the Period of Coverage with respect to an Illness or Injury suffered or sustained by the Insured Person during the Period of Coverage and while this Policy is in effect, so long as the Charges are Usual, Reasonable and Customary and are incurred for Treatment or supplies that are Medically Necessary ("Eligible Medical Expenses"):

(1) Pre-existing Conditions:

(a) Charges relating to Treatment for Known Disclosed Conditions that are not excluded or restricted through a Rider attached to this Policy are covered the same as any other Illness or Injury.

(b) Charges relating to Treatment for Unknown Conditions are covered subject to the limits set forth in the BENEFIT SUMMARY.

(2) Charges incurred at a Hospital for:

(a) daily room and board, nursing services, and Ancillary Services:

(i) In the first 36 months of coverage: not to exceed the average semi-private room rate. A private room will be considered when no semi-private room is available.

(ii) After 36 months of coverage: not to exceed the maximum as stated in the BENEFIT SUMMARY.

(b) daily room and board, nursing services, and Ancillary Services in an Intensive Care Unit

(c) use of operating, Treatment or recovery room

(d) services and supplies which are routinely provided by the Hospital to persons for use while an Inpatient

(e) Emergency Treatment of an Injury, even if Hospital confinement is not required

(f) Emergency Treatment of an Illness; however an additional deductible (as shown in the BENEFIT SUMMARY) will be required unless the Insured Person is directly admitted to the Hospital as Inpatient for further Treatment of that Illness

(3) Charges incurred for Surgery at an Outpatient Surgical Facility, including services and supplies

(4) Charges by a Physician for professional services rendered, including Surgery; provided, however, that Charges by or for an assistant surgeon will be limited and covered at the rate of up to twenty percent (20%) of the Usual, Reasonable and Customary charge of the primary surgeon; and provided, further, that the standby availability of a Physician or surgeon will not be deemed to be a professional service and is not eligible for coverage

(5) Charges incurred for:

(a) dressings, sutures, casts or other supplies which are Medically Necessary

(b) diagnostic testing using radiology, ultrasonography or laboratory services. Laboratory services billed for professional component fees are covered if the pathologist has direct involvement in providing a written report or verbal consultation for specimen-specific pathology services

(c) Implant devices that are Medically Necessary; however, any Implants provided outside the PPO network are limited payment of no more than one hundred fifty percent (150%) of the established invoice price and/or list price for that item

(d) basic functional artificial limbs, eye or larynx or breast prostheses, but not the replacement or repair thereof

(e) reconstructive Surgery when the Surgery is incidental to or follows Surgery which was covered hereunder

(f) radiation therapy or Treatment, and chemotherapy

(g) hemodialysis and the Charges by a Hospital for processing and administration of blood or blood components

(h) oxygen and other gases and their administration

(i) anesthetics and their administration by a Physician

(j) drugs which require prescription by a Physician for Treatment of Illness or Injury, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, and for a maximum supply of ninety (90) days of any one (1) prescription

(k) care in a licensed Extended Care Facility upon direct transfer from an acute care Hospital

(l) Home Nursing Care in bed by a qualified licensed professional, provided by a Home Health Care Agency upon direct transfer from an acute care Hospital

(m) Emergency Local Ambulance Transport necessarily incurred in connection with:

(i) an Injury

(ii) an Illness resulting in Hospital confinement as an Inpatient.

(n) Interfacility Ambulance Transfer must be a result of an Inpatient Hospital Admission, Medically Necessary and from one licensed health care Facility to another licensed health care Facility via air or land ambulance

(o) Treatment of Mental or Nervous Disorders, only after the Insured Person has maintained coverage under this insurance plan continuously for the number of months shown in the BENEFIT SUMMARY

(p) physical therapy prescribed by a Physician and performed by a professional physical therapist, and necessarily incurred to continue recovery from a covered Injury or covered Illness

(q) Medically Necessary rental of Durable Medical Equipment, up to the purchase price

(r) For Insured Persons with Area 3 coverage only: a Teladoc phone or video consultation with a Physician

(s) the initial purchase, fitting, repair and replacement of orthotic appliances such as braces, splints or other appliances required for support of an injured or deformed part of the body as a result of an Injury or Illness

(t) the following Charges made by Hospice:

(i) Room and board charged by the Hospice and part-time nursing by a Registered Nurse when the following conditions apply: The Physician must certify that the Insured Person is terminally ill with six (6) months or less to live; and services for the Insured Person must be received in an Inpatient Hospice Facility or in the Insured Person’s home

(ii) Charges incurred for Bereavement Counseling for the Insured Person and the Family. Services must be rendered by a licensed social worker or a licensed pastoral counselor. Services must be received prior to or within six (6) months after the patient's death; and payments and visits will be limited to the amount shown in the BENEFIT SUMMARY.

(u) drugs prescribed by a Physician specifically for malaria prevention

(6) Charges for Podiatry Care up to the amount shown in the BENEFIT SUMMARY

(7) Charges for Treatment of an Injury to the foot due to an Accident covered hereunder

(8) Charges for Treatment of an Illness for which foot Surgery is Medically Necessary and determined to be the only appropriate method of Treatment

(9) Charges for Dental Treatment as follows up to the amount shown in the BENEFIT SUMMARY:

(a) Charges for Treatment following Traumatic Dental Injury from a covered Accident that resulted in physical Injury to the Insured Person

(b) Charges for necessary Dental Treatment of Unexpected pain to sound natural teeth

(c) Charges incurred for non-emergency Dental Treatment necessary due to an Accident covered hereunder

J. **COMPLEMENTARY MEDICINE**: Subject to the Deductible and Coinsurance and the other Terms of this insurance, including without limitation the **Conditions and Limitations** set forth below, the Company will reimburse the Insured Person up to the amount indicated in the BENEFIT SUMMARY for Charges incurred by the Insured Person for Complementary Medical Services.

Conditions and Limitations: In order to be eligible for reimbursement of the Complementary Medical Services described above, the Insured Person must:

(1) be seeking Medically Necessary Treatment for a specific medical Illness which has been diagnosed, is being treated by a licensed Physician, and is otherwise covered by the Terms of this insurance

(2) not be seeking Complementary Medical Services for any Mental or Nervous Disorder.

K. **EMERGENCY MEDICAL EVACUATION**:

(1) Subject to the applicable Maximum Limit set forth in the BENEFIT SUMMARY, and the other Terms of this insurance, including the EXCLUSIONS provision and the CONDITIONS AND RESTRICTIONS subparagraph below, the Company will reimburse the Insured Person for the following transportation costs, when the Company or Plan Administrator arranges such transportation, and expenses incurred by the Insured Person arising out of or in connection with an Emergency Medical Evacuation occurring while this Policy is in effect and during the Period of Coverage:

(a) Emergency air transportation to a suitable airport nearest to the Hospital where the Insured Person will receive Treatment

(b) Emergency ground transportation necessarily preceding Emergency air transportation and from the destination airport to the Hospital where the Insured Person will receive Treatment

(2) **CONDITIONS AND RESTRICTIONS**: To be eligible for coverage for Emergency Medical Evacuation benefits, the Insured Person must be in compliance with all Terms of this insurance. The Company will provide Emergency Medical Evacuation benefits only when the condition, Illness, Injury or occurrence giving rise to the Emergency Medical Evacuation is covered under the Terms of this insurance. The Company will provide Emergency Medical Evacuation benefits only when all of the following conditions and restrictions are met:

(a) Medically Necessary Treatment cannot be provided locally

(b) transportation by any other means or methods would result in loss of the Insured Person's life or limb within twenty-four (24) hours, based upon a reasonable medical certainty

(c) Emergency Medical Evacuation is recommended by the attending Physician who certifies to the matters in subparagraphs (a) and (b), above

(d) Emergency Medical Evacuation is agreed to by the Insured Person or a Relative of the Insured Person

(e) Emergency Medical Evacuation is provided by designated, licensed, qualified, professional emergency personnel acting within the scope of such license and approved in advance and all arrangements are coordinated by the Company

(f) the condition, Illness, Injury or occurrence giving rise to the need for the Emergency Medical Evacuation:

(i) occurred suddenly, Unexpectedly, and spontaneously, and without: (1) advance warning, (2) advance Treatment, diagnosis or recommendation for Treatment by a Physician, or (3) prior manifestation of symptoms or conditions which would have caused a reasonably prudent person to seek medical attention prior to the onset of the Emergency

(ii) was not a Pre-existing Condition.

