SIGNATURE HEALTH PLAN

POLICY WORDING

PAG SPC Signature #7215
Rev 04-2014

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DEFINITIONS

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. In this Policy, use of the masculine gender, automatically encompass the feminine gender, unless the context clearly indicates otherwise. The following words and phrases are defined as follows.

ACCIDENT Means an unforeseen, unexpected, and unintentional event due exclusively to an external cause of a violent nature beyond the control of the Covered Person, resulting, directly and independently of all other causes, in bodily trauma to the Covered Person.

ACT OF TERRORISM Means an act, including but not limited to, the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

EMERGENCY MEDICAL EVACUATION/ AIR AMBULANC Refers to Emergency transportation on an Air Ambulance to the nearest suitable medical facility, for treatment of a Covered Condition for which treatment cannot be provided locally and the attending Physician, in consultation with the Company's Medical Consultant, considers the situation to be life threatening and transportation by any other method would result in loss of life or limb. Air Ambulance transportation must be pre-approved and coordinated by the Company and evacuation would be provided by the Company's Air Ambulance Provider.

ANNUAL MEDICAL EXAMINATION Means a medical examination that takes place outside of a Hospital as part of the Insured regular wellness examination, which is not for the purpose of the diagnosis, and treatment of an illness or injury.

AMBULATORY SURGICAL CENTER Means a facility which: has its primary purpose to provide elective surgical care; and admits and discharges a patient within the same working day; and is not part of a Hospital.

Ambulatory Surgical Center Does not include: (1) any facility whose primary purpose is the termination of pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained by a Dentist for the practice of dentistry.

APPLICATION FORM or DECLARATION FORM Means the form either written or via electronic transfer completed and signed by the Insured to request insurance coverage under this Policy. It includes any medical history, questionnaires, and other documents requested by Us prior to the issuance of the Policy.

BIRTH CENTER Means a facility, which is mainly a place for the delivery of a child or children at the end of a normal pregnancy; and is licensed as a Birth Center under the laws of the jurisdiction where it is located; and/or it meets all the following requirements:

1. It is operated in accordance with the laws of the jurisdiction where it is located;
2. It is equipped to perform all necessary routine diagnostic and laboratory tests;
3. It has trained staff and equipment required to properly treat potential emergencies of the mother and of the child;
4. It is operated under the full-time supervision of a Physician or a Registered Nurse (R.N.);
5. It has at all times a written agreement with at least one Hospital in the area for immediate acceptance of a patient in the event of complications;
6. It maintains medical records for each patient ; and
7. It is expected to discharge or transfer each patient within twenty-four (24) hours after the delivery.

CAESAREAN SECTION Means the delivery of the fetus through an abdominal incision in conditions where the vaginal route is contraindicated.

CERTIFICATE OF COVERAGE Means the document that is issued to the insured, which describes and provides an outline and evidence of eligible coverages and benefits to or for the benefit of the insureds under this policy.

CHIROPRACTIC SERVICES Uses the recuperative powers of the body and the relationship between the musculoskeletal structures and functions of the body, particularly of the spinal column and the nervous system, in the restoration and maintenance of health. Coverage as indicated in the Schedule of Benefits and prescribed by the attending Physician.

CLOSE RELATIVE Means You or Your Spouse, or Your or Your Spouse's Child, brother, sister or parent.

COMPANY or WE, US, or OUR Means the Premier Assurance Group SPC, Ltd on behalf of Global Assurance Segregated Portfolio (PA Group).

COMPLICATIONS OF PREGNANCY Means Cesarean section; ectopic pregnancy; or spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy do not include occasional spotting; Physician prescribed rest during the period of pregnancy, or morning sickness. Complications of Pregnancy also include, when pregnancy is not terminated (by delivery or otherwise), conditions which require Hospital Confinement, whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as, but not limited to:

1. Acute nephritis; or
2. Nephrosis; or
3. Cardiac decompensation; or
4. Missed abortion.

CONFINEMENT Means any admission and/or subsequent readmission(s) to a Hospital occurring within sixty (60) consecutive days for a related condition. A new Confinement begins when a Covered Person has been discharged from a Hospital for more than sixty (60) days.

COMPLICATIONS OF BIRTH Means any disorder related to the birth of a newborn, not caused by genetic factors, manifested during the first thirty-one (31) days of life, including, but not limited to hyperbilirubinemia (jaundice), cerebral hypoxia, hypoglycemia, prematurity, respiratory distress and birth trauma.

COMPLICATONS OF MATERNITY Is defined as, medical complications that may arise at the time of delivery, or the perinatal period (labor, delivery and post delivery periods) such as, heart, liver or renal failure, severe bleeding, coagulation disorders, hepatic encephalopathy, decompensation, shock, or other delivery related medical/surgical condition.

CONGENITAL CONDITIONS Are any heredity condition, birth defect, physical anomaly and/or any other disorder or defect, inherited or acquired genetic disorders, mutation which is existing from the time of birth or before birth, regardless of its cause, and whether or not it has been first identified or diagnosed at birth, after birth, or in later years condition from normal development present at birth, which may or may not be apparent at that time. These deviations, either physical or mental, include but are not limited to, genetic and non-genetic factors or inborn errors of metabolism. Benefits for such conditions are available only to newborn infants of a covered pregnancy having coverage effective with PA Group and subject to the limitation specified in this contract.

COORDINATION OF BENEFITS Means when an insured has coverage under two or more insurance contracts, and a service received is covered by more than one of the contracts, benefits will be reduced to avoid duplication of benefits available under the other contract(s), including benefits that would have been payable had the insured claimed for them. In no event will more than 100% of the allowable charge and or maximum benefit for the covered services be reimbursed. It is the duty of the Insured to inform PA Group of all other coverages.

COUNTRY OF NATIONALITY Means for the purpose of this policy, the country to which you hold a passport.

COUNTRY OF RESIDENCE/HOST COUNTRY Means the Country of Residence declared in the Application Form or Host Country where an Insured Person, and if applicable, an insured person's eligible Dependent(s) maintain legal domicile outside of the U.S.A, Puerto Rico, or U.S. Virgin Islands, and an Insured Person must be present and residing for at least one hundred eighty (180) days of any three hundred sixty five (365) days period.

COVERED EXPENSES Means the Reasonable and Customary Charges incurred by a Covered Person for Medically Necessary treatments, services or supplies covered under this Policy. Covered Expenses under this Policy also means certain Reasonable and Customary Charges incurred by a Covered Person in connection with Emergency Assistance Services, as stated in this Policy. Covered Expenses are listed in the benefits payable section of this policy.

COVERED PERSON Means an Insured or his Dependent(s) who has applied for and is entitled to coverage under this Policy and for whom the required premium has been paid.

CUSTODIAL CARE Means treatment or services which could be rendered safely and reasonably by a person not medically skilled, regardless of who recommends them and where they are provided, and which are designed mainly to help the patient with daily living activities. Such activities include but are not limited to:

- Help in walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
- Preparing meals or special diets;
- Moving the patient;
- Acting as a companion or sitter; and
- Supervising medication which can usually be self-administered.

Custodial Care includes: (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and (3) rest cures, respite care, and home care provided by family members.

Upon receipt and review of a claim, the Company or an independent medical review will determine if a service or treatment is Custodial Care.

DENTIST Is a legally qualified dentist who is licensed to do the dental work he or she performs by the duly constituted authority in the area in which the service is rendered, and when acting within the scope of such licensure.

DIAGNOSIS Means the determination by a physician or specialist of the nature of a disease or condition made from a study of the signs and symptoms of a disease or condition.

DURABLE MEDICAL EQUIPMENT Means any equipment prescribed by an M.D. designed for repeated and prolonged use and which is Medically Necessary to improve the functioning of a malformation of the body, treatment of an Illness, or to prevent further deterioration of a Covered Person's medical condition. Durable Medical Equipment includes non-motorized wheelchairs, Hospital beds, respirators and such other items as determined by the Company.

Not included is equipment such as whirlpools, portable whirlpool pumps, saunas ,baths, massage devices, overbed tables, elevators, communication aids, vision aids and telephone alert systems.

EFFECTIVE DATE Means that date on which coverage for a covered person begins under the Policy as indicated in the Certificate of Coverage.

ELECTIVE Means any care, service, treatment, or surgery performed at the choice of the patient, for which there is no Medical Necessity, and/or which does not treat an Illness or Injury (such as care provided primarily as a convenience or to improve or preserve appearance, self steem or future possible effects on health, posture or body function).

EMERGENCY ASSISTANCE AND EVACUATION CENTER Means a Company's 24-hour facility whose primary function is to provide orientation, referral services, and coordination of emergency services as described under this Policy to Covered Persons while this Policy is in force.

EMERGENCY CONDITION Means the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition, which, if the procedure or treatment was not performed right away could result in: loss of life or limb, significant impairment to bodily function, or permanent dysfunction of a body part, as determined by PA Group. This defined condition could result in emergency care required at the hospital level because the care could not safely and adequately have been provided outside of the hospital setting or adequate care was not available elsewhere in the area at the time and place. This defined condition could also result in an admission to the hospital or treatment facility as deemed by the physician.

EMERGENCY MEDICAL SERVICES The initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably result in:

- Permanently placing the Covered Insured's health in jeopardy;
- Causing other serious medical consequences;
- Causing serious impairment to bodily functions; or
- Causing serious and permanent dysfunction of any bodily organ or part;
- Causing loss of life or limb.

ESTIMATE Means the assumed cost for the services or procedures to be conducted either by a doctor, surgeon or laboratory for the services to the patient for a given diagnosis or as part of an investigation in order to obtain a diagnosis.

EXPERIMENTAL or INVESTIGATIVE EXPERIMENTAL or INVESTIGATIVE Means any treatment, procedure, equipment, drug, drug usage device or supply that fails to meet one or more of the following criteria:

1. Controlled studies published in peer review medical literature demonstrate that such service or supply has a net beneficial effect on health outcomes for a specific diagnosis; or under study, investigation, trial period or is limited to research; or

2. Such service or supply is in accordance with generally accepted standards of medical practice in the United States of America; or

3. At the time such service or supply is received by a Covered Person, it has been approved for the particular indication or application in question by the United States Food and Drug Administration (FDA) or other federal or state governmental agency whose approval is required in the United States, regardless of where the medical expenses are incurred.

EXTENDED CARE OR SKILLED NURSING FACILITY Is a licensed facility operating pursuant to law which is primarily engaged in providing (for compensation from its patients) skilled nursing care on an Impatient basis during the convalescent state or Illness or Injury under 24-hour a day supervision of a Physician or registered graduate Nurse, and which maintains permanent facilities for the care of ten or more bed patients. Such a facility must maintain complete medical records on each patient and have established methods and procedures for the dispensing and administering of drugs. In no event shall the term include a facility that is primarily:

1. A rest home, retirement home or home for the aged;
2. A school or similar institution;
3. Engaged in the care and treatment of Substance Abuse, or of mentally ill or senile persons; or
4. Engaged in Custodial Care.

HOSPITAL Means an institution that:

1. Is operated in accordance with the laws pertaining to Hospitals of the area in which the Hospital is located;
2. Which, for compensation from its patients and on an inpatient basis, is primarily engaged in providing surgical and medical diagnosis, treatment, and care of injured and sick persons;
3. Is under the supervision of a staff of duly licensed doctors of medicine;
4. Which continuously provides twenty-four (24) hours a day nursing service by registered nurses (R.N.); and
5. Which is not mainly a place for rest, for the aged, for addicts, for alcoholics or a nursing or convalescent home or institution;
6. Makes charges.