(g) The Company will cover reimbursement for the above-described costs and expenses and will arrange Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary Treatment to prevent the Insured Person's loss of life or limb.

The Insured Person may select a different Hospital in his/her Home Country at his/her option, but in such event the Insured Person shall be solely responsible for all costs and expenses in excess of the amounts that would have been incurred had the Insured Person used the nearest qualified Hospital. If a Hospital other than the nearest qualified Hospital is selected by the Insured Person, then the attending Physician, Insured Person, or a Relative of the Insured Person shall certify to the Company the Insured Person's understanding and acknowledgement of such responsibility for excess costs and expenses in addition to the matters set forth in the CONDITIONS AND RESTRICTIONS subparagraph, above. In all cases the Company will make the necessary arrangements for the Emergency Medical Evacuation and will use its best efforts to arrange with independent, third-party contractors any Emergency Medical Evacuation within the least amount of time reasonably possible.

By acceptance of this Policy and request for Emergency Medical Evacuation benefits hereunder, the Insured Person understands, acknowledges and agrees that the timeliness, duration, occurrences during, and outcome of an Emergency Medical Evacuation can be directly and indirectly affected by events and/or circumstances which are not within the supervision or control of the Company, including but not limited to: the availability, limitations, physical condition, reliability, maintenance and training schedules and procedures, and performance or non-performance of competent transportation equipment, supplies and/or staff of such third-party contractors; delays or restrictions on flights or other modes or means of

transportation caused by mechanical problems, government officials, telecommunications problems, non-availability of routes, and/or other travel, geographical or weather conditions; and other acts of God and unforeseeable and/or uncontrollable occurrences.

The Insured Person agrees to release and to hold the Company, the Plan Administrator and their agents and representatives harmless from, and agrees that the Company, the Plan Administrator and their agents and representatives shall not be held liable or responsible for, any delays, losses, damages, further Injuries or Illnesses, or any other claims that arise from or are caused in whole or in part by the acts or omissions of such independent third-party contractors or their agents, employees or representatives, or that arise from or are caused in whole or in part by any acts, omissions, events or circumstances that are not within the direct and immediate supervision and control of the Company, the Plan Administrator and/or their authorized agents and representatives, including without limitation the events and circumstances set forth above.

The Insured Person further agrees that upon seeking an Emergency Medical Evacuation, he or she will cooperate fully as required by the CONDITIONS AND GENERAL PROVISIONS, COOPERATION provision. Failure to so cooperate and/or failure to use or accept Emergency Medical Evacuation once it has been arranged by the Company or Plan Administrator will require the Insured Person to reimburse the Company for costs incurred for any Emergency Medical Evacuation that was arranged, but not used, by the Insured Person. Furthermore, the Insured Person may be required to arrange for payment of any subsequent Emergency Medical Evacuation and seek reimbursement thereafter for eligible costs associated with that subsequent Emergency Medical Evacuation.

L. EMERGENCY REUNION:

(1) Subject to the Terms of this insurance, including without limitation the CONDITIONS AND RESTRICTIONS subparagraph below, Emergency Reunion expenses will be reimbursed to an Insured Person as outlined in the BENEFIT SUMMARY, in cases where there has been an Emergency Medical Evacuation covered under the Terms of this insurance. Subject to the applicable Deductible and Coinsurance and other limits and sub-limits as specified in the BENEFIT SUMMARY, and subject to the CONDITIONS AND RESTRICTIONS subparagraph below, the following costs and expenses incurred in respect of travel by a Relative or friend of the Insured Person will be reimbursable to the Insured Person upon the recommendation and prior approval of the Company:

(a) the cost of a round-trip economy air ticket for one (1) Relative or friend from the airport nearest to the location of the Relative or friend at the time of the Emergency to the airport serving the area where the Insured Person is Hospitalized as a result of the Emergency or is to be Hospitalized as a result of the Emergency Medical Evacuation (to be determined pursuant to the Terms of the CONDITIONS AND RESTRICTIONS subparagraph, below), and return from whichever of such locations is actually selected to the point of the original departure

(b) reasonable and necessary travel costs, meals (up to the amount shown in the BENEFIT SUMMARY), transportation and accommodation expenses incurred in relation to the Emergency Reunion (but excluding entertainment).

(2) CONDITIONS AND RESTRICTIONS:

(a) The allowable period of coverage for the Emergency Reunion shall not exceed fifteen (15) days, including travel days, and all costs and expenses incurred beyond such period of coverage shall be retained for the sole account and responsibility of the Insured Person, Relative or friend

(b) the Emergency Reunion must be due to an Emergency Medical Evacuation covered under the Terms of this insurance

(c) the Insured Person must be so seriously ill that the attending Physician deems it necessary and recommends the presence of a Relative or friend at either the location where the Insured Person is being evacuated from or the destination of the evacuation, whichever is considered by the attending Physician and the Company to be the more reasonable

(d) all Emergency Reunion travel, transportation and accommodation arrangements and benefits must be approved in advance by the Company in order to be eligible for coverage under this insurance

(e) The Insured Person, Relative and/or friend must submit to the Company upon completion of the Emergency Reunion travel legible and verifiable copies of all paid receipts for the travel and transportation costs and expenses so incurred for which reimbursement is sought.

M. HOSPITAL INDEMNITY: Subject to the Terms of this insurance and in the event the Insured Person has been Hospitalized in a Facility outside the United States, during the Period of Coverage, the Company will pay the Insured Person the amount shown in the BENEFIT SUMMARY for each overnight Hospitalization as an Inpatient, so long as the Treatment received during the overnight Hospitalization is considered to be an Eligible Medical Expense.

N. PREVENTATIVE CARE: Provided the Insured Person has been continuously insured under this insurance plan for not less than twelve (12) months and subject to the Terms of this insurance, the Company will reimburse the Insured Person for the following expenses incurred while this Policy is in effect:

(1) for Males nineteen (19) years of age and older: one (1) Routine Physical Examination, including routine vaccinations commonly administered to adults. Limited to the amount shown in the BENEFIT SUMMARY and provided at least twelve (12) months have elapsed since the Insured Person's most recent Routine Physical Examination

(2) for Females nineteen (19) years of age and older: one (1) Routine Physical Examination, including routine vaccinations commonly administered to adults. Limited to the amount shown in the BENEFIT SUMMARY, including expenses for

mammography examinations and pap smears, and provided at least twelve (12) months have elapsed since the Insured Person's most recent Routine Physical Examination

(3) for a Child, limited to the amount shown in the BENEFIT SUMMARY:

(a) one (1) Routine Physical Examination per Period of Coverage, provided at least twelve (12) months have elapsed since the Child's most recent Routine Physical Examination

(b) routine inoculations and vaccinations commonly administered to children less than nineteen (19) years of age in accordance with standard medical practice.

O. **RECREATIONAL UNDERWATER ACTIVITIES**: Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the BENEFIT SUMMARY, the Exclusions provision, and the **Special Exclusions and Limitations** below, the Company will reimburse the Insured Person for Eligible Medical Expenses incurred by the Insured Person with respect to an Illness or Injury suffered or sustained by the Insured Person while engaged in Sports Diving during the Period of Coverage, so long as the same is carried out in strict accordance with the guidelines, codes of good practice, and recommendations for safe diving practices set forth by an Authoritative Diving Body.

Special Exclusions and Limitations: In addition to the Exclusions provisions, this insurance does not cover any charges, costs, expenses and/or claims incurred by the Insured Person relating to, arising from, as a consequence of, or in connection with, directly or indirectly, any of the following acts, omissions, events, occurrences or conditions:

(1) Diving by the Insured Person without holding a recognized certificate issued by an Authoritative Diving Body for the type of diving being undertaken, or not under professional instruction

(2) Diving without proper and well-maintained equipment in good working order and/or contrary to the guidelines, codes of good practice and/or recommendations set forth by the Authoritative Diving Body under which the Insured Person has been certified

(3) Diving to depths greater than thirty (30) meters, or diving requiring decompression stops

(4) Solo diving

(5) Any form of cave diving

(6) Flying within twenty-four (24) hours of the last dive or diving within ten (10) hours of flying

(7) Diving for hire, reward, or treasure

(8) Diving while suffering from a cold, influenza or any other condition, Illness or Injury causing an obstruction of the sinuses or ears, or diving while otherwise medically unfit to dive

(9) Diving by an Insured Person under twelve (12) years of age or over sixty-five (65) years of age

(10) Willfully self-inflicted Injury or Illness, the effects of alcohol or drugs (other than as prescribed by a licensed Physician in full awareness of the Insured Person's sub-aqua activities) and any self-exposure to needless peril (unless in an attempt to save human life)

(11) Any condition for which the Insured Person was undergoing, recovering from or awaiting Treatment immediately prior to the sub-aqua activities

(12) Diving with artificial or other underwater breathing apparatus containing any gas other than compressed air.

It is a condition precedent to the Company's liability under this insurance that any prospective diver applying for coverage under this insurance is medically fit to dive. If in any doubt, the Insured Person should refrain from participating in Sports Diving until medical advice and approval has been obtained from a qualified Physician.

P. **RETURN OF MORTAL REMAINS**: In the event of the death of the Insured Person during the Period of Coverage as a result of an Illness or Injury covered under this insurance while the Insured Person is outside of his/her Home Country, the Company will reimburse the authorized personal representative or the estate of the Insured Person up to the amount shown in the BENEFIT SUMMARY for the costs and expenses incurred to return the Insured Person's Mortal Remains to his/her Home Country and thereafter to the place of burial or other final disposition (but not including any costs of burial or other disposition); provided, however, that the Company must approve all costs and expenses related to the return of the Insured Person's Mortal Remains in advance as a condition to the availability of this benefit; or up to the amount shown in the BENEFIT SUMMARY for preparation, local burial or cremation of the Insured Person's mortal remains at the place of death in accordance with the commonly accepted cultural and religious beliefs practiced by the Insured Person. Coverage is not provided for burial and cremation costs incurred for religious practitioners, flowers, music, food or beverages.

Q. **SUPPLEMENTAL ACCIDENT BENEFIT**: In the event of an Accident which gives rise to benefits covered under the Terms of this insurance, as a supplemental benefit the Company will also reimburse the Insured Person up to the amount shown in the BENEFIT SUMMARY related to the Treatment of an Injury resulting from such Accident, before applying any Deductible.

R. **TRANSPLANT**: Subject to the Terms of this insurance, the insurance plan shown in the Declaration, and the conditions and restrictions set forth below, the Company will reimburse the Insured Person up to the amount shown in the BENEFIT SUMMARY for the following costs, Charges and expenses incurred by the Insured Person with respect to a Covered

Transplant obtained or received by the Insured Person while this Policy is in effect, so long as such costs, Charges or expenses are Usual, Reasonable and Customary:

(1) Eligible Medical Expenses incurred by a live donor will be treated as if they were the expenses of the Insured Person receiving a Covered Transplant if the Insured Person received an organ or tissue of the live donor

(2) organ procurement and harvesting costs, including donor preparation, excluding acquisition or purchase of the actual organ or tissue, up to the amount shown in the BENEFIT SUMMARY

(3) Charges incurred for pre-transplant evaluation, the Covered Transplant procedure, re-transplantation (if incurred during the initial Hospital confinement as an Inpatient for the Covered Transplant), and post-transplant care

(4) reasonable travel and lodging expenses of the Insured Person if travel of more than fifty (50) miles is necessary to receive the Covered Transplant Treatment and supplies from a Managed Transplant System Network Provider, up to the amount shown in the BENEFIT SUMMARY.

Transplant Pre-certification: To become eligible for Transplant benefits under this insurance, the Transplant must be a Covered Transplant. The Insured Person must receive all Covered Transplant Treatment and supplies from an independent transplant network provider ("Managed Transplant System Network") approved by the Company through the Plan Administrator and the Covered Transplant must be Pre-certified by the Company in accordance with the Terms of this insurance. If the Insured Person receives Covered Transplant Treatment and supplies from a provider that is not an approved member of the Company's independent Managed Transplant System Network, or if the transplant is not a Covered Transplant or is not properly Pre-certified, no Transplant benefits shall be available under this insurance. Neither the Company nor the Plan Administrator shall have any right, obligation, or authority of any kind to ultimately select Physicians, Hospitals, or other healthcare providers for the Insured Person or to make any medical Treatment decisions for or on behalf of the Insured Person regarding transplants, and all such decisions shall be made solely and exclusively by the Insured Person and/or his/her family members, treating Physicians, and other healthcare providers. All claims for Transplant benefits are subject to the Terms of this insurance and the insurance plan shown in the BENEFIT SUMMARY.

S. EXCLUSIONS: Except as expressly provided for in the BENEFIT SUMMARY, all Charges, costs, expenses and/or claims incurred by the Insured Person, and directly or indirectly relating to or arising or resulting from or in connection with any of the following acts, omissions, events, conditions, Charges, consequences, claims, Treatment (including diagnoses, consultations, tests, examinations and evaluations related thereto), services and/or supplies are expressly excluded from coverage under this insurance, and the Company shall provide no benefits or reimbursements and shall have no liability or obligation for any coverage thereof or therefor:

(1) WAR; MILITARY ACTION: The Company shall not be liable for and will not provide coverage or benefits for any claim or Charges incurred with respect to any Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising or incurred in connection with or as a result of any of the following acts or occurrences:

(a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war

(b) mutiny, riot, strike, military or popular uprising, insurrection, rebellion, revolution, military or usurped power

(c) any act of any person acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the Government de jure or de facto or to the influencing of it by violence of any type

(d) martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege

(e) any use of radiological, chemical, nuclear or biological weapons or any other radiological, chemical, nuclear or biological events of any type (including in connection with an act of Terrorism).