HOSPITAL INTENSIVE CARE UNIT Means a section, ward or wing within the Hospital which is separated from other facilities and is operated exclusively for the purpose of providing twenty four (24) hour professional medical treatment for critically ill patients and is equipped with supplies and equipment for such medical treatment.

HOME HEALTH CARE AGENCY Means an agency that:

1. Mainly provides skilled nursing and other therapeutic services; and
2. Is associated with a professional group which makes policy. This group must have at least one physician and one R.N.; and
3. Has full-time supervision by a physician or an R.N.; and
4. Keeps complete medical records on each patient; and
5. Has a full-time administrator; and
6. Meets licensing standards.

HOSPICE CARE Is care given to a Terminally Ill person by under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

HUMAN ORGAN Means a part of the human body which is self contained and performs a specific vital function.

INCURRED Means the date a disease, illness or injury occurred. Covered Person receives the service or supply for which the charge is made.

ILLNESS Means a physical condition, disorder, or infirmity. For the Insured or his Dependent spouse insured under this Policy, Illness also means a pregnancy including Complications of Pregnancy (as defined).

INFECTIOUS DISEASE Means a condition or disease caused by or capable of being communicated by infection.

INJURY Means bodily trauma or lesion caused directly and independently of all other causes from an Accident occurring while coverage under this Policy is in force.

INSURED or YOU, YOUR, and YOURS Means the person named as the Insured in the Certificate of Coverage page of this Policy, and in the Application Form, for whom the required premium has been paid, and to whom this Policy of Insurance has been issued.

MAINTENANCE Means continuation of care and management of the patient when the therapeutic goals of a treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, and the provision of covered services for a condition ceases to be of therapeutic value.

MATERNITY Means care provided and billed by a Provider for any condition during and resulting from pregnancy, including delivery, prenatal and postnatal care, and Complications of Pregnancy (as defined).

MEDICAL EMERGENCY Means the sudden and unexpected onset of a medical condition accompanied by severe symptoms and requiring medical care, which a Covered Person secures immediately after the onset or as soon thereafter as the care can be made available, but in no event later than seventy-two (72) hours after the onset.

MEDICALLY NECESSARY or MEDICAL NECESSITY Means services or supplies ordered and provided by a Hospital, Physician or other Provider which the Company determines:

1. Are appropriate to the diagnosis or treatment of a Covered Person's Illness or Injury;
2. Are consistent with accepted medical or professional standards of practice;
3. Are not primarily for the personal comfort or convenience of a Covered Person, his family, his Physician or other Provider;
4. Are the most appropriate levels of services or supplies that can safely be provided to a Covered Person; and
5. In the case of inpatient care, cannot be provided safely on an outpatient basis.

The Company reserves the right to determine Medical Necessity. The fact that a Hospital, Physician, or other Provider has prescribed, recommended or approved a service or supply does not, in itself, make it Medically Necessary.

MENTAL HEALTH Inpatient mental health, as indicated on the Schedule of Benefits and approved by the Company for severe psychotic or Neurotic episodes, where treatment cannot be given on an outpatient basis for risk of injury to self or others. Medications prescribed to be administered on an outpatient basis are not covered by the policy. Mental Health does not include learning disabilities, behavioural disorders, eating disorders, disciplinary problems or anxiety attacks.

NERVOUS OR MENTAL DISORDER Means those psychiatric illnesses listed in the latest edition of:

1. The Standard Nomenclature of Diseases and Operations of the American Medical Association; or,
2. The Diagnostic and Statistical manual for Mental Disorders of the American Psychiatric Association.

Nervous or Mental Disorder does not include learning disabilities, attitudinal disorders, or disciplinary problems because these are not illnesses.

NURSING SERVICES Home nursing care (only payable if prescribed by attending physician and approved by the company). The service must immediately start after the patient is discharged from the hospital for a maximum of 30 days per covered person up to the policy limits indicated in your schedule of benefits.

Nursing services related to aid in the activities of daily living such as but not limited to bathing, clothing, eating, mobilization, etc, are not covered by the policy.

NURSE MIDWIFE Means a person:

1. Certified to practice as a Nurse Midwife; and
2. Licensed by a board of nurses as a Registered Nurse (R.N.); and
3. Who has completed a program for the preparation of Nurse Midwives, approved by the jurisdiction in which the person is practicing.

ORGAN Means a part of the human body that performs a specific function.

ORGAN TRANSPLANT PROVIDER NETWORK Means a group of Hospitals and Physicians contracted on behalf of the Insurer for the purpose of providing organ transplant benefits to the Insured. The list of hospitals and physicians in the Organ Transplant Net work of Providers is available from Our Claims Administrator and may change at any time without prior notice.

OTHER HEALTH INSURANCE PLAN Means a plan that provides insurance, reimbursement or service benefits for Hospital, surgical or other medical expenses. This includes:

1. Individual, group, blanket or franchise health insurance policies, or any other benefit plan for individuals of a group;
2. Group health care service contracts and health maintenance organization agreements, or other group practice or pre- payment coverages;
3. Self-insured group plans;
4. Medical coverage provisions under automobile insurance issued or renewed in accordance with applicable law;
5. Service provided or payment received under laws or programs of any national, state or local government. If coverage is provided on a service basis, the reasonable cash value of the services rendered will be taken as the cost of the service.

OUT OF POCKET LIMIT Means the total co-insurance amount the Insured pays for Covered Expenses after the Deductible as indicated in the Schedule of Benefits. Out of pocket limit does not include co-payments, deductibles, penalties or amounts over usual customary charges.

OUTPATIENT SERVICES Means Medically Necessary services provided to a Covered Person, who is not a registered In-Patient in a Hospital, to prevent and treat injuries or illnesses. Outpatient Services shall include, but are not limited to:

1. Comprehensive diagnostic and evaluation services;
2. Outpatient care and treatment, pre-care, aftercare, emergency care, rehabilitation and habilitation, and supportive transitional services; and
3. Professional consultation.

PHYSICIAN Means a person licensed as a Physician (M.D., PH.D., D.O.) by the duly constituted authority in the area in which the service is rendered, and when acting within the scope of such licensure. For the purpose of this Policy a Physician is not the Covered Person's immediate family.

POLICY YEAR Means the period that begins on the Effective Date shown on the Certificate of Coverage of this Policy and ends twelve (12) months after the said Effective Date.

PRE-EXISTING CONDITION(S) PRE-EXISTING CONDITION Means a Condition:

a. Resulting from Illness or Injury for which a Covered Person has received a diagnosis, consultation, medical treatment, services, supply or drug prescription prior to the effective date of the Policy or its reinstatement;
b. For which symptom, medical advice or treatment was recommended by or received from a physician prior to the effective date of the Policy or its Reinstatement;
c. For which symptom, medical advice or treatment was recommended by or received from a physician prior to the effective date of the Policy or its Reinstatement date unless disclosed on your medical application. Disclosed medical conditions will be covered as described on your benefit schedule.

PREFERRED PROVIDER NETWORK Means a group of hospitals and physicians approved and contracted to treat Insured Persons on behalf of the Insurer. The list of Hospitals and Physicians in the Preferred Provider Network is available from your online member access and may change at any time without prior notice.

PREMATURITY or PREMATURE INFANT Means the delivery of a fetus before thirty seven (37) completed weeks of gestation.

PRESCRIPTION MEDICATION Means medications whose sale and use are legally restricted to the order of a Physician and which can only be obtained with a Physician's written prescription, must be dispensed by a Physician or licensed Pharmacist and approved by the FDA in the USA or other applicable administrative organizations and cannot be obtained over the counter at a Pharmacy.

PROCEDURE or TREATMENT Means a practice, a series of steps, or treatment to follow after a given diagnosis is obtained.

PROOF OF INSURABILITY Means a health history and other proof as We may require, which We will use to determine if a person is acceptable to Us to qualify for coverage under the Policy.

PROSTHESIS Means an artificial body part which will be limited to an artificial limb or eye.

PROVIDER Means, when licensed or certified as such by the duly constituted authority in the area in which the service is rendered and when acting within the scope of such licensure or certification, an Ambulatory Surgical Center or Hospital, Physician (M.D. or D.O.), a dentist (D.D.S. or D.M.D.), a Nurse Midwife or any other non- physician and non-dentist practitioner for whose services benefits are provided under this Policy.

PSYCHIATRIC PHYSICIAN A physician who specializes in psychiatry or has the training or experience to do the required evaluation and treatment of mental illness. Services to be offered only by a licensed Psychiatrist. Medications prescribed as a result of this treatment are not covered by this policy.

REASONABLE and CUSTOMARY CHARGE Means the charge or fee determined by the Company to be the general rate charged by others who render or furnish such treatments, services or supplies to persons who reside in the same area; and whose Injury or Illness is comparable in nature and severity.

The Reasonable and Customary Charge for a treatment, service, or supply that is unusual, or not often provided in the area, or that is provided by only a small number of Providers in the area, will be determined by the Company. The Company will consider such factors as: complexity; degree of skill needed; type of specialist required; range of services or supplies provided by a facility; and the prevailing charge in other areas. The term "area" means a city, a county or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment.

REHABILITATION (Institution for Prolonged Care) Means a registered medical center with licensed nurses and doctors that have been approved by the Company. This center gives specialized services to patients that have been released from a hospital's intensive care unit requiring rehabilitation for their recovery and have been placed in this center as an alternative to staying hospitalized. This does not include Hospice care or extended stay for critical care.

REIMBURSEMENT (of medical expenses) Means the amount of money refunded to the Insured for Usual and Customary covered expenses, as indicated in the Schedule of Benefits of this Policy.

RIDER Means an endorsement added to the policy that modifies the coverage.

ROOM AND BOARD Means a Hospital semi-private room equipped to accommodate two persons. If there are no such rooms, PA Group will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area. Or an Intensive care or other Specialty care unit

SECOND SURGICAL OR MEDICAL OPINION Means the medical opinion of a Physician approved and required by Us or Our Claims Administrator

SOUND NATURAL TOOTH Means a healthy unrepaired tooth, or a tooth of which a major portion remains after restorative work. A Sound Natural Tooth is not carious, abscessed or defective. It does not include artificial items, such as: (1) crowns or caps; (2) braces or bands; (3) jackets; (4) inlays; (5) bridges or dentures, which were installed before the date of the Injury. Repair or replacement of these items is not covered under this Policy.

SURGICAL EXPENSES/SURGERY Means the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for surgery includes an allowance for related pre-operative and post-operative care. Treatment for burns, fractures and dislocations are also considered surgery.

SYMPTOM Means a sensation or feeling that the Insured may experience and consider not to be normal. Such feeling or sensation may be in the form of pain or change in bodily fluids. This Symptom will not be considered an illness or a medical condition until a licensed physician or specialist gives a diagnosis.

This Diagnosis would need to be an eligible benefit approved and covered under the Insured Policy.

TERMINALLY ILL Is a medical prognosis of 6 months or less to live.

TOTALLY DISABLED Means that due to injury or disease that You are not able to engage in your customary occupation and or daily activities and are not working for pay or profit. Your Dependents is not able to engage in most of the normal activities of a person of like age and sex in good health.

TRANSPLANT Means the Medically Necessary procedure, performed while a Covered Person's coverage under this Policy is in effect, during which:

1. One or more Human Organs are surgically moved from a donor (living or deceased), to a Covered Person as the recipient;
2. Tissue is surgically moved to a Covered Person, as the recipient:
- **a.** A donor (living or deceased);
- **b.** The same Covered Person.

TRANSPLANT MEDICAL CENTER Means a Hospital (as the term is defined in this Policy), which meets the Assistance Center criteria to be considered a Transplant Medical Center. Such criteria include, but are not limited to the following requirements. The Center:

1. Provides comprehensive transplant services, including, but not limited to having:
- **a.** The ability to provide continuity of care;
- **b.** Medicare certification; and
- **c.** Satisfactory transplant experience;

2. Requires a minimum of two (2) years for transplant surgeon certification; and
3. Is affiliated with the United Network of Organ Sharing (UNOS).