Any claim, Charges, Illness, Injury or other consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether or not directly or indirectly, proximately or remotely occasioned by, or contributed to by, traceable to, or arising in connection with, any of the said occurrences shall be deemed and considered to be consequences for which the Company shall not be liable under this Policy, except to the extent that the Insured Person shall prove that such claim, Charges, Illness, Injury or other consequence happened independently of the existence of such abnormal conditions and/or occurrences.

(2) TERRORISM: The Company shall not be liable for and will not provide coverage or benefits for any claim or charges, Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with any act of Terrorism. Further, the Company shall not be liable for and will not provide any coverage or benefits for any claim, charges, Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with the following:

(a) the Insured Person's active and voluntary planning or coordination of or participation in any act of Terrorism

(b) any act of Terrorism that takes place in a location, post, area, territory or country for which a Travel Warning was issued or in effect on or within six (6) months prior to the Insured Person's date of arrival in said location, post, area, territory or country

(c) any act of Terrorism that takes place in a location, post, area, territory or country for which a Travel Warning becomes effective or is in effect on or after the Insured Person's date of arrival in said location, post, area, territory or country,

and the Insured Person unreasonably fails or refuses to heed such warning and thereafter remains in said location, post, area, territory or country.

(3) **PRE-EXISTING CONDITIONS**:

(a) Charges relating directly or indirectly to Unknown Conditions are excluded from coverage under this insurance until the Insured Person has maintained coverage under this insurance plan continuously for the number of months shown in the BENEFIT SUMMARY.

(b) Charges incurred, obtained or received by an Insured Person relating directly or indirectly to any Non-disclosed Condition are excluded under this insurance.

(4) **ILLNESS OR SURGERY WITHIN 180 DAYS**: Charges for Treatment of the following Illnesses or Surgeries which manifest themselves and/or involve procedures which take place and/or are recommended during the first one-hundred eighty (180) days of coverage under this insurance plan, beginning on the Initial Effective Date: acne, asthma, allergies, any condition of the breast, any condition of the prostate, tonsillectomy, adenoidectomy, hemorrhoids or hemorrhoidectomy, disorders of the reproductive system, diverticulitis, hysterectomy, hernia, intervertebral disc disease, gall bladder disease or gall stones and kidney stones. Note: Coverage and/or benefits for these Illnesses or Surgeries (or for similar or different Illnesses or Surgeries) may be separately or further limited.

(5) **MATERNITY AND NEWBORN CARE**: Charges for pre-natal care, delivery, post-natal care, and care of Newborns, including complications of Pregnancy, miscarriage, complications of delivery and/or of Newborns are excluded from this insurance

(6) **MENTAL OR NERVOUS DISORDERS**: Charges for Treatment of Mental or Nervous Disorders are excluded from coverage under this insurance until the Insured Person has maintained coverage under this insurance plan continuously for the number of months shown in the BENEFIT SUMMARY

(7) Charges for any Treatment or supplies that are:

(a) not incurred, obtained or received by an Insured Person during the Period of Coverage

(b) not presented to the Company for payment by way of a complete Proof of Claim within ninety (90) days of the date such Charges are incurred

(c) not administered or ordered by a Physician

(d) not Medically Necessary for the diagnosis, care or Treatment of the physical or mental condition involved. This also applies when and if they are prescribed, recommended or approved by the attending Physician

(e) provided at no cost to the Insured Person or for which the Insured Person is not otherwise liable

(f) in excess of Usual, Reasonable, and Customary

(g) incurred by an Insured Person who was HIV + on or before the Initial Effective Date of this insurance, whether or not the Insured Person had knowledge of his/her HIV status prior to the Effective Date, and whether or not the Charges are incurred in relation to or as a result of said status. This exclusion includes charges for any Treatment or supplies relating to or arising or resulting directly or indirectly from HIV, AIDS virus, AIDS related Illness, ARC Syndrome, AIDS and/or any other Illness arising or resulting from any complications or consequences of any of the foregoing conditions

(h) provided by or at the direction or recommendation of a chiropractor, unless ordered in advance by a Physician

(i) performed or provided by a Relative of the Insured Person

(j) not expressly included in the ELIGIBLE MEDICAL EXPENSES provision

(k) provided by a person who resides or has resided with the Insured Person or in the Insured Person's home

(l) required or recommended as a result of complications or consequences arising from or related to any Treatment, Illness, Injury, or supply excluded from coverage or which is otherwise not covered under this insurance

(m) for Congenital Disorders and conditions arising out of or resulting there from

(8) Except as incurred using Teladoc, Telemedicine consultations through an established Telemedicine protocol system will be considered individually based on medical necessity and appropriateness as determined by the Company under the plan

(9) Charges incurred for failure to keep a scheduled appointment

(10) Charges incurred for Surgeries, Treatment or supplies which are Investigational, Experimental, and for research purposes

(11) Charges incurred related to genetic medicine, genetic testing, surveillance testing and/or wellness screening procedures for genetically predisposed conditions indicated by genetic medicine or genetic testing, including, but not limited to amniocentesis, genetic screening, risk assessment, preventive and prophylactic surgeries recommended by genetic testing, and/or any procedures used to determine genetic pre-disposition, provide genetic counseling, or administration of gene therapy

(12) Charges incurred for testing that attempts to measure aspects of an Insured Person's mental ability, intelligence, aptitude, personality and stress management. Such testing may include but is not limited to psychometric, behavioral and educational testing

(13) Charges incurred for Custodial Care

(14) Charges incurred for Educational or Rehabilitative Care that specifically relates to training or retraining an Insured Person to function in a normal or near-normal manner. Such care may include but is not limited to job or vocational training, counseling, occupational therapy and speech therapy

(15) Charges for weight modification or any Inpatient, Outpatient, Surgical or other Treatment of obesity (including without limitation morbid obesity), including without limitation wiring of the teeth and all forms or procedures of bariatric Surgery by whatever name called, or reversal thereof, including without limitation intestinal bypass, gastric bypass, gastric banding, vertical banded gastroplasty, biliopancreatic diversion, duodenal switch, or stomach reduction or stapling

(16) Charges for modification of the physical body in order to change or improve or attempt to change or improve the physical appearance or psychological, mental or emotional well-being of the Insured Person (such as but not limited to sex-change Surgery or Surgery relating to sexual performance or enhancement thereof)

(17) Charges or Treatment for cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is Medically Necessary and is directly related to and/or follows a Surgery which was covered under this insurance

(18) elective Surgery or Treatment of any kind

(19) Charges incurred for any Treatment or supply that either promotes or prevents or attempts to promote or prevent conception, insemination (natural or otherwise) or birth, including but not limited to: artificial insemination; oral contraceptives; Treatment for infertility or impotency; vasectomy, or reversal of vasectomy; sterilization; reversal of sterilization; surrogacy or abortion

(20) Charges incurred for any Treatment or supply that either promotes, enhances or corrects or attempts to promote, enhance or correct impotency or sexual dysfunction

(21) any Illness or Injury sustained while taking part in, practicing or training for: Amateur Athletics; Professional Athletics; or athletic activities that are sponsored by any Governing Body or Authority including the National Collegiate Athletic Association, any other collegiate sanctioning or Governing Body or the International Olympic Committee

(22) any Illness or Injury sustained while taking part in activities designated as Adventure Sports, which are limited to the following: abseiling; BMX; bobsledding; bungee jumping; canyoning; caving; hot air ballooning; jungle zip lining; parachuting; paragliding; parascending; rappelling; skydiving; spelunking; whitewater kayaking or whitewater rafting in water less than Class V difficulty; wildlife safaris; and windsurfing