Pre-certifications Procedures

OUTSIDE OF NORTH AMERICA (U. S. AND CANADA)
Pre-Certification is required for any of the below mentioned treatments no restrictions are imposed regarding the choice of physician, laboratory, hospital, clinic, etc. except that the facilities must be licensed and the treatment performed by legally qualified providers and physicians practicing within the scope of their license.

U.S. PRE-CERTIFICATION AND PPO UTILIZATION
Pre-certification and use of the utilization manager service provider PPO Network is required. Penalties to the benefits payable under this policy may apply if the requirements are not met. Please refer to the section labeled Pre-Certification of Services for a more detailed description. You must contact the utilization manager provider's number listed on your identification card. The following services must be pre-certified:

- In-patient hospitalization
- Emergency Air Ambulance
- Cardiac Care
- Emergency Transportation of a Family Member
- Home Health Care
- Repatriation of Mortal Remains
- Organ Transplants
- Evacuations
- Oncology Treatment /Radiation and Chemotherapy Inpatient and Outpatient.

***** *Failure to perform the pre-certification requirements within a minimum of 72-hours in advance of a non- emergency service or within 48-hours of an emergency service will result in a penalty of 50% of the allowable charge for the entire episode of care. This out-of-pocket and co-insurance amount will not be applied towards your defined limit shown on the Certificate of Coverage.*

Effect On Benefits

Subject to all provisions of this Policy, when the requirements of the Pre-Certification Program are properly followed and Certification is obtained for Hospital admissions, Transplant procedures, and/or Emergency Assistance Services provided in the U.S. and any of its territories, benefits for Covered Expenses will be payable as described in the schedule of benefits in this Policy and in any rider to this Policy.

BENEFITS PAYABLE FOR COVERED EXPENSES The benefits payable for Covered Expenses incurred for all Treatments, services, and supplies related to the claim will be reduced to and payable at 50% for entire episode of care. This penalty does not count towards your coinsurance maximum or deductible maximums (whether or not the Out of Pocket Limit has been met).

PRE-CERTIFICATION DOES NOT GUARANTEE BENEFITS
Benefits payable under this Policy are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations and exclusions, and provisions of this Policy. Certification does not guarantee or confirm benefits under this Policy. Benefits for Covered Expenses will be payable at the level that they are shown on the schedule of benefits and the percentage listed for each benefit.

REIMBURSEMENT OF MEDICAL BENEFITS The Comprehensive Medical Expense Coverage applicable to you and your dependents is based on the plan selection shown on your Certificate of Coverage. Benefits for Covered Expenses will be payable at the percentages and maximums that are shown on the schedule of benefits and are subject to the deductibles and co- insurance listed for each benefit.

Covered Medical Expenses

Are the expenses for certain hospital and other medical services and supplies that must be for the medically necessary treatment of an injury or illness. Benefits will be limited to the Reasonable and Customary Charges allocated to the area of service.

Benefits will be applied in accordance with Selected Plan Option as indicated in the schedule of benefits for the covered medical expenses listed below.

HOSPITAL EXPENSES
1. Room and board charges as outlines in your Certificate of Coverage. This benefit is limited to private or semi- private accommodation(s) and strictly subject to plan option purchased. It is further limited to number of consecutive days, and policy year day maximums as well as possible dollar limits. Plan option determines the limitations. Master Suites are excluded from coverage and will be at patient's expense.
2. Intensive Care Unit (ICU) charges as outlined in your Certificate of Coverage. This benefit may be limited to maximum confinement days and maximum policy year days as well as a maximum daily dollar limit. Plan option determines the limit of coverage.
3. Other hospital services and supplies other than personal or comfort items.

OUTPATIENT HOSPITAL EXPENSES Covered Expenses include reasonable and customary charges incurred for medically necessary treatment provided in a hospital emergency room, or outpatient facility, or for surgical procedures performed in an Ambulatory Surgical Center.

EMERGENCY ROOM MEDICAL SERVICES The initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably result in:

- Permanently placing the Covered Insured's health in jeopardy;
- Causing other serious medical consequences;
- Causing serious impairment to bodily functions; or
- Causing serious and permanent dysfunction of any bodily organ or part
- Causing loss of life or limb

Emergency room visits and related charges are subject to a $250.00 co-payment per visit which does not apply towards the deductible or co-insurance maximums. Coverage of Emergency room visits must meet the below definition for coverage to be provided.

EXTENDED CARE OR IN-PATIENT REHABILITATION Covered expenses include reasonable and customary charges incurred for medically necessary treatment provided as described under the definitions section of this policy. Care must begin upon discharge from a hospital confinement of no less than 3 days. This benefit is limited to a 30 days maximum per policy year.

Physician's Care

1. Office visits
2. Inpatient Hospital visits covered expenses are limited to one visit per day of confinement per specialty. However, no separate Hospital visit benefits are payable for visits related to a surgical procedure or to physiotherapy.
3. Surgery covered expenses include charges for medically necessary surgical procedures, including, but not limited to, treatment of fractures and dislocated bones and operations necessary for the treatment or diagnosis of an Illness, involving cutting, incision, or suturing of a wound, provided such procedures are covered under this Policy; and performed in a Hospital, Physician's office, or Ambulatory Surgical Center.
When multiple surgical procedures are performed during the same surgical session or through the same incision, benefits are payable as follows:

- 100% allowed on the primary procedure
- 50% allowed on the secondary procedure only if it is medically necessary

With regard to Reconstructive Surgery, as defined, benefits are only payable when such surgery is Medically Necessary; or due to a mastectomy performed while you or your Dependent are insured under this Policy;
4. Assistant Surgeon- Limited to 20% of the approved primary surgeon's fees when approved Claims Administrator. It must be medically necessary.
5. Anesthesiologist- Limited to the lesser of usual reasonable and customary or 20% of the approved primary surgeon's fees.
6. Second Surgical Opinion
7. Chiropractic Care with a physician's referral and treatment plan. Plan option determines visit limits and or dollar limits.
8. Diagnostic lab work and x-rays
9. X-ray, radium and radioactive isotope therapy
10. MRI, CT Scans, Pet Scans- Subject to maximum payable per scan as determined based on plan option chosen.
11. Oxygen

THERAPEUTIC SERVICES: PHYSICAL, OCCUPATIONAL AND SPEECH Limited to treatment resulting from surgery or illness. Treatment plan must be provided to include length of time and the number of treatments weekly. Speech therapy covered for restoration of lost function only. Coverage is provided based on plan option and may be limited by policy year day maximums, or dollar maximum per visit.

INFUSION THERAPY Drugs and medicines which by law need a physician's prescription will be covered as defined under the schedule of benefits. Therapies that would qualify for this benefit are but are not limited to: Chemotherapy, Pain Management, I.V. Gamma Globulin, Enteral Nutrition, Antibiotic Therapy, Aerosol Therapies, Epogen & Neupogen, Human Growth Hormone, Transfusions, Total Parenteral Nutrition

ALTERNATIVE MEDICINE Depending on plan option selected your plan offers coverage for: Accupuncture, Aromatherapy, Herbal Therapy, Magnetic Therapy, Massage Therapy, Vitamin Therapy. This benefits is subject to deductible and the maximum dollar limit per policy. This benefit is subject to any dollar limits or policy year limits provided that the treatment is for a medical condition covered with a physician's referral.

Human Organ Transplant Benefits

Are available for the medically necessary, non-experimental transplantation of a Human Organ. A two organ transplant performed during the same surgical session will be considered as one transplant. Subject to all other conditions, limitations and exclusion of this Policy, the following are available and payable in accordance with the current schedule of benefits. Storage and transportation costs approved by PA Group, which are incurred and directly related to the donation of a human organ used in a covered transplant procedure. The Insured or Insured's physician must give prior notice in writing to before a covered transplant procedure in addition to pre-certifying the transplant with the management company listed on your identification card. Failure to either pre-notify PA Group or the management company listed on your identification card or failure to have the procedure performed in an approved facility will result in a reimbursement reduction of 50% of covered charges. Your specific organ transplant benefits are outlined in your Certificate of Coverage.
Organs covered for transplants are limited to the following:

- Heart
- Lung
- Kidney
- Liver
- Pancreas
- Cornea

Bone marrow transplants are covered only for approved diagnoses;

- Aplastic Anemia
- Severe Immune Deficiency
- Hodgkin's Disease
- Granulocytic Leukemia
- Acute and Chronic Myelogeneous
- Multiple Myeloma

BENEFITS ARE LIMITED AS FOLLOWS

- Lifetime maximum per insured as stipulated in your Certificate of Coverage for all transplants and related services, supplies, drugs and treatments.
- No organ transplant benefits are available for the first twenty-four (24) months of the Insured's coverage.This period is determined from the effective date of coverage shown on your Certificate of Coverage.
- Transplant must be deemed necessary by two (2) Independent medical or surgical consultants in the relevant medical specialty most closely related to the transplant.
- Benefits are provided to insured transplant recipients only. Costs related to organ donors are not covered. Subsequent transplants are not covered if the initial transplant was not covered under the Policy for any reason.
- Transplants resulting from or made necessary by congenital conditions are not covered under this Human.
- Organ Transplant benefit. They are subject to the limitations and benefits applicable to the congenital conditions benefit specified in the Policy in accordance with the schedule of benefits.
- Transplant must be performed in a licensed network transplant center and must be a participating facility under the network.
- Transplants outside the participating provider network are not covered.
- Transplant procedures and related services deemed experimental by PA Group are not covered.

Diagnostic Services

DIAGNOSTIC SERVICES The necessary treatment or services prescribed by the attending Physician as defined under the schedule of benefits section. Please note that services within this section could require pre-certification with the management company shown on your identification card. Depending on plan option MRI, CT Scans, PET Scans may be limited to a per scan dollar maximum, or dollar limit. These are subject to pre-certification in order to avoid a 50% penalty. X-rays, labs and pathology are payable in accordance to the percentages specified under the plan option.

HOME HEALTH CARE SERVICES Covered expenses as defined under the schedule of benefits must be accompanied by attending physician's orders. The requirements are (a) the charges are made by a home health care agency; (b) the attending physician provides written orders of care and; (c) the care is given to a person in his or her home. Covered expenses are charges for:

1. Part-time or intermittent care by an R.N., or by an L.P.N.
2. Part-time of intermittent home health aide services for patient care.
3. Physical, occupational and speech therapy.
4. Medical supplies, drugs and medicines prescribed by a physician; and
5. Laboratory services provided by or for a home health care agency.

Depending on plan option this benefit may be limited to a 30 day policy year maximum. The home healthcare provider must submit all the home health notes of services performed during such visits.

Maternity Care

Benefits are payable for pregnancy-related expenses of insured or insured's spouse as outline in the schedule of benefits. Expenses must be incurred while the person is covered under this Plan. Pregnancy and/or any condition related to pregnancy that arises during the first twelve (12) months of coverage are excluded.
Depending on Plan Option elected this benefit may require a Maternity Rider. For Plan options whereby the rider has been purchased and the deductible options is $250, $500, $1000, $2500 the deductible will be waived. For Deductible options $5000 and over maternity benefit will be subject to deductible first.
The maximum days approved whilst inpatient for maternity will be as follows:

1. 48 hours (2 days) maximum after a non-cesarean delivery or elective c-section or
2. 96 hours (4 days) maximum after a cesarean section on medical grounds.

Inpatient stays past the above mentioned require substantiation of medical necessity and are limited to the amounts as set forth in your schedule of benefits.

MATERNITY CARE / ELECTION C-SECTION Includes all cost associated including but not limited to hospital fees for mother and newborn, obstetrician fees or midwife fees, child birth, prenatal and postnatal care.

C-SECTION DELIVERY ON MEDICAL GROUNDS Medical necessary cesarean, all cost associated including hospital fees for mother and newborn, obstetrician fees, prenatal and postnatal care: physician must submit complete medical records for review of Medical Necessity.
Any fertility/infertility services, tests, treatment or procedures of any kind, including, but not limited to fertility/infertility drugs, artificial insemination, in-vitro fertilization, gamete intrafallopian transfer (GIFT), surrogate mother and all other procedures and services related to such treatments, complications of that pregnancy, delivery and postpartum care are also excluded. Children born to mothers who received fertility/infertility treatments are subject to the current underwriting guidelines and eligibility requirements; no guarantee is made for their acceptance for coverage. Elective abortions are limited to abortions performed because the life of the mother would be in danger if the fetus were carried to term and those, which result in medical complications.

CONGENITAL BIRTH DEFECTS For premature newborns birth of covered pregnancies, congenital conditions and birth anomalies are subject to a US$250,000 lifetime maximum for newborns enrolled within 31-days of date of birth.
Coverage for Congenital Conditions is available only to infants born of a covered pregnancy and having continuous coverage under the PA Group effective as of the date of birth. When coverage is available, benefits are provided for medically necessary inpatient and outpatient treatment, services and supplies for congenital conditions as those conditions are defined herein. Benefits for Congenital Conditions are payable in accordance to the schedule of benefits.

Hospice Care

Benefits as defined under the schedule of benefits to patients who are deemed terminally ill.

1. An inpatient charge made by a Hospice Care Agency which is certified by the terminally ill patient's doctor;
2. By a hospital or home health agency for home health care furnished to a terminally ill patient under the direction of a Hospice, including custodial care if it is given during a regular visit by a private duty nurse or home health aid;
3. By a private duty nurse, if the doctor or the Hospice certifies that nursing care is necessary;
4. Medical supplies:
a. Drugs and medicines prescribed or ordered by a terminally ill patient's doctor for symptom control, and for their administration;
b. The rental for durable equipment of a medical or surgical nature which is used solely for treating a terminally ill patient's injury or sickness;
5. For the following other expenses made by a Hospice Care Agency:
a. Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day;
b. Medical social services under the direction of a physician. These include:
• Assessment of the person's social, emotional and medical needs, and the home and family situation;
• Identification of the community resources needed to meet the person;
• Assisting the person to obtain those resources needed to meet the person's assessed needs;
• Psychological and dietary counseling. Consultation or case management services by a physician;
• Physical and occupational therapy;
• Part-time or intermittent home health aide services for up to 8 hours in any one day. This consists mainly of caring for the person;
• Medical supplies, drugs and medicines prescribed by a physician;
6. Charges made by the providers below, but only if the provider is not a insured of a Hospice Care Agency; and such agency retains responsibility for the care of the person;
7. A physician for consultant or case management services;
8. A physical or occupational therapist;
9. A Home Health Care Agency for physical or occu pational therapy;
10. Part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;
11. Medical supplies, drugs and medicines prescribed by a physician;
12. Psychological and dietary counseling.

HOSPICE CARE CONTINUED Not more than the Hospice Maximum will be paid for all Hospice Care Expenses incurred. Not included are charges made:
1. For bereavement counseling;
2. For funeral arrangements;
3. For pastoral counseling;
4. For financial or legal counseling. These include estate planning or the drafting of a will;
5. For homemaker or caretaker services. These are services, which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning: and maintenance of the house;
6. For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not attend to the person's needs.

EMERGENCY GROUND AMBULANCE The schedule of benefits defines the maximum payable for this benefit. Expense is limited to one trip to the nearest hospital as medically necessary. Depending on plan option elected this benefit may have a dollar limit per trip.

MENTAL AND NERVOUS The schedule of benefits defines the maximum payable for this benefit and the lifetime maximums. This benefit is subject to a 12 month waiting period. Both inpatient and outpatient coverage is available under this Policy limited to the percentage and benefits shown on the schedule of benefits. (Outpatient) visits, as indicated in your Schedule of benefits and approved by the Company. Services to be offered only by a licensed Psychiatrist. Medications prescribed as a result of this treatment are not covered by this policy.

PRESCRIPTIONS Drugs and medicines which by law need a physician's prescription and are not obtainable over the counter (OTC) will be covered as defined under the schedule of benefits. Medications for mental nervous conditions are excluded from coverage. Member is required to submit a copy of the physicians prescription, prescription receipt, and proof of payment. Benefits are payable in accordance with the schedule of benefits percentage reflected and limited to $20,000 per policy year per insured.

DURABLE MEDICAL EQUIPMENT Durable Medical Equipment made for and used in the treatment of disease or injury and not for use in altering air quality or temperature. Rental or purchase of durable medical or surgical equipment to the extent that the length of time required will not exceed the reasonable cost of the equipment. Benefit will include charges for only one item of equipment for the same or similar purpose. Must be prescribed by an M.D. designed for repeated use and which is Medically Necessary to improve the functioning of a malformation of the body, treatment of an Illness, or to prevent further deterioration of a Covered Person's medical condition. Durable Medical Equipment

includes non-motorized wheelchairs, Hospital beds, respirators and such other items as determined by the Company.

RECONSTRUCTIVE SURGERY Is limited to surgery that takes place immediately after or within 90 days from a covered surgical procedure or accident, and is medically necessary in order to maintain or restore normal bodily function. Reconstructive surgery is not covered for congenital, hereditary or birth abnormalities for adults covered under this policy. Surgery which does not itself restore the function of an abnormal body structure and which is elective to, or the result of, a previous surgery necessary due to Illness, Injury, or Congenital Defect. This benefit is payable at the percentage specified under your schedule of benefits and in accordance with purchased plan option.

Wellness Care

This benefit is available depending on plan option elected. The schedule of benefits defines the maximum payable for this benefit for the charges made by a physician for a routine physical exam. A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease. For all exams given to you and your eligible dependents not more than one exam will be covered per calendar year per person. Included as part of the exam are;

- For Females: this includes the following: Routine Mammograms for females over age 45. Office visit, routine blood, urinalysis. Pap test;
- For Males: this includes office visit,, routine blood, urinalysis and PSA exams;
- A physical exam may also include the materials for and the administration of immunizations for infectious disease and for tuberculosis.

Not covered are charges for:

- Services which are covered to any extent under any other group plan of your Employer;
- Services which are for diagnosis or treatment of a suspected or identified injury or disease;
- Exams given while the person is confined in a hospital other facility, for medical care;
- Services which are not given by a physician or under his or her direct supervision;
- Medicines, drugs, appliances, equipment, or supplies;
- Psychiatric, psychological, personality or emotional testing or exams. Exams in any way related to employment;
- Premarital exams;
- Vision, hearing or dental exams;
- A physician's office visit in connection with immunizations or testing for tuberculosis;
- Screening Colonoscopies or other test not listed and named under the schedule of benefit under wellness.

Emergency Assistance

The following services are additional benefits to your health insurance contract. Reimbursement for Medical Evacuation and Repatriation of Mortal Remains are subject to the benefits, exclusions and instructions specified in the schedule of benefits.

To comply with the terms and conditions, the insured is required to contact the medical management company shown on your personal identification card for pre-authorization and assistance before the insured incurs any evacuation and assistance costs. If the insured fails to follow this condition, he or she will be liable to pay full costs for any transportation.

EVACUATION If an insured is involved in an accident or suffers a sudden illness and adequate medical facilities are not available locally, a medically supervised evacuation to the nearest facility capable of providing an adequate level of care will be coordinated by the medical management company shown on your personal identification card.

REPATRIATION OF MORTAL REMAINS The necessary clearances for the return of an Insured's mortal remains by air transport to the home country will be coordinated by the medical management company shown on your personal identification card.

Other Medical Expenses

Covered expenses are limited to the reasonable and customary charges incurred for medically necessary services with benefits payable as defined under the schedule of benefits section. Care is limited to treatment resulting from surgery or illness.

1. Blood or blood plasma and its administration not donated or replaced;
2. Out-patient medical supplies;
3. Cast, splint , crutch, walker, truss or brace;
4. Oxygen;
5. Prosthetics as in artificial limbs and eyes for the initial replacement of a natural limb or eye which is lost while the person is a covered person;
6. Expenses for the treatment of or related to conditions of the mouth, jaw joints, supporting tissues (includes bones, muscles and nerves) and teeth are covered. For these expenses, 'physician" includes a dentist;

- **a.** Treat a fracture, dislocation, or wound;
- **b.** Cut out teeth partly or completely; impacted in the bone of the jaw;
- **c.** Teeth that will not erupt through the gum;
- **d.** Other teeth that cannot be removed without cutting into bone;
- **e.** The roots of a tooth without removing the entire tooth;
- **f.** Cysts, tumors, or other diseased tissues;
- **g.** Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth;
- **h.** Alter the jaw, jaw joints, or bite relation ships by a cutting procedure when appliance therapy alone cannot result in functional improvement;
- **i.** Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth;

7. Dental work, surgery and orthodontic treatment needed to remove, repair, replace, restore or reposition natural teeth damaged, lost or removed; or other body tissues of the mouth fractured or cut. Due to injury the accident causing the injury must occur while the person is covered under this Plan. Any such teeth must have been free from decay; or in good repair and firmly attached to the jaw bone at the time of the injury, The treatment must be done in the calendar year of the accident or the next on if crowns (caps), Dentures (false teeth), bridgework or in-mouth appliances are installed due to such injury. Covered Medical Expenses include only charges for:

- • The first denture or fixed bridgework to replace lost teeth;
- • The first crown needed to repair each damaged tooth; and
- • In-mouth appliance used in the first course of Orthodontic Treatment after the injury.

Not included are charges:

- To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing to repair, replace, or restore fillings, crowns, dentures or bridgework;
- For non-surgical periodontal treatment;
- For in-mouth scaling, planning, or scraping;
- For myofunctional therapy; this is muscle training therapy training to correct or control harmful habits;
- For in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services except as provided for injury; whether or not the purpose of such services or supplies;
- Is to relieve pain;
- For root canal therapy or dental cleaning;
- For routine tooth removal (not needing cutting of bone), except as provided for injury.

EMERGENCY DENTAL TREATMENT Coverage is provided for treatment necessary to restore or replace Sound natural teeth, damaged or lost as a consequence of a covered accident/injury for which treatment is received in an emergency room of a hospital or that causes hospital confinement, provided that the dental treatment takes place within the first 90 days after the accident or injury. The level of coverage is defined by your plan election and may be limited a maximum dollar limit.

Benefits Dental And Vision Care

Benefits for Covered Expenses will be payable at the percentages and maximums that are shown on the schedule of benefits and are subject to the deductibles and co-insurance listed for each benefit. This benefit is based on the plan option purchased and may be limited to a dollar maximum per policy year.

**For Select Plan Option we will cover up to $100 per policy year maximum for the dental benefits due to sudden unexpected pain due to dental emergency.*

COMPREHENSIVE DENTAL EXPENSE COVERAGE This Plan pays benefits for charges for dental services and supplies incurred for routine dental care or treatment of a dental disease or injury based on plan option elected and is subject to a six (6) month waiting period. The dentist's charge for the services and supplies listed below which, for the condition being treated, must be necessary and customarily used nationwide and deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice. These benefits apply separately to each covered person. As a part of proof of any claim PA Group has the right to require an oral exam of the person at its own expense. You must give PA Group diagnostic and evaluation material which they may require. These include: x-rays, models, charts and written reports. The benefits for a course of treatment may be for a lesser amount than would otherwise be paid; if any required verifying material is not furnished. In this event, benefits will be reduced by the amount of covered dental expenses that PA Group cannot verify.