(23) any Illness or Injury sustained while taking part in activities designated as Extreme Sports, which include but are in no way limited to the following (and include any combination or derivative of the following): BASE jumping; cave diving; cliff diving; downhill mountain biking and racing; extreme skiing; freediving; free flying; free running; free skiing; freestyle scootering; gliding; heli-skiing; ice canoeing; ice climbing; kitesurfing; mixed martial arts; motocross; motorcycle racing; motor rally; mountaineering above elevation of 4500 meters from ground level; parkour; piloting a commercial or non-commercial aircraft; powerbocking; scuba diving or sub aqua pursuits below a depth of 50 meters; snowmobile racing; truck racing; whitewater kayaking or whitewater rafting Class V and higher difficulty; and wingsuit flying

(24) any Illness or Injury sustained while taking part in snow skiing, snowboarding or snowmobiling where the Insured Person is in violation of applicable laws, rules or regulations of a ski resort, including backcountry skiing, off-piste, out of bounds or in unmarked or unpatrolled areas

(25) any Illness or Injury sustained while taking part in athletic or recreational activities where the Insured Person is not physically or medically fit or does not hold the necessary qualifications to engage in said activities

(26) any Illness or Injury sustained while taking part in Collision Sports

(27) any Illness or Injury sustained while participating in any sporting, recreational or adventure activity where such activity is undertaken against the advice or direction of any local authority or any qualified instructor or contrary to the rules, recommendations and procedures of a recognized governing body for the sport or activity

(28) any Illness or Injury sustained while participating in any activity where such activity is undertaken in disregard of or against the recommendations, Treatment programs, or medical advice of a Physician or other healthcare provider

(29) any Injury or Illness sustained as a result of being under the influence of or due wholly or partly to the effects of alcohol, liquor, intoxicating substance, narcotics or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician but not for the Treatment of Substance Abuse

(30) any Injury or Illness sustained while operating a moving vehicle after consumption of intoxicating liquor or drugs in excess of the applicable blood/alcohol legal limit, other than drugs taken in accordance with Treatment prescribed and directed by a Physician. For purposes of this exclusion, "vehicle" shall include motorized devices regardless of whether or not a driver or operator license is required (including watercraft and aircraft) and non-motorized bicycles and scooters for which no permit or license is required

(31) any willfully Self-inflicted Injury or Illness

(32) any sexually transmitted or venereal disease

(33) any testing for the following when not Medically Necessary: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS

(34) any Illness or Injury resulting from or occurring during the commission of a violation of law by the Insured Person, including, without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations

(35) any Substance Abuse

(36) biofeedback, recreational, sleep or music therapy

(37) orthoptics, visual therapy or visual eye training

(38) any non-surgical Illness or Treatment of the feet, including without limitation: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; Treatment of weak, strained, flat, unstable or unbalanced feet; metatarsalgia, bone spurs, hammer toes or bunions; and any Treatment or supplies for corns, calluses or toenails; except as otherwise expressly set forth

(39) hair loss, including without limitation wigs, hair transplants or any drug that promises to promote hair growth, whether or not prescribed by a Physician

(40) any sleep disorder, including without limitation sleep apnea

(41) any exercise and/or fitness program or equipment, whether or not prescribed or recommended by a Physician

(42) any exposure to any non-medical nuclear or atomic radiation, and/or radioactive material(s)

(43) any organ or tissue or other transplant or related services, Treatment or supplies except as otherwise expressly set forth

(44) any artificial or mechanical devices designed to replace human organs temporarily or permanently after termination of Inpatient status

(45) any transplant expenses incurred outside the Company's approved independent Managed Transplant System Network

(46) any efforts to keep a donor alive for a transplant procedure

(47) any Covered Transplant in excess of one (1) during any twelve (12) month period of coverage under this insurance plan, except re-transplantation Charges if incurred during the initial Covered Transplant Hospitalization

(48) Any Illness or Injury incurred in the Host Country as a result of epidemics, pandemics, public health emergencies, Natural Disasters, or other disease outbreak conditions that may affect a person's health when, prior to the Insured Person's entry into the Host Country, any of the following were issued regarding the Host Country

(a) the World Health Organization had issued an Emergency Travel Advisory

(b) the United States Centers for Disease Control & Prevention had issued a Warning Level 3 (avoid nonessential travel)

(c) a similar governmental agency of the Insured Person's Home Country had published, communicated or issued a Travel Warning restriction or official declaration informing the public about such health issues before the Insured Person traveled to the Host Country

(49) Charges incurred for eyeglasses, contact lenses, hearing aids or hearing implants and Charges for any Treatment, supply, examination or fitting related to these devices, or for eye refraction for any reason

(50) Charges incurred for eye Surgery, such as but not limited to radial keratotomy, when the primary purpose is to correct or attempt to correct nearsightedness, farsightedness, or astigmatism

(51) Charges incurred for Treatment or supplies for temporomandibular joint (TMJ) including but not limited to TMJ syndrome, craniomandibular syndrome, chronic TMJ pain, orthognathic Surgery, Le-Fort Surgery or splints

(52) Charges incurred by the Insured Person for the Treatment of his/her Newborns (or for supplies related thereto)

(53) Charges incurred for any immunizations and/or Routine Physical Examinations except as otherwise expressly provided for hereunder

(54) Charges incurred for any travel, meals, transportation and/or accommodations, except as otherwise expressly provided for in this insurance

(55) Except as otherwise expressly provided for in this insurance, Charges or expenses incurred for nonprescription drugs, medicines, vitamins, food extracts, or nutritional supplements; IV vitamin or herbal therapy; drugs or medicines not approved by the U.S. Food and Drug Administration or which are considered "off-label" drug use; and for drugs or medicines not prescribed by a Physician

(56) Charges incurred for Dental Treatment, except as specifically provided for hereunder

(57) Wear and tear of teeth due to cavities and chewing or biting down on hard objects, such as but not limited to pencils, ice cubes, nuts, popcorn, and hard candies

(58) Dental Injury without associated face, skull, neck and/or jaws Injury or that can be evaluated and treated in a dental office

(59) Dental Treatment for services which provide oral care maintenance including tooth repair by fillings, root canals, tooth removal and x-rays

T. **DEFINITIONS**: Certain words and phrases used in this Policy are defined below. Other words and phrases may be defined elsewhere in this Policy, including where they are first used.

Accident: An Unexpected occurrence directly caused by external, visible means and resulting in physical Injury to the Insured Person.

Adventure Sports: Activities undertaken for the purposes of recreation, an unusual experience or excitement. These activities are typically undertaken outdoors and involve a medium degree of risk.

Affidavit of Eligibility: The properly completed form provided to the Company that certifies that an applicant is eligible to be covered under this insurance plan because they do not meet the citizenship and/or residency requirements of other insurance companies in the area where they reside.

AIDS: Acquired Immune Deficiency Syndrome, as that term is defined by the United States Centers for Disease Control.

Amateur Athletics: An amateur or other non-professional sporting, recreational, or athletic activity that is organized, sponsored and/or sanctioned, and/or involves regular or scheduled practices, games and/or competitions. Amateur Athletics does not include athletic activities that are non-organized, non-contact, non-collision, and engaged in by the Insured Person solely for recreational, entertainment or fitness purposes.

Ancillary Services: All hospital services for a patient other than room and board and professional services. Laboratory tests and radiology are examples of Ancillary Services.