TYPE A TREATMENT

- Oral exams once every 6 months. This includes: prophylaxis and cleaning of teeth;
- Topical application of sodium or stannous fluoride for persons under 15 years of age. Emergency palliative treatment;
- First installation of a space maintainer for persons under 19 years of age to replace any baby tooth which is lost prematurely;
- X-rays for diagnosis. Also other x-rays not to exceed: one full mouth series in a 36 month period; and one set of bitewings in a 6 month period.

TYPE B TREATMENT

- Non-surgical extractions;
- Fillings;
- Injection of antibiotic drugs;
- Repair of re-cementing of crowns, inlays, bridgework or dentures. General anesthetics given in connection with covered dental services. Non-surgical endodontic treatment. This includes root canal therapy;
- Relining or rebasing of dentures not to exceed one of these in any 36 consecutive month period. Neither of these is covered for the six months after the denture is first installed or replaced.

TYPE C TREATMENT
• Extracoronal and other splinting when a necessary part of complete periodontal treatment;
• Inlays, onlays, gold fillings or crowns. This includes precision attachments for dentures;
• First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered. This includes inlays and crowns as abutments;
• Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework. But, the "Prosthesis Replacement Rule" below must be met;
• First installation of removable dentures to replace one or more natural teeth extracted while the person is covered. This includes adjustments for the 6 month period following the date they were installed;
• Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture. But, the 'Prosthesis Replacement Rule' below must be met.

PROSTHESIS REPLACEMENT RULE Certain replacements or additions to existing dentures or bridgework will be covered under this Policy. But proof satisfactory to PA Group must be given:

- The replacement or addition of teeth is required to replace teeth extracted after the present denture or bridgework was installed;
- The person must have been covered when the tooth was extracted;
- The present denture or bridgework cannot be made serviceable. Also, it must be at least 5 years old;
- The present denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered and cannot be made permanent. If replacement by a permanent denture is needed it must takes place within 12 months from the date the immediate temporary one was first installed and while coverage is still in-force.

ORTHODONTIC TREATMENTS A dentist's charges for services and supplies for Orthodontic treatment are included as covered dental expense in addition to all other terms of this dental benefit. Benefits will not exceed the orthodontic maximum for all expenses incurred by a family member in his or her lifetime (this applies even if there is a break in coverage).

Orthodontic treatments furnished to prevent or to diagnose or to correct a misalignment of the teeth, of the bite, of the jaws or jaw joint relationship whether or not for the purpose of relieving pain.

Not included is: The installation of a space maintainer, or a surgical procedure to correct malocclusion.

DENTAL LIMITATIONS When the Alternate Treatment part of this Plan applies, benefits will be limited. Some examples of how this works follow.

RESTORATIVE Gold, Baked Porcelain Crowns, and Jackets. covered dental expenses will be limited to the reasonable charge for the procedure using amalgam or like material, if it would restore a tooth. This limit applies even if you and the dentist choose some other type of restoration.

Reconstruction covered dental expenses will be limited to the reasonable charges for the procedure needed to eliminate oral disease; and replace missing teeth. Appliances or restorations needed to increase vertical dimension or restore the occlusion are deemed to be optional. They are not covered.

PROSTHODONTICS Partial dentures covered dental expenses will be limited to the reasonable charge for a cast chrome or acrylic denture if this would satisfactorily restore an arch. This limit applies even if you and the dentist choose a more elaborate or precision appliance.

Complete dentures covered dental expenses will be limited to the reasonable charge for a standardized procedure. This limit applies even if you and the dentist choose personalized or specialized treatment.

Replacement of existing dentures this will be covered only if the existing denture cannot be used or repaired. If it can be used or repaired, covered dental expenses will be limited to the reasonable charge for the services needed to make the denture usable.

DENTAL EXCLUSIONS
• Any dental services and supplies which are covered in whole or in part under any part of this Policy, or under any other plan of group benefits provided by your Employer;
• Treatment by other than a dentist except treatments by a licensed dental hygienist that are supervised by a dentist and acting within the scope of the license. Services such as routine scaling of teeth, cleaning of teeth and topical application of fluoride. Services or supplies that are cosmetic in nature. This includes charges for personalization or characteristics of dentures;
• The replacement of a prosthetic device that is lost, missing or stolen;
• Any services or supplies which are for Orthodontic treatment except as specifically provided;
• Services or supplies to increase vertical dimension which are:

- **a.** Dentures;
- **b.** Crowns;
- **c.** Inlays and onlay;
- **d.** bridgework; or
- **e.** Any other appliance or service.

DENTAL BENEFITS AFTER TERMINATION OF COVERAGE This section applies to a person whose coverage ceases while not 'totally disabled" as defined in the definitions section of the policy. To determine eligibility the item must be ordered. Ordered" means that impressions have been taken from which the dentures, crowns, or fixed bridgework will be made. To fixed bridgework and crowns the teeth must have been fully prepared it they will serve as retainers or support, or they are being restored. This applies only if the item is finally installed or delivered no more than thirty (30) days after

coverage ends. Expenses incurred for the following after the person's coverage ceases under this benefit section will be deemed to be incurred when ordered.

- Dentures;
- Fixed Bridgework;
- Crowns.

VISION CARE BENEFIT Benefits for Covered Expenses will be payable at the percentages and maximums that are shown on the schedule of benefits and are subject to the deductibles and co-insurance listed for each benefit.

1. OPHTHALMOLOGY The policy pays the reasonable and customary charges for the benefits shown in the schedule of benefits for eye examinations.

2. EYEGLASSES, CONTACTS The policy pays the reasonable and customary charges indicated in the schedule of benefits for eyeglasses or contacts prescribed as the result of an eye examination to correct defective eyesight.

Benefit applies only if the eyeglasses or contacts are prescribed as a result of an eye examination made while insured under the policy. The date on which the eyeglasses or contacts are ordered shall be considered to be the date on which charges are incurred and the eyeglasses or contacts are furnished. This benefit is provided based on plan option elected. The vision examination is limited to one every two years and is subject to a 24 month waiting period.

General Medical Exclusions

Applicable to health expense, Coverage is not provided for the following charges:

1. Services and supplies not necessary, as determined by PA Group for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist and which any school system is required to provide under any law.

2. Any pre-existing medical condition or related condition directly or indirectly for which the enrollee or insured person has received treatment, had symptoms of, manifestations, took medication or sought advice for prior to the date of entry and or any complications due to lack of treatment of the pre-existing condition.

3. Any treatment for the following conditions, illnesses or surgeries which manifest themselves or are recommended, or which symptoms occur during the first 180 days (6 months) from the effective date of coverage will not be covered: Asthma, Allergies, any conditions of the breast, any condition of the prostate, tonsillectomy, adenoidectomy, hemorrhoids or hemorrhoidectomy, disorders of the reproductive system, intervertebral disc disease, gall stones or kidney stones.

4. Cost incurred in connection with locating a replacement organ or any cost incurred for removal of the organ from the donor, transportation cost of sam and all associated administration costs.

5. Treatment received in health hydros, nature cure clinics, spas or similar establishment or private beds registered as Medical Facility or nursing home attached to such establishment or Medical Facility where the Medical Facility has effectively become the enrolled person's home or permanent abode or where admission is arranged wholly or partly for domestic or social reasons.

6. Weight reduction charges incurred for any surgery, treatment or supplies relating to, arising from or in connection with, for, or as a result of weight modification or surgical treatment of obesity (including without limitation morbid obesity), including without limitation wiring of teeth and all forms of bariatric surgery by any 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.

7. Smoking cessation, or hair restoration drugs are not covered, even if prescribed by a physician. Prescribed drugs related to human organ transplants and subsequent treatment are governed by the benefits and limitations listed in the human organ transplant amendment. All prescription drug benefits are payable in accordance with the current benefit schedule.

8. Services or supplies that promote or prevent conception included but not limited to artificial insemination, contraceptive drugs, treatment of fertility or infertility, impotency, sterilization or reversal or sterilization, surrogacy or abortion are excluded. Therapy or supplies for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

9. Care, treatment, services or supplies that are not prescribed, recommended and approved by the person's attending physician or dentist. No coverage will be provided under this policy where treatment or advice of a medical condition whatsoever whether related or not, was a result of auto therapy (self administered) or where such treatment or advice had been given by a relative including but not limited to spouse, partner, grand parent child or guardian.
10. Services of a resident physician or intern rendered in that capacity.
11. Any pregnancy or complications of pregnancy expenses whatsoever relating to unmarried children or dependent child of the main insured.
12. Services to the extent they are not reasonable charges, as determined by PA Group.
13. Services that are made only because there is coverage.
14. Services that a covered person is not legally obliged to pay or provided by a close relative or family member.
15. Services as determined by PA Group to be for custodial care.
16. To the extent allowed by the law of the jurisdiction where the Policy is delivered, those for services and supplies: Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government. Furnished, paid for, or for which benefits are provided or required under any law of a government other than a national. (This does not include a plan established by a government for its own insureds or their dependents or Medicaid.)
17. Improve the function of a part of the body that is not a tooth or a structure that supports the teeth, is malformed, as a result of a severe birth defect, this includes harelip or webbed fingers or toes; as a direct result of disease; or surgery performed to treat a disease or injury.
18. Services for or related to any eye surgery mainly to correct refractive errors.
19. Services for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
20. Plastic surgery, reconstructive surgery, cosmetic surgery; or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to; Repair an injury which occurs while the person is covered under this Plan. Surgery must be performed; in the calendar year of the accident which causes the injury; or in the next calendar year.
21. Services for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; or carbon dioxide therapy.
22. Treatment of covered health providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
23. Services, treatment, education testing or training related to learning disabilities or developmental delays.
24. Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
25. For or related to sex change surgery or to any treatment of gender identity disorders.
26. a) any Injury or Illness sustained while taking part in: Amateur Athletics, Professional Athletics and adventure sports and activities, including, without limitation the following (including any combination or derivative of the following) abseiling, mountaineering, mountain climbing, rock climbing, whitewater rafting or canoeing involving white water rapids in excess of grade 5 and subaqua pursuits involving underwater breathing apparatus,bullfighting, any type of aviation sports, kiteboarding, hang gliding and parachuting, bicycle motorcross or BMX, BASE jumping, bobsledding, canyoning, caving, high diving, heli-skiing, hot air ballooning, inline skating, jet skiing, jungle zip lining, kayaking, luge, mountain biking, paragliding, sky diving, parascending, rappelling, rodeo, parapenting, test of velocity racing of any kind including by horse, motor vehicle(of any type) or motorcycle, snow skiing except for recreational downhill and/or cross country snow skiing (no cover provided whilst skiing in violation of applicable laws, rules or regulations; away from prepared and marked in-bound territories; and/or against the advice of the local ski school or local authoritative body), snowboarding, snowmobiling, ski jumping, spelunking, surfing, trekking, windsurfing, wildlife safaris. Scuba diving at a depth of more than 30 metres. Boxing, bungee jumping Practice or training in preparation for any excluded activity which results in injury will be considered as activity while taking part in such activity; and/or (b) 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; and/or (c) any Illness or Injury sustained while participating in any activity where such activity is undertaken against medical advice (d) participation in any extreme sport or participation in a sport for compensation as a professional.
27. Services for any injury or illness sustained as a result of being under the influence or intoxicating liquor or drugs other than those taken in accordance with treatment prescribed by a physician. Any substance abuse.
28. Services related to a self inflicted injury or illness.
29. Services for any illness or injury occurring from the commission of a violation of the law.
30. Services for orthotics, visual therapy, vision perception training or visual eye training.
31. Services for treatment of feet (weak, strained, or flat) unless an open cutting procedure is required.
32. Services for any insomnia sleep disorder, sleep apnea, fatigue, jet lag, stress or any related condition.
33. Exercise program.
34. Services incurred for dental treatment or the temporomandibular joint except as shown or the schedule of benefits.
35. Services incurred for travel, meals, transportation and or accommodations except as indicated on the schedule of benefits.
36. Charges for taxes, assessments, charges, fees or surcharges imposed by any governmental agency or fees for required medical records where a member is required to substantiate his claim.
37. Services related to the complications or a consequence of a treatment, illness or supply excluded from coverage.
38. Related to genetic medicine, genetic testing or screening and preventative prophylactic surgeries recommended by genetic testing.
39. For routine physical exams: routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies.
40. For or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.

41. Acupuncture therapy. Not excluded is acupuncture when it is performed by a physician, and as a form of anesthesia in connection with surgery that is covered under this Plan.
42. For or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
43. Treatment and expenses directly or indirectly arising from or required as a consequence of: war, invasion, acts of foreign enemy hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege or attempted overthrow of government or any Act of Terrorism unless the Insured Person sustains Bodily Injury while an innocent bystander resulting from an Act of Terrorism.
44. Regardless of any contributory clause(s), this insurance does not cover Treatment of a Medical Condition which is in any way caused or contributed to by an Act of Terrorism involving the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent. If we allege that by reason of this exclusion any claim is not covered by this insurance then the burden of providing the contrary shall be upon you.
45. Treatment directly or indirectly arising from or required as a result of chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel, asbestosis or any related condition.
46. Dietary supplements and substances, which are available naturally and can be purchased without prescription, including but not limited to vitamins, minerals and organic substances.
47. The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid. Any exclusion above will not apply to the extent that coverage is specifically provided by name in your Certificate of Coverage or coverage of the charges is required under any law that applies to the coverage. These excluded charges will not be used when figuring benefits.

GENERAL MEDICAL EXCLUSIONS CONTINUED
EXPERIMENTAL AND/OR INVESTIGATIONAL Experimental and/or investigational services or supplies are those that are, as determined by PA Group to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:

1. There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
2. If required by the FDA, approval has not been granted for marketing; or
3. A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
4. The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

General Provisions

ENTIRE CONTRACT The Policy, the Coverage Summary, the Schedule of Benefits, the Application, and any Amendments, Riders, or Endorsements, make up the entire contract between the parties.

TERM OF THE POLICY This Policy has a term of twelve (12) months renewable for a like term upon payment of the renewal premium.

NOTICE Means any notice required under this contract must be in writing. Any notice given by us will be mailed either to the Insured or to the Insured Agent or Broker. Any notice given to the Company will be sent to the Company's administrative offices at: c/o IHA 135 San Lorenzo Avenue PH-850, Coral Gables Fl 33146.

CHANGES TO THE POLICY We retain the right to make any changes to the Policy at the time of renewal. The changes will be valid only if made by a new Policy wording a Policy Amendment or Endorsement or by a Policy Rider duly approved and signed by an officer of the Company. Any change in the provisions of this Policy, including any increase or decrease of premium, shall become effective thirty (30) days after written notice of such change is mailed by the Company to the Insured and the Insured broker or agent.

PREMIUM The premium due for coverage under this Policy is for a one (1) year term, must be paid in US currency, and is due on each renewal date of the policy or other due dates if authorized by Us. We retain the right to change the premiums at the time of renewal. The policyholder is responsible to send the premium to the Company on time. Premium notices are provided as a courtesy. If the Insured have not received a premium notice thirty (30) days prior to the due date the Insured should contact the Insured's agent or Us.

REFUND PROVISION The premium will only be reimbursed to the Insured if the Insured decide to cancel the Insured coverage within ten (10) days from the date the Insured received this Policy. If We terminate a Policy due to: Change of Residence to the U.S. (or to any country in which coverage under this Policy is not available), or by Class, Death, or Fraud, We will refund the pro-rated premium amount based on the unearned number of months of the coverage paid, less administrative charges, and thirty five percent (35%) of the base premium.

GRACE PERIOD After the first premium payment, a grace period of thirty (30) days will be allowed for payment of each premium due. If premium is not paid within the grace period, the Company will terminate this Policy on the due date of the unpaid premium. Benefits are not provided under the Policy during the grace period unless it is renewed.

REINSTATEMENT If this Policy is terminated due to non-payment of premium, the Insured may submit an Application for reinstatement of coverage to Us within sixty (60) days of the date of termination. The Insured Application will be subject to proof of Insurability.

CLERICAL ERROR Clerical error or delays in keeping records by the Company: (a) will not deny insurance which should otherwise have been granted; and (b) will not extend insurance which should otherwise have been terminated; and (c) will be subject to proper adjustment of premium when an adjustment is needed.

COUNTRY OF RESIDENCE The coverage evidenced by this Policy will become null and void unless the Company is notified of any change in the declared Country of Residence of the Insured within thirty (30) days of the date of the change. All terms and conditions of this Policy are subject to revision upon a change in the declared Country of Residence. Residents of U.S.A., Puerto Rico or the U.S. Virgin Islands are not eligible for coverage.

CURRENCY All payment of benefits made by the Company under the Policy shall be made in the same currency as that in which premiums were received unless otherwise arranged by mutual agreement between the Covered Insured and the Company. All claims payments will be paid in accordance with the incurred date of treatment by using the currency exchange rate under www.oanda.com.

MISSTATEMENT OF AGE If it is discovered that the Insured or the Insured Dependents' age has been misstated and the error has an effect on premium or coverage, an adjustment of the premium will be made and it will be determined whether coverage is valid under this policy for the Insured or the Insured Dependent.

THIRD PARTY ACT OR OMISSION The Company shall not be liable for any acts or omissions by any Hospital, Physician or other parties.

FRAUD If any claims presented under this Policy are in any respect fraudulent or if any fraudulent means or devices are used by the Insured or anyone acting on the Insured behalf, such as misrepresentation on the Application Form, Omission of Information or any attempts, through deceit, to obtain benefits for any person that otherwise would not be provided or payable, We will deny benefits and terminate the Policy. Termination will be effective as of the Effective Date of the Insured's coverage under this Policy. We will refund all premiums as indicated in the Refunds Provision less any benefit paid to or on behalf of the Insured and any of his Dependent(s). If the value of the benefits paid exceeds the amount of premiums paid, the Insured will pay Us an amount equal to such excess.

APPLICABLE LAW This contract is entered into, interpreted in accordance with, and is subject to the laws of Cayman Islands

ARBITRATION All disputes arising out of or relating to this Policy, or any matter that is related directly or indirectly to this insurance, which cannot first be resolved by the parties through settlement negotiations for a period of sixty (60) days, shall be resolved exclusively through binding, non-appealable and confidential private arbitration. The arbitration shall be administered based on the Arbitration laws of the Cayman Islands. Notice requesting arbitration must be in writing and sent certified or registered mail, return receipt requested.

Each party shall choose one arbitrator and the two arbitrators shall choose an impartial third arbitrator who shall preside over the arbitration proceeding. If either party fails to appoint its arbitrator within thirty (30) days after being requested to do so by the other party, the latter, after ten (10) days notice by certified or registered mail of its intention to do so , may appoint the second arbitrator.

Within thirty (30) days after notice of appointment of all arbitrators, the panel shall meet and determine timely periods for briefs, discovery procedures and schedules for hearings. The panel shall be relieved of all judicial formality and shall not be bound by the strict rules of procedure and evidence. The decision of any two arbitrators when rendered in writing shall be final and binding. The panel is empowered to grant interim relief as it may deem appropriate. The place of any arbitration hearing shall be Cayman Islands.

The panel shall interpret this Contract as an honorable engagement rather than as merely a legal obligation and shall make its decision considering the custom and practice of the applicable Insurance business as promptly as possible following the termination of the hearings. The law applicable to the insurance policy and the arbitration proceeding shall be the law of Cayman Islands.

RIGHT TO RECOVER PAYMENTS IN ERROR If the Company should pay for any contractually excluded services through inadvertence or error, the Company maintains the right to seek recovery of such payment from the Provider or Covered insured to whom such payment was made.

RIGHT TO ENFORCE CONTRACT PROVISION If the Company shall choose to waive their rights under the Contract regarding a specific term or provision, it shall not be interpreted as a waiver of their right to otherwise administer or enforce this contract in strict accordance with the terms and provisions.

TERMINATION We retain the right to cancel, modify or rescind the policy immediately;

1. If statements on the application are found to be misrepresentations incomplete or incorrect or that fraud has been committed, leading the Company to approve an application when, with the correct or complete information, We would have issued the policy with restrictions or declined coverage; or by submission or falsification of any information including fraudulent claims is also grounds for rescission or cancellation of the policy.
2. On the date the Company ceases to renew cover age for any class or classes of business under which an Insured is covered. The Company will notify the Insured of this action sixty (60) days prior to termination.
3. If the Grace Period has ended without payment of the required premium.
4. Upon written request from the Policyholder to terminate a dependent coverage or to terminate the Policy on the last day of the Period for which premium has been paid.
5. As specified by the Conditions of the Policy.
6. If the Insured does not comply with the residency requirements of the policy.

LARGE CLAIM MANAGEMENT The Company may determine that a particular claim occurring under this policy may require specific cost containment and case management. In the event that the Company determines that a particular claim meets the large case management requirements, the Company reserves the right to recommend and make payment for expenses that may not be covered under the terms of this insurance. Further, when in the Company's opinion, there are alternative treatments or procedures which may be more cost effective, the Company reserves the right to deny payment for expenses which are incurred which are over the amount the Company would pay if the recommendations of the Company had been followed.

NOTIFICATION REQUIREMENTS You are responsible for notifying Us within thirty (31) days of: (a) any change in Your or a Dependent's residency, occupation, marital status, newborns; or (b) any other change which may impact Your or Your Dependent's eligibility for coverage under this Policy. Failure to notify us could result in the immediate termination of Your, and Your Dependent's coverage under this Policy.

Residency

To be eligible for this policy you must reside outside of the United States (U.S.). However, visits up to 180 days in a Policy Year are allowed. Should an Insured remain longer than 180 days, coverage will terminate at the end of the 180th day.

ELIGIBILTY

ELIGIBLE INSURED To be eligible for coverage under this Policy, the Insured, as an Insured, must:

- Not be physically residing in the United States of America and any of its territories more than six (6) months in any Policy Year;
- Not be working on a permanent or temporary basis in the United States of America and any of its territories;
- Be in good health and not confined to a hospital or nursing home on the effective date of coverage. You are eligible for this plan if you have completed and signed an application. Received written acceptance from the Company, paid the required premium on or before the due date, under the age of seventy-four (74) and 11 months at the time of the application, and not be pregnant, hospitalized or disabled on the effective date of coverage.

ELIGIBLE DEPENDENT(S) To be eligible for coverage, the following individuals will be considered Dependent(s) under this Policy if they live with the Insured and they are:

- Wife or husband; and biological children adopted children
- The Insured unmarried children under age 19;
- The Insured unmarried children from age 19 to 26 years old, who are full-time students in an accredited university or college in or outside their Country of Residence, and receive financial support from the Insured;
- Not be physically residing in the United States of America and any of its territories for more than six (6) months.

TO BECOME EFFECTIVE: INSUREDS (PRIMARY INSURED) Your coverage under this Policy begins at 12:01 a.m. Greenwich Mean Time at your residence on the Effective Date shown on the Certificate of Coverage of this Policy. For your coverage to be effective on the date shown on the Certificate of Coverage you must be under the age of seventy-five (75) and 11 months, and not be pregnant, hospitalized or disabled and you must be able to perform your principle activity on the effective date of coverage. Should any or all of the requirements not be met, the effective date will be delayed until the requirements are met.