Application: The fully answered and signed form entitled "Application" submitted by or on behalf of the Insured Person for acceptance into, renewal of coverage under, or Reinstatement in this insurance plan. The Application shall be incorporated in and become part of this Policy and the insurance contract. Any insurance agent/broker or other person or entity assigned to, soliciting, or assisting with the Application is the representative of the applicant/Insured Person and is not and shall not be deemed or considered as an agent or representative for or on behalf of the Company or the Plan Administrator.

ARC: AIDS related complex, as that term is defined by the United States Centers for Disease Control.

Charges: Any cost, fee or tax incurred for Eligible Medical Expenses incurred in the treatment of an Injury or Illness.

Child; Children: An Insured Person who is at least fourteen (14) days old but less than nineteen (19) years of age.

Class V: A section of a river, stream or other waterway or watercourse where the current moves with enough speed or force to meet, but not to exceed, the qualifications of Class V as determined by the International Scale of River Difficulty or as commonly published by a local authority or government agency.

Coinsurance: The payment by or obligations of the Insured Person for payment of Eligible Medical Expenses at the percentage specified in the BENEFIT SUMMARY contained herein and not including any applicable Deductible.

Collision Sports: A sport in which the participants purposely hit or collide with each other or inanimate objects, including the ground, with great force and limited to the following: American football, boxing, ice hockey, lacrosse, full contact martial arts, rodeo, rugby and wrestling.

Company: The Company, as referred to in this Policy, is Certain Underwriters at Lloyd's. This insurance and its risks are underwritten by the Company as the insurer and carrier, and the Company is solely obligated and liable for the coverage and benefits provided by this insurance.

Congenital Disorder: A physical abnormality, defect or medical condition existing at or before birth, regardless of cause, when diagnosed or treated.

Convalescent: Treatment, services and supplies provided to aid in the recovery of a patient to reach a degree of body functioning to permit self-care in essential daily activities.

Covered Transplant: A transplant involving the heart, heart/lung, lung, kidney, kidney/pancreas, liver and allogeneic or autologous bone marrow.

Custodial Care: Those types of Treatment, care or services, wherever furnished and by whatever name called, that are designed primarily to assist an individual in activities of daily life.

Declaration: The Declaration of Insurance issued by the Plan Administrator for and on behalf of the Company to the Insured Person contemporaneously with this Policy (and/or upon renewal or Reinstatement hereof) evidencing the Insured Person's insurance coverage under the Policy as evidenced by this Policy.

Deductible: The dollar amount, as selected on the Application and specified in the Declaration, that the Insured Person must pay of ELIGIBLE MEDICAL EXPENSES per Period of Coverage prior to receiving benefits or coverage under this insurance, and not including any applicable Coinsurance.

Dental Provider; Dentist: A person duly licensed to practice dentistry in the state or country in which the dental service is rendered.

Dental Treatment: Treatment or supplies relating to the care, maintenance or repair of teeth, gums or bones supporting the teeth, including dentures and preparation for dentures.

Disabled: A person who has a congenital or acquired mental or physical defect that interferes with normal functioning of the body system or the ability to be self-sufficient.

Durable Medical Equipment (DME): Equipment that meets the following criteria: prescribed by a physician; provides therapeutic benefits or enables individuals to perform certain tasks he or she is unable to undertake otherwise due to certain medical conditions or illnesses; can withstand repeated use; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of an Illness or Injury; and is appropriate for use in the home but may be transported to other locations to allow the individual to complete instrumental activities of daily living, which are more complex tasks required for independent living.

Educational or Rehabilitative Care: Care for restoration (by education or training) of a person's ability to function in a normal or near normal manner following an Illness or Injury. This type of care includes, but is not limited to job training, counseling, vocational or occupational therapy, and speech therapy.

Effective Date; Effective Date of Coverage: The date coverage for the Insured Person begins under the Terms of this Policy, as indicated on the Declaration.

Emergency: A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within twenty-four (24) hours, based upon a reasonable medical certainty. Immediate medical intervention and attention is required as a result of a severe, life threatening or potentially disabling condition.

Emergency Medical Evacuation: Emergency transportation from the Hospital or medical Facility where the Insured Person is located to a non-local Hospital or medical Facility following recommendation by the attending Physician who certifies, to a reasonable medical certainty, that the Insured Person has experienced:

(a) a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within twenty-four (24) hours; and

(b) where Medically Necessary Treatment cannot be provided locally, either in the Facility of the attending Physician or another local Facility.

EST: United States Eastern Standard Time.

Experimental: Any Treatment that includes completely new, untested drugs, procedures, or services, or the use of which is for a purpose other than the use for which they have previously been approved; new drug procedure or service combinations; and/or alternative therapies which are not generally accepted standards of current medical practice.

Extended Care Facility: An institution, or a distinct part of an institution, which is licensed as a Hospital, Extended Care Facility or rehabilitation Facility by the state or country in which it operates; and is regularly engaged in providing twenty-four (24) hour skilled nursing care under the regular supervision of a Physician and the direct supervision of a Registered Nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation prescribed by a Physician; and provides each patient with active Treatment of an Illness or Injury. Extended Care Facility does not include a facility primarily for rest, the aged, Substance Abuse, Custodial Care, nursing care, or for care of Mental or Nervous Disorders or the mentally incompetent.

Extreme Sports: Recreational activities involving a high degree of risk. These activities often involve speed, height, a high level of physical exertion, and/or highly specialized gear and often carry the potential risk of serious or permanent physical injury and even death.

Facility: Licensed health care entity such as a Hospital, clinic, rehabilitation, and/or Extended Care Facility.

Family: An Insured Person, his/her Spouse, and any Child or Children who are covered as an Insured Person under this insurance plan.

Governing Body or Authority: A nationally-recognized controlling organization for a sport or activity, or an organization that provides guidelines and recommendations in safety practices for a sport or activity.

HIV: Human Immunodeficiency Virus, as that term is defined by the United States Centers of Disease Control.

HIV +: Laboratory evidence defined by the United States Centers for Disease Control as being positive for Human Immunodeficiency Virus infection.

Home Country: For United States citizens, the Home Country is the United States. For non-United States citizens, the Home Country is the country of which the Insured Person is a citizen or national; including any country where the Insured Person maintains his/her primary residence or usual place of abode and any country of which the Insured Person is the possessor of a validly issued passport. In the event there is more than one (1) Home Country under the above-listed criteria, the Home Country is the country meeting the above-listed criteria and listed by the Insured Person as his or her country of residence on the Application.

Home Health Care Agency: A public or private agency or one of its subdivisions, which operates pursuant to law; and is regularly engaged in providing Home Nursing Care under the supervision of a Registered Nurse; and maintains a daily

record on each patient; and provides each patient with a planned program of observation and Treatment prescribed by a Physician.

Home Nursing Care: Services and/or Treatment provided by a Home Health Care Agency and supervised by a Registered Nurse that are directed toward the Convalescent care of a patient, provided always that such care is Medically Necessary and in lieu of Medically Necessary Inpatient care. Home Nursing Care does not include services or Treatment primarily for Custodial Care or rehabilitative purposes.

Hospice: An institution which operates as a hospice; is licensed by the state or country in which it operates; and operates primarily for the reception, care and palliative control of pain for terminally ill persons who have, as certified by a Physician, a life expectancy of not more than six (6) months.

Hospital: An institution which operates as a hospital pursuant to law; is licensed by the state or country in which it operates; operates primarily for the reception, care, and Treatment of sick or injured persons as Inpatients; provides twenty-four (24) hour nursing service by Registered Nurses on duty or call; has a staff of one or more Physicians available at all times; provides organized Facilities and equipment for diagnosis and Treatment of acute medical, surgical or mental/nervous conditions on its premises; and is not primarily a long-term care Facility, Extended Care Facility, nursing, rest, Custodial Care, convalescent home, place for the aged, drug addicts or abusers, alcoholics or runaways, or similar establishment.

Hospitalization; Hospitalized: Confined and/or treated in a Hospital as an Inpatient.

Host Country: The country or countries other than the Home Country that the Insured Person is traveling to or within.

Illness: A sickness, disorder, illness, pathology, abnormality, malady, morbidity, affliction, disability, defect, handicap, deformity, birth defect, congenital defect, symptomatology, syndrome, malaise, infection, infirmity, ailment, disease of any kind, or any other medical, physical or health condition. Provided, however, that Illness does not include learning disabilities, or attitudinal disorders or disciplinary problems. All Illnesses that exist simultaneously or which arise subsequent to a prior Illness and which directly or indirectly relate to or result or arise from the same or related causes or as a consequence thereof or from one another are considered to be a single Illness. Further, if a subsequent Illness results or arises from causes or consequences that are the same as or related to the causes or consequences of a prior Illness, the subsequent Illness will be deemed to be a continuation of the prior Illness and not a separate Illness.

Implant: Any device, object, or medical item that is surgically imbedded, inserted, or installed for medical purposes within or on a patient's body, including for orthotic or prosthetic reasons.

Initial Effective Date: The date the Insured Person originally obtains coverage under the Global Medical Insurance plan and maintains continuous unbroken coverage thereafter.

Injury: Bodily injury resulting or arising directly from an Accident. All Injuries resulting or arising from the same Accident shall be deemed to be a single Injury.

Inpatient: A person who has been admitted to and charged by a Hospital for bed occupancy for purposes of receiving Inpatient Hospital services. Generally, a patient is considered an Inpatient if billed by the Hospital for Charges as an Inpatient, and formally admitted as an Inpatient with the expectation that person will occupy a bed and (a) remain at least overnight or (b) is expected to need Hospital care for twenty-four (24) hours or more.

Insured Person: The person named as the Insured Person on the Declaration.

Intensive Care Unit: An area or unit of a Hospital that meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations for Special Care Units.

Interfacility Ambulance Transfer: Movement of the patient locally within the United States from one licensed health care Facility to another licensed health care Facility via air or land ambulance. (Examples: Hospital to Hospital, clinic to Hospital, Hospital to Extended Care Facility.) The Interfacility Ambulance Transfer must be Medically Necessary and Pre-certified in advance to be an Eligible Medical Expense.

Investigational: Treatment that includes drugs, procedures, or services that are still in the clinical stages of evaluation and not yet released for distribution by the US Food and Drug Administration.

Known Disclosed Condition: An Illness or Injury that meets both of the following criteria:

(a) Was diagnosed, treated, or known to the Insured prior to completing the Application for coverage under this insurance

(b) Was fully disclosed on the Application.

Local Ambulance Transport; Local Ambulance Expense: Transportation and accompanying Treatment provided by designated, licensed, qualified, professional emergency personnel from the location of an Accident, Injury or acute Illness to a Hospital or other appropriate health care Facility. Local ambulance transport does not include subsequent Interfacility transfers of admitted patients.

Maximum Limit: The cumulative total dollar amount of benefit payments and/or reimbursements available to an Insured Person under this insurance during the lifetime of the Policy. When the Maximum Limit is reached, no further benefits, reimbursements or payments will be available under this insurance.

Medically Necessary; Medical Necessity: A Treatment, service, medicine or supply which is necessary and appropriate for the diagnosis or Treatment of an Illness or Injury based on generally accepted standards of current medical practice as

determined by the Company. By way of example but not limitation, a service, Treatment, medicine or supply will not be considered Medically Necessary or a Medical Necessity if it is provided or obtained only as a convenience to the Insured Person or his/her provider; and/or if it is not necessary or appropriate for the Insured Person's Treatment, diagnosis or symptoms; and/or if it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or Treatment.

Mental or Nervous Disorders: Any mental, nervous, or emotional Illness which generally denotes an Illness of the brain with predominant behavioral symptoms; an Illness of the mind or personality, evidenced by abnormal behavior; or an Illness or disorder of conduct evidenced by socially deviant behavior. Mental or Nervous Disorders include without limitation: psychosis; depression; schizophrenia; bipolar affective disorder; any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases as published by the U.S. Department of Health and Human Services; and those psychiatric and other mental Illnesses listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders published by the American Psychiatric Association. For purposes of this insurance, Mental or Nervous Disorders do not include Substance Abuse, learning disabilities, developmental delay, conduct disorders, behavioral problems, and attitudinal disorders or disciplinary problems.

Mortal Remains: The bodily remains or ashes of an Insured Person.

Natural Disaster: Widespread disruption of human lives by disasters such as flood, drought, tidal wave, fire, hurricane, earthquake, windstorm, or other storm, landslide, or other natural catastrophe or event resulting in migration of the human population for its safety. The occurrence must be a disaster that is due entirely to the forces of nature and could not reasonably have been prevented.

Newborn: An infant from the moment of birth through the first thirty-one (31) days of life.

Non-disclosed Condition: An Illness or Injury diagnosed, treated, or known to the Insured prior to completing the Application for coverage under this insurance but not disclosed, revealed, listed, or otherwise made known on the Application.

Outpatient: A person who receives Medically Necessary Treatment by a Physician or other healthcare provider and is not an Inpatient, regardless of the hour that the person arrived at the hospital, whether a bed was used, or whether the person remained in the hospital past midnight.

Period of Coverage: The period beginning on the Effective Date of Coverage of this Policy and ending on the earliest of the following dates:

(a) the termination date specified in the Declaration; or

(b) the termination date as determined in accordance with the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF COVERAGE FOR INSURED PERSONS provision.

The Period of Coverage can be no more than twelve (12) consecutive months.

Physician: A duly educated, trained and licensed practitioner of the medical arts. A Physician must be currently and appropriately licensed by the state or country in which the services are provided, and the services must be within the scope of that license, training, experience, competence, and health professions standards of practice.

Plan Administrator: The Plan Administrator for this insurance is International Medical Group®, Inc., 2960 North Meridian Street, Indianapolis, Indiana, 46208, Telephone Number +1.317.655.4500, or +1.800.628.4664, Fax Number +1.317.655.4505, Website: http://www.imglobal.com, Email: insurance@imglobal.com. As the Plan Administrator, International Medical Group, Inc., acts solely as the disclosed and authorized agent and representative for and on behalf of the Company, and does not have, and shall not be deemed, considered or alleged to have any, direct, indirect, joint, several, separate, individual, or independent liability, responsibility or obligation of any kind under the Declaration or this Policy to the Insured Person or to any other person or entity, including without limitation to any Physician, Hospital, Extended Care Facility, Home Health Care Agency, or any other health care or medical service provider or supplier.

Podiatry Care: Care of the feet, including Treatment of for corns, calluses or toenails weak, strained, flat, unstable or unbalanced feet, metatarsalgia, bone spurs, hammer toes or bunions.

Policy; Policy of Insurance: This document, including any Riders, as issued to the Insured Person, which describes and provides an outline and evidence of eligible insurance coverage and benefits payable to or for the benefit of the Insured Person under this Policy. The Application is incorporated herein by this reference and made a part hereof.