DEPENDENTS Coverage for those who are your dependents as of the date your coverage takes effect will become effective on that date, if, by then PA Group has received notification of your written request for coverage of such dependents.

EFFECTIVE DATE AND ENROLLMENT FOR NEW DEPENDENTS To enroll new Dependents after commencement of coverage, the Insured must submit a new Application and evidence of insurability acceptable to Us. Coverage will be effective on the first day of the month following the date the New Dependent is accepted by Us, provided any required premium has been paid, and subject to the waiting periods and all other terms and conditions of the Policy.

EFFECTIVE DATE AND ENROLLMENT FOR NEWBORN CHILDREN Coverage will be effective on the child's date of birth:

- Provided that a child is born to the Insured or the Insured dependent spouse after the effective date of the Insured Policy and covered under the Maternity Benefit;
- Provided that the required Application Form has been completed and submitted to us within thirty (30) days following such child's date of birth and any required premiums paid.

If the Insured fail to enroll a newborn eligible dependent within thirty (30) days of eligibility as described above, the Dependent will be considered a new dependent and will be required to provide evidence of insurability. Newborn children born as a result of fertility treatment will not be covered automatically, the Insured must submit an Application to enroll the New Dependents and it will be subject to proof of insurability.

DEPENDENT CHILD AGE LIMIT When a Dependent child marries or attains Age nineteen (19) or twenty–six (26) if full time student in an accredited college or university, coverage will continue until the end of the Policy year. Thereon the Company will issue a separate Policy with the same plan option, deductible and conditions of the previous one, coverage will continue provided that the applicable premium is paid within thirty (30) of the date of commencement.

DEATH OF INSURED In the event of the Insured's death the Covered Dependent(s) will be covered under this Policy until the end of the contract year. Thereon the Company will issue a new Policy under the same plan, deductible and conditions of the previous one, coverage will continue provided that the applicable premium is paid within thirty (30) of the date of commencement.

DIVORCE If marital status changes due to divorce, the Insured should notify the company within thirty (30) days of the date of the divorce. Coverage for the Dependent spouse, under this Policy will cease at the end of the contract year in the Policy. Thereon the Company will issue a new Policy under the same plan, deductible and conditions of the previous one, coverage will continue provided that the applicable premium is paid within thirty (30) of the date of commencement.

HANDICAPPED DEPENDENT CHILD Health Care Coverage for your fully handicapped child may be continued past the maximum age for a dependent child. Proof that your child is fully handicapped must be submitted to PA Group no later than 30 days after the date your child reaches the maximum age.

Your child is fully handicapped if:

- He or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children; and
- He or she depends chiefly on you for support and maintenance.

Coverage will cease on the first to occur of:

- Cessation of the handicap;
- Failure to give proof that the handicap continues; Failure to have any required exam;
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

PA Group will have the right to require proof of the continuation of the handicap. PA Group also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age.

LATE ENROLLMENT OF DEPENDENTS If you fail to apply for insurance of an Eligible Dependent within thirty-one (31) days of eligibility, as described above, the Dependent will be considered a late applicant and will be required to provide evidence of insurability, at no cost to PA Group Coverage for the Dependent will be effective on the first day of the month following the date the Company acknowledges the evidence of insurability is satisfactory, provided any required premium has been paid on his behalf. The Company may exclude a Dependent from coverage or may exclude from coverage treatment of specified conditions.

TERMINATION OF COVERAGE Coverage under this Policy terminates at 12:01 a.m. Greenwich Mean Time at the first to occur of: When premiums payments are not made.

- When membership in the Worldwide Expatriate Association ceases;
- When you are no longer eligible as defined;
- When you fail to make any required contributions;
- The date the primary insured becomes a resident within the U.S.;
- When you have been in the U.S. for more than one hundred and eighty days (180) during a Policy Year.

TERMINATION OF DEPENDENT'S COVERAGE A dependent's coverage will terminate at the first to occur of:

- When a dependent becomes covered as an insured;
- When such person is no longer a defined dependent;
- When your coverage terminates.

CONTINUATION OF COVERAGE This policy is not HIPAA or COBRA compliant.

CHANGE OF RISK We reserve the right to alter the Policy terms or cancel cover for an Insured Person following a change of risk, e.g. change to a hazardous occupation.

Premiums

The Premiums set forth as stated in the application shall be effective for the initial term of the policy. Thereafter, if PA Group gives a minimum of thirty (30) days' prior written notice to the policyholder, PA Group may change the premium:

- Upon the renewal date of this policy; or
- Upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to policyholders.

Payment of the applicable premium on and after that date shall constitute acceptance of those changes by the policyholder, individually and on behalf of all dependents enrolled under the policy.

Premiums are payable to PA Group on or in advance of each premium due date at the corporate offices of PA Group unless otherwise specified by PA Group in writing. The payment of any premium shall not maintain coverage under the policy in force beyond the date when the next payment becomes due; however, a 31-day grace period, during which time this policy will remain in force, shall be granted for payment of each amount due after the first. The policyholder shall remain liable for the payment of the premium for the time coverage was in effect during the grace period and the policyholder shall remain liable for co- payments owed. A check is not a payment until it is honored by a bank. PA Group reserves the right to return a check issued against insufficient funds without resorting to a second deposit attempt.

Premiums shall be paid in full for policyholders whose coverage is effective on the premium due date or whose coverage terminates on the last day of the premium period.

Coordination Of Benefits (COB)

Under this policy, this COB provision applies to you or your dependents (if applicable) who may be entitled to benefits as a result of any other Plan.

EFFECT OF BENEFITS UNDER OTHER PLANS Some persons have health coverage in addition to coverage under this Plan. When this is a Medicare case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans. In a calendar year, this Plan will pay its regular benefits in full, or a reduced amount of benefits. To calculate this amount please subtract B from A as shown next:

1. 100% of any other coverage. COB limits the total benefits payable by all Plans to the amount of the "Allowable Expenses" actually incurred during a policy year by an Insured. In no event will more than 100% of the allowable charge and/or maximum benefit for the covered services be reimbursed. This provision applies whether or not a claim is filed under the other coverages. In order to administer this provision, it is the duty of the Insured to inform PA Group of all other applicable plans.

2. The benefits payable by the "other plans". When plans provide benefits in the form of services rather than cash payments, is the cash value will be used.

"Allowable Expenses" means any necessary and reasonable health expense, part of all which is covered under any of the plans covering the person for whom claim is made. Not included is any expense listed in General Exclusions.

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent.

3. Except in the case of all other coverage. PA Group can release or obtain data. PA Group can also make or recover payments.

OTHER PLANS

- Group Insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not, or any other insurance policy, or any plan sponsored, underwritten, subsidized, or otherwise provided for, by, or through a government or instrumentality of a nation.

ALLOWABLE EXPENSES Means any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made. Not included is any expense listed under General Exclusions.

ORDER OF BENEFIT DETERMINATION Is the order in which the various plans will pay benefits. This will be determined as follows:

- A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
- A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent.
- Dependent child whose parents ARE NOT divorced or separated: the plan, which covers the Person as a dependent of a Person whose birthday comes later in that calendar year. If the other plan does not have this provision regarding birthdays, then the rule set forth in the plan will determine the order of benefits.
- In the case of a dependent child whose parents are divorced or separated and the covered person is insured under two or more Plans as a dependent child, benefits for such child are determined in the following order:

1. First, the Plan of the parent with custody of the child;

2. Then, the Plan of the spouse of the parent with custody of the child; and

3. Finally, the Plan of the parent not having custody of the child.

If there is a court decree which should establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

- Dependent child/Joint Custody where the specific terms of b. If there is not such a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering such child will follow the order of benefit determination stated under the Dependent Child whose parents ARE NOT separated or divorced.

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

COORDINATION OF BENEFITS CONTINUED If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined. Continuation Coverage for a covered person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the order of benefit determination is as follows:

- Before the benefits of a plan which covers that child as a dependent of the step parent. The benefits of a plan which covers that child as a dependent of the

stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

a. First, the benefits of a Plan covering such covered person as an employee, member or subscriber or as such covered person's dependent;

b. Second, the benefits under the continuation of coverage.

If the other Plan does not contain the order of benefit determination stated in this rule, this rule will be ignored.

• If the above rules 1,2 and 3, do not establish an order of payment, the Plan under which the person has been covered for the longer period of time will be deemed to pay its benefits first as the primary Plan. The following applies in determining the period of time the covered person as been covered under a Plan, except that:

a. Two Plans are considered one continuous Plan, if the covered person is eligible for coverage under the second plan within 24-hours after the first Plan ended.

b. A new Plan does not start because of changes: (1) in the amount or scope of a Plan's benefits; (2) in the carrier insuring the Plan; or (3) from one type of Plan to another.

c. The covered person's length of time under a Plan begins with his or her effective date of coverage under such Plan, except that if such date is not available, the length of time under a Plan begins with the date he or she became a member of the group.

EFFECT ON BENEFITS PA Group will determine which Plan will be primary by the rules outlined above. PA Group will determine its benefits first and the benefits payable by any other Plan(s) will be ignored based on the following formula whether or not a claim is made under the other coverages:

The benefits that would be payable for the allowable expenses under the policy in the absence of this COB provision, and, The benefits that would be payable under the other Plan(s), in the absence of provisions similar to this COB provision, whether or not claim is made; exceeds such allowable expenses in a claim determination period. In this case, the benefits of this policy will be reduced so that such benefits and the benefits payable under the other Plan(s) do not total more than such allowable expenses.

Right to Receive and Release Needed Information PA Group has the right, without the consent of any person, to determine which facts it needs to apply this COB provision and may get such needed facts from or give them to any other organization or person. Each covered person claiming benefits under this Plan must give PA Group any facts it needs to adjudicate such claim.

PA Group reserves the right to review the original documents.

Coordination of Benefits with Medicare or such Government Policies Applies when a covered person is eligible to apply for Medicare or the Government policy and or has incurred covered expenses which are payable under both the Policy and Medicare or the Government policy.

Benefit Determination with Medicare or such Government Policies Will be determined by the amount otherwise payable under this Policy and the amount payable by Medicare or such Government Policies. The amount payable by Medicare or such Government Policies will be determined as if the covered person has enrolled in Medicare or the Government Policies.

Facility of Payment Applies if a payment is made, including the reasonable case value of benefit provided in the form of services, under another Plan which includes an amount which should have been paid under this Policy, Premier Assurance Group SPC, Ltd on behalf of Global Assurance Segregated Portfolio will pay that amount to the organization which made such payment and or treat such amount as a benefit paid under this Policy.

Right Of Recovery If PA Group pays, including the reasonable case value of benefits provided in the form of services, more than it should have under this COB provision it may recover such excess from any person to or on whose behalf it has made such payments; or from any insurance company, or any other plan, service plan or organization.

SUBROGATION REIMBURSEMENT This provision defines:

• Claim as benefits paid under the Policy.

• Claimant as a covered person, or the parents or legal guardians of an insured child.

COORDINATION OF BENEFITS CONTINUED

Right to Subrogation To the extent permitted by law, PA Group shall be subrogated to all rights of recovery of a claimant to the extent of any claim paid. The subrogation right applies against any third party or insurer responsible for paying the present and future costs for the injury, sickness or pregnancy to which the claim relates.

Right of Reimbursement When the claimant shall reimburse PA Group for all payments made under the Policy for the claim. This reimbursement shall be made from the proceeds of any settlement or judgment resulting from the claimant's exercise of any rights of recovery against a third party responsible for the injury, sickness or pregnancy to which the claim relates.

Third Party Liability Exclusion Will apply when no benefits will be paid under the Policy to or on behalf of a claimant, to the extent the claimant has received payment from a third party or such third party's insurer for past or future expenses covered under the Policy.

Action Required of Claimant The claimant shall notify (a) any third party, or its insurer, against whom he or she shall exercise any right of recovery, of the existence of PA Group's rights under the provision; and (b) PA Group of any claim brought against such third party; as soon as practical. If requested in writing by PA Group or their authorized representative, the claimant or claimant's authorized representative shall: (i) take such action as necessary or appropriate to recover, as damages, payments made by PA Group ; or (ii) joining PA Group as parties to any litigation that is commenced.
The claimant shall hold in trust for PA Group's benefit any money recovered from such third party. The claimant shall reimburse PA Group immediately upon recovery.

Severability In the event any section of this provision is considered illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining sections of this provision and Policy. Such section shall be fully severable. The Policy shall be construed and enforced as if such illegal or invalid provisions had never been inserted in the Policy.

OTHER PLAN This means any other plan of health expense coverage under: Group Insurance. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not, or any other insurance policy, or any plan sponsored, underwritten, subsidized, or otherwise provided for, by, or through a government or instrumentality of a nation.

GENERAL INFORMATION ABOUT YOUR COVERAGE The Signature Healthcare Plan is underwritten by Premier Assurance Group SPC, Ltd on behalf of Global Assurance Segregated Portfolio. The benefits and main points of the group contract for persons covered under this Plan are set forth in this Policy. They are effective only while you are covered under the policy.

ISSUE DATE Your Plan effective date is the date upon your acceptance by Premier Assurance Group SPC, Ltd on behalf of Global Assurance Segregated Portfolio.

CERTIFICATION DOES NOT GUARANTEE BENEFITS Benefits payable under this Policy are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations and exclusions, and provisions of this Policy. Certification does not guarantee or confirm benefits under this Policy.

24-HOUR EMERGENCY ASSISTANCE AND EVACUATION SERVICES The Signature Healthcare Plan includes 24-hour emergency assistance and evacuation services.

Insured's should contact the pre-certification company listed on your personal identification card.

Multi-lingual customer service representatives are available 24-hours a day to answer inquiries, conduct pre-certification assist in locating providers or coordinating an emergency evacuation or repatriation of remains.

TYPE OF COVERAGE Coverage under the Signature Healthcare Plan for benefits is non-occupational. Only non-occupational accidental injuries and non-occupational diseases are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

If you are employed at a location that is not governed by a worker's compensation law or similar law providing occupational coverage, the terms "non-occupational disease" and "non-occupational injury" shall also mean any disease or injury which arises out of or in the course of your work with your Employer, provided you are not covered under any worker's compensation coverage.

PHYSICAL EXAMINATIONS PA Group will have the right and opportunity to have a physician of its choice examine any person for whom pre-certification or benefits have been requested. The cost associates with this examination are the responsibility for PA Group.

LEGAL ACTION No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Premier Assurance Group SPC, Ltd on behalf of Global Assurance Segregated Portfolio will not reduce or deny a benefit payment on the grounds that a condition was not disclosed on the application before the members coverage went into effect, if the initial date of loss occurs more than 5 years from the date coverage commenced. This will not apply to conditions excluded on your Certificate of Coverage.

ADDITIONAL PROVISIONS
- Insured's cannot have multiple coverage under this Policy.
- In the event of a misstatement, omission, concealment or fraud, either in the Insured's application which forms a part of the Policy and the Certificate of Coverage, or in relation to any statement, certification or warranty made by the Insured or their representatives, agents or proxies, whether in writing or otherwise, to the Company or the Plan Administrator of their respective agents, employees or representatives, or in connection with the making of any claim under this insurance, shall render this coverage null and void and all claims and benefits under the insurance shall be forfeited and waived, of any fact affecting your coverage under this Plan.
- Assignment of coverage may be assigned only with the written consent of PA Group.

Recovery Of Overpayment

In the event of overpayment by the Company of any claim for benefits under this insurance, for any reason, including without limitation because:

a. All or part of the claim was not incurred by or paid by or on behalf of the Insured Person; or
b. The Insured Person or any member of the Insured's Person's family, whether or not the family member 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 by Other Coverage or by or from a source other than the Company; or
c. All or part of the claim was not eligible for payment or coverage under the Terms of this insurance; or
d. All or part of the claim was paid or reimbursed based on an incorrect or mistaken application of benefits under this insurance; or
e. All or part of the claim has been excused, waived, abandoned, forfeited, discounted or released by the provider; or
f. The Insured Person is not liable or responsible as a matter of law for all part of a claim.

The Company shall have the right to a refund of and to recover the amount of overpayment from the Insured Person and/or the Hospital, Physician, or other provider of services or supplies, as the case may be. For overpayment of claims under paragraphs (c) and (d) above, the amount of the refund and recovery shall be the difference between: (i) the amount actually paid by the Company, and (ii) 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 or the 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 full extent of the refund due to the Company and/or (ii) cancel this Certificate of Coverage and all further coverage of the Insured Person under the Master Policy by giving thirty (30) days advance written notice by mail to the Insured Person's 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.

Explanation Of Some Important Plan Provisions Payment Of Benefits

PA Group has the right to pay any health benefits to the service provider. This will be done unless you have notified PA Group otherwise by the time you file the claim. Any such payments will fully discharge PA Group's obligation to the extent PA Group will not be responsible as to how the payment is applied.

RECORD OF EXPENSES PA Group recommends that you keep copies of complete records of the expense of each person. They will be required when claim is made. Very important including, but not limited to: names of physicians, dentists and others who furnish services, dates expenses are incurred and copies of bills and receipts. PA Group reserves the right to review original documents upon request.

PROOF OF CLAIM Proof of claim must be submitted with a complete claim form and either the original itemized bill, or legible copies of an itemized bill that has been filed via facsimile or PDF file. Each bill must be a complete itemized bill from the provider of service and must show the patient's full name, service or supply rendered and the date(s) of service. PA Group reserves the right to request the original bill(s) at any time prior to releasing the benefits.

REMIT CLAIMS TO

International Healthcare Administrators
135 San Lorenzo Avenue PH-860
Coral Gables Fl 33146
Claims@iha-assist.com.

NOTICE OF CLAIM AND TIME LIMITATION Requests for payment of benefits must be received by PA Group no later than three (3) months or 90 days following the date on which the Insured received the service. Claims received after this date will be denied. After termination of this Policy, claims for expenses incurred while the Policy was in force shall be considered if they reach the Insurer within 90 days of such termination. After expiration of this term, the Policyholder, the Insured Persons, the recipient of benefit and the Insurer have neither rights nor obligations.

POLICY YEAR DEDUCTIBLE The Deductible amount applies to all Covered Expenses, unless otherwise noted. The following will not be used to satisfy the Deductible amount: (a) amounts which are greater than Usual, Customary and Reasonable Charges (UCR); (b) charges incurred for treatment, services, or supplies which are not covered under this policy; (c) charges which are in excess of benefit limitations (e.g. number of days, months, visits, or dollar amounts); and (d) any other type of charges as stated in a Policy Rider.

LIFETIME MAXIMUM BENEFIT This is the maximum amount that will be payable under this Plan for any person during his lifetime.

PRE-EXISTING CONDITION Means a Condition:

a. Resulting from Illness or Injury for which a Covered Person has received a diagnosis, consultation, medical treatment, services, supply or drug prescription prior to the effective date of the Policy or its reinstatement;

b. For which symptom, medical advice or treatment was recommended by or received from a physician prior to the effective date of the Policy or its Rein statement;

c. For which symptom and/or sign of illness, if presented to a physician would have resulted in the diagnosis of illness or medical condition.

ANNUAL OUT OF POCKET CO-INSURANCE LIMIT For the period of coverage, and where a co-insurance applies, we will pay the percentage of costs in the schedule of benefits up to the co-insurane limit (payment limit). Thereafter we will pay 100% of the eligible treatment expenses up to applicable limits. Eligible treatments requiring pre-certification and not pre-certified will be subject to a 50% co-insurance without a limit. Co-payments, deductibles, fees over usual and customary do not count towards the out of pocket co-insurance limit.

The Maximum Annual Benefit Amount includes any and all other maximum benefit amounts shown in this Schedule of Benefits or added by Policy rider including benefits for Emergency Assistance Services. It also includes the fees incurred in the negotiations and/or contractual fees incurred to reduce the cost of such services Any unused portion of the Maximum Annual Benefit Amount, or of any other maximum benefit amount shown in this Schedule of Benefits will only be payable for expenses incurred while coverage under this Policy is in force for a Covered Person.

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group contract. Requests for amounts other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Policy is underwritten by Premier Assurance Group SPC, Ltd on behalf of Global Assurance Segregated Portfolio.

Procedures For Claims Submission And Payment

CLAIM PAYMENT Benefits under this Policy will only be accepted and processed if proof of claim is submitted to Us or to Our Claims Administrator within ninety (90) days of date of service. No benefits will be paid for claims presented to Us after ninety (90) days from the date services were rendered or supplies were furnished. In order to process claim payment, we must receive:

- A Claims form for each Covered Person fully completed, including diagnosis, signed by the attending Physician. Claim forms are furnished with the policy or may be obtained by contacting the Insured agent, Us or Our Claims Administrator;
- The original itemized bills or receipts for treatment or service, prescription and pharmacy bills, Such bills must include the name of the patient, the date of service and be in the currency of the country where services are performed; on the providers letterhead to include the name of the practice and or provider, address and phone number;
- Patient's medical history;
- Any additional documentation requested by Us necessary for the review and/or payment of the claim within the terms of this Policy. All documents and materials (including but not limited to original accounts, certificates and x-rays) that we require to support a claim, an application for coverage or change in coverage shall be provided without expense to us. Including if requested by us medical report from enrolled persons physician or specialist physician and details of enrolled person's medical history prior to any claim. In cases where the medical information is required by us for consideration of a claim but it is not available to us, it is your responsibility to obtain such information from the enrolled person's current or previous physician as appropriate.

CLAIMS APPEAL PROCEDURE The Company will provide a written explanation of the reason it denies, in whole or in part, a claim for benefits under this Policy. If there is any question about the settlement or denial of a claim, the Insured has the right to request a full and fair review of that claim. The process is as follows:

- Within sixty (60) days of receiving a claim denial, a signed letter by the insuredmust be sent to the Company stating the reasons for appeal and any additional information to support the claim;
- With the Insured appeal, the Insured must include the Insured Policy number, the Insured name and the name of the Covered Person for whom claim was made, the Provider, the amount of the claim, the date the claim was made, and the date it was denied;
- Within sixty (60) days of the written appeal, the Company will notify the Insured by mail of the final decision and the specific explanation for the decision. If more extensive review is required, a final decision will be made within one hundred twenty (120) days from the date of the appeal;
- All correspondence regarding claim appeals should be sent to our Claims Administrator.

SIGNATURE HEALTH PLAN

POLICY WORDING

Policies are underwritten by Premier Assurance Group SPC LTD on behalf of the Global Assurance Segregated Portfolio (PA Group), regulated by Cayman Island Monetary Authority, and issued by WEA, Ltd, and administered by International Healthcare Administrators, Inc. (IHA). Registered address: 135 San Lorenzo Ave. PH-860 Coral Cables, FL 33146.

PA Group does not provide care or guarantee access to health services. Not all health services are covered. Health information packages provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of cover. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about WEA Benefits plans, refer to www.weadirect.com/signature. Underwritten by: Premier Assurance Group SPC LTD on behalf of the Global Assurance Segregated Portfolio (PA Group), regulated by Cayman Island Monetary Authority (CIMA).

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Rev 04-2014