Pre-certification; Pre-certify: A general determination of Medical Necessity only, made by the Company in reliance and based upon the completeness and accuracy of the information provided by the Insured Person and/or the Insured Person's healthcare or medical service providers, guardians, Relatives and/or proxies at the time thereof. Pre-certification is not an assurance, authorization, pre-authorization or verification of coverage, a verification of benefits, or a guarantee of payment.

Pre-existing Condition: Any Illness, Injury, sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment that, with reasonable medical certainty, existed at the time of Application or at any time prior to the Effective Date of this insurance, whether or not previously manifested, symptomatic or known, diagnosed, Treated, or disclosed to the Company prior to the Effective Date, and including any and all chronic, subsequent or recurring complications or consequences related thereto or resulting or arising therefrom.

Pregnancy; Pregnant: The process of growth and development within a woman's reproductive organs of a new individual from the time of conception through the phases where the embryo grows and fetus develops to birth.

Premium: The Premium payments required to effectuate and maintain the Insured Person's insurance coverage and benefits under this insurance, in the amounts and at the times ("Due Dates") established by the Company in its sole discretion from time to time.

Professional Athletics: A sport activity, including practice, preparation, and actual sporting events, for any individual or organized team that is a member of a recognized professional sports organization; is directly supported or sponsored by a professional team or professional sports organization; is a member of a playing league that is directly supported or sponsored by a professional team or professional sports organization; or has any athlete receiving for his or her participation any kind of payment or compensation, directly or indirectly, from a professional team or professional sports organization.

Proof of Claim: Duly completed and signed claim form, authorization to release medical information, Physician, Hospital and other healthcare provider's statement detailing out the cost and services rendered and proof of payment for services rendered. Refer to the PROOF OF CLAIM provision for further details.

Radiology: Specialty services that use medical imaging to diagnose and treat diseases seen within the body. Imaging techniques used in radiology include X-ray, radiography, ultrasound, computed tomography (CT), nuclear medicine including positron emission tomography (PET), and magnetic resonance imaging (MRI).

Registered Nurse: A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." after his or her name.

Relative: A parent, legal guardian, spouse, son, daughter, or immediate family member of the Insured Person.

Renewal Premium: The first Premium payment of each Period of Coverage. The Renewal Premium does not apply to the first Period of Coverage.

Rider: Any exhibit, schedule, attachment, amendment, endorsement, Rider or other document attached to, issued in connection with, or otherwise expressly made a part of or applicable to this Policy, the Declaration, or the Application, as the case may be.

Routine Physical Examination: Examination of the physical body by a Physician for preventative or informative purposes only, and not for the Treatment of any previously manifested, symptomatic, diagnosed or known Illness or Injury.

Self-inflicted: Action or inaction by the Insured Person that the Insured Person consciously understands will or may cause or contribute, directly or indirectly, to his or her personal Injury or Illness. Self-inflicted specifically includes failure of an Insured Person to follow his or her doctor's orders, complete prescriptions as directed, or follow any health care protocol or procedures designed to return or maintain his or her health.

Short Rate Cancellation Table: The table used by the Company to calculate Short Rate Earned Premium in the event of cancellation. A copy of this table is available to the Insured Person upon request.

Sports Diving: Recreational underwater diving activities requiring the use of underwater or artificial breathing apparatus, and carried out in strict accordance with the guidelines, codes of good practice, and recommendations for safe diving practices as established by an Authoritative Diving Body.

Spouse: An Insured Person's legal Spouse or domestic partner. Such relationship must have met all requirements of a valid marriage contract, domestic partnership, or civil union in the state or country of residence where the parties' ceremony was performed.

Substance Abuse: Alcohol, drug or chemical abuse, misuse, illegal use, overuse or dependency.

Surgery; Surgical Procedure: An invasive diagnostic or surgical procedure, or the Treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

Teladoc: A phone or video consultation provided by Teladoc Physicians, PA, a network of board-certified providers in the United States available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for non-emergency medical issues. Teladoc does not replace existing primary care Physician relationships, but supplements them.

Telemedicine: The use of medical information (beyond a verbal history) exchanged from one healthcare provider site to another via electronic communications to improve patients' health status. Videoconferencing, transmission of still images, and remote monitoring of vital signs are all considered part of Telemedicine. Telemedicine services that would be considered for Medical Necessity and appropriateness by the Company under the plan would include without limit:

(a) Specialist referral services which typically involve a specialist assisting a general practitioner in rendering a diagnosis to guide Treatment.

(b) Patient consultations using telecommunications to provide medical data, which may include audio, still or live images, between a patient and a Physician or other healthcare provider for use in rendering a diagnosis and Treatment plan. This might originate from a remote clinic to a Physician's office using a direct transmission link or may include communicating electronically.

(c) Remote patient monitoring using devices to remotely collect and send data from a medical Facility to a monitoring station for interpretation. Such applications might include a specific vital sign, such as blood glucose or heart ECG.

Terms: All Terms, provisions, conditions, definitions, deductibles, coinsurance, limits, sub-limits, limitations, wordings, restrictions, requirements, qualifications and/or exclusions that bind the Insured Person as set forth in this Policy, Application and any Riders.

Terrorism: Criminal acts, including against civilians, committed with the intent to cause death or serious bodily injury, or taking of hostages, with the purpose to provide a state of terror in the general public or in a group of persons or particular persons, intimidate a population, or compel a government or international organization to do or to abstain from doing an act.

Traumatic Dental Injury: An injury that includes:

(a) Trauma involving the face, skull, neck and/or jaws which resulted in loss of teeth or a serious dental Injury; and

(b) Injury requiring evaluation and Treatment in a Hospital Emergency room or a Hospital confinement setting.

Travel Warning: Published statement or website document issued by the United States Department of State, Bureau of Consular Affairs, Centers for Disease Control and Prevention, United Nations, World Health Organization, or similar government or non-governmental agency of the Insured Person's Home Country, warning that travel to specific identified countries, regions or locations is hazardous and is not advised.

Treated; Treatment: Any and all services and procedures rendered in the management and/or care of a patient for the purpose of identifying, diagnosing, treating, curing, preventing, controlling and/or combating any Illness or Injury, including without limitation: verbal or written advice, consultation, examination, discussion, diagnostic testing or evaluation of any kind, pharmacotherapy or other medication, and/or Surgery.

Unexpected: Sudden, unintentional, not expected and unforeseen.

Unknown Condition: An Illness or Injury that was not previously manifested, symptomatic, known to the Insured Person, diagnosed, or Treated prior to the Effective Date.

Usual, Reasonable and Customary: A typical and reasonable amount of reimbursement for similar services, medicines, or supplies within the area in which the Charge is incurred. In determining the typical and reasonable amount of reimbursement, the Company may, in its reasonable discretion, consider one or more of the following factors, without limitation: the amount charged by the provider; the amount charged by similar providers or providers in the same or similar locality; the amount reimbursed by other payors for the same or comparable services, medicines or supplies in the same or similar locality; whether the services or supplies were unbundled or should have been included in the allowance of another service; the amount reimbursed by other payors for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or service as compared to the length of time required to perform other similar services; the length of time required to perform the procedure or service as compared to national standards and/or benchmarks; the severity or nature of the Illness or Injury being treated; and such other factors as the Company, in the reasonable exercise of its discretion, determines are appropriate.

Global Medical Insurance Gold

Policy of Insurance

Plan Administered by:

Plan Underwritten by: