Certificate of Insurance

Global Medical Insurance®

Platinum

IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA): This insurance is not subject to, and does not provide benefits required by, PPACA. On January 1, 2014, PPACA requires U.S. citizens, US nationals and resident-aliens to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so. Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is solely your responsibility to determine if PPACA is applicable to you and the Company and IMG shall have no liability whatsoever, including for any penalties that you may incur, for your failure to obtain required PPACA compliant coverage.

SURPLUS LINES NOTICE: THIS INSURANCE IS ISSUED PURSUANT TO APPLICABLE SURPLUS LINES LAW. PERSONS INSURED BY SURPLUS LINES CARRIERS DO NOT HAVE THE PROTECTION OF STATE INSURANCE GUARANTY LAWS TO THE EXTENT OF ANY RIGHT OF RECOVERY FOR THE OBLIGATION OF AN INSOLVENT UNLICENSED INSURER.

A. AGREEMENT - Sirius International Insurance Corporation (publ) (the Company) promises and agrees to provide the Insured Person with the benefits described in the Master Policy, as outlined herein and coverage for which is certified hereunder by the Company. The Company makes this promise and agreement in consideration of the Assured's Application, the accuracy and truthfulness of the Insured Person's Application and payment of Premium, and subject to all of the Terms of the Master Policy and as contained therein, including any Riders. The Master Policy is effective as of January 1, 2014, and shall remain in effect until terminated in accordance with the TERMINATION OF MASTER POLICY section. This Certificate shall be effective as of the Effective Date of Coverage shown on the Declaration, and shall remain in effect until terminated in accordance with the TERMINATION OF COVERAGE FOR INSURED PERSON section. This Certificate is not part of the insurance contract. The contract is the Master Policy, the Application, and any applicable Riders. This Certificate is merely a description of and evidence of the Insured Person's rights and benefits under the contract. The Declaration likewise is evidence of the coverage under the contract and a statement of the Effective Date of Coverage, subject always to the terms of coverage contained within the contract. The Company hereby recognizes International Medical Group®, Inc., as the Company's authorized agent and representative, and as the Plan Administrator of the Master Policy and this Certificate. Subject to the provisions of the SERVICE OF SUIT; VENUE; CHOICE OF LAW; TRIAL BY COURT section, all communications, notices and payments to the Company that are required or permitted under the Master Policy and/or as described in this Certificate shall be transmitted through the Plan Administrator, and receipt of same by the Plan Administrator shall be considered receipt by the Company.

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

(1) ENTIRE AGREEMENT - The Master Policy, including the Application, and any Riders, shall constitute the entire agreement among the Company, the Assured, and the Insured Person. This Certificate, including the Application, the Declaration, and any Riders, is an outline and evidence of the insurance provided by the Master Policy. This Certificate does not extend or change the coverage provided by the Master Policy. The insurance evidenced by this Certificate is subject to all Terms of the Master Policy, including the Application, and any Riders.

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

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

(b) prior to any reinstatement under the REINSTATEMENT OF COVERAGE FOR INSURED PERSONS section; and

(c) on or before any renewal date as specified in the RENEWAL; AMENDMENTS section.

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

(3) PROOF OF CLAIM - When the Company receives notice of a claim for benefits under this insurance from or on behalf of an Insured Person it will provide the Insured Person with Claimant's Statement and Authorization Forms ("Claim Forms") for filing Proof of Claim. The following items must be submitted by or on behalf of the Insured Person to be considered a complete Proof of Claim eligible for consideration of coverage under this insurance ("Proof of Claim"):

(a) a duly completed, timely submitted, and signed Claim Form and authorization for release of information; and

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

(c) all original receipts for any costs, fees or expenses that have been incurred or paid by or on behalf of the Insured Person with respect to the claim, including without limitation all original receipts for any cash and/or credit card payments.

The Insured Person and/or Physician, Hospital and other healthcare and medical service providers and supplier shall have ninety (90) days from the date a claim is incurred to submit a complete Proof of Claim, and the Company at its option may pend resolution and adjudication of submitted claims and/or may deny coverage: for Proofs of Claim submitted thereafter; or for incomplete Proofs of Claim; and/or for failure to submit a Proof of Claim; provided, however, that the Company at its option may waive the requirements regarding submission of a new Claim Form for subsequent claims incurred by an Insured Person relating to a continuing Illness, Injury or other medical condition for which a properly completed and signed Claim Form has previously been submitted and received.

(4) APPEALING A CLAIM - In the event the Company denies all or part of a claim, the Insured Person shall have a reasonable opportunity to appeal the denial under which there will be a review of the claim and the determination. Insured Persons shall have sixty (60) days from the date that the notice of denial was mailed to the Insured Person's last known residence or mailing address within which to appeal the determination, and shall have the opportunity to submit written comments, documents, records, and other information relating to the claim. The Company's review will take into account all comments, documents, records, and other information submitted by the Insured Person relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. Insured Persons must file two (2) appeals of a claim denial prior to bringing any legal action under the contract of insurance. Upon receipt of a written appeal, the Company shall have an opportunity for further reasonable investigation and/or review as set forth in the Explanation or Verification of Benefits section, and will respond in writing as soon as reasonably practicable, and in any event within ninety (90) days from receipt thereof.

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

(6) SERVICE OF SUIT; VENUE; CHOICE OF LAW; TRIAL BY COURT - No action at law or in equity can be brought by an Insured Person to recover on the contract of insurance prior to the later of (1) expiration of sixty (60) days after written Proof of Claim has been furnished in accordance with the contract of insurance or (2) exhaustion of two (2) appeals under the APPEALING A CLAIM provision above. No action at law or in equity can be brought after the expiration of three (3) years after the time written Proof of Claim is required to be furnished under the contract of insurance. The contract of insurance between the Insured Person and the Company as represented by the Master Policy and evidenced by this Certificate shall be deemed issued, finalized and made in Indianapolis, Indiana. Sole and exclusive jurisdiction and venue for any court action or administrative proceeding relating to this insurance shall be in Marion County, Indiana, for which the Insured Person expressly consents. The subjects, risks and benefits of insurance covered by the Master Policy and evidenced by this Certificate are not intended or considered by the Insured Person or the Company (or the Plan Administrator) to be resident, located, or to be performed in any particular State of the United States. Indiana surplus lines law shall govern all rights and claims raised under this Certificate of Insurance. Under Indiana surplus lines law, this Certificate of Insurance and the Master Policy are not subject to approval of rates or policy forms, nor are they subject to regulation of mandatory statutory policy language required of admitted insurance carriers in Indiana.

In the event of the failure of the Company to provide benefits or pay or reimburse any amount claimed to be due under this insurance, the Company, at the request of the Insured Person and upon receipt of lawful process or summons, will submit to the jurisdiction of a court of competent subject matter jurisdiction located in Marion County, Indiana. The Company and the Insured Person consent to the exclusive personal jurisdiction and exclusive venue in the Circuit and/or Superior Courts of Marion County, Indiana, and in the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful). All trials regarding any dispute under this insurance

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

Nothing in this section constitutes or should be deemed, considered or understood to constitute a waiver of the Company's or the Insured Person's rights to: (i) oppose venue, procedural and/or substantive choice of law, personal jurisdiction, or subject matter jurisdiction in any forum other than the Circuit or Superior Courts of Marion County, Indiana, or the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful), (ii) oppose commencement of an action in any court of competent jurisdiction in or outside of the United States, other than an action commenced in the Circuit or Superior Courts of Marion County, Indiana, or the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful), (iii) remove an action to a United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful), or (iv) seek transfer of an action in any court of competent jurisdiction in or outside of the United States, other than an action commenced in the Circuit or Superior Courts of Marion County, Indiana, or the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful).

Subject to and without limiting, expanding, superseding, modifying or waiving any of the foregoing Terms contained in this section pursuant to any statute of any State, territory or district of the United States which makes provision thereof, the Company hereby designates the Superintendent, Commissioner, or Director of Insurance (or such other officer specified for that purpose in the statute), or his successor or successors in office, as its true and lawful attorney, under a special power of attorney, upon whom may be served any lawful process issued in connection with the initiation of any action, suit or proceeding instituted by or on behalf of the Insured Person arising out of this insurance, including specifically the Commissioner of Insurance for the Indiana Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, IN 46204, and hereby designates and appoints John P. Dearie, Jr., Esq., Edwards Wildman, LLP, 750 Lexington Avenue, New York, New York 10022, as its attorney-in-fact and agent for service of process to whom said officer or Commissioner is authorized to mail or serve any such process or a true copy thereof.

For Florida residents only: If any dispute shall arise as under the terms and conditions of this Certificate, such dispute may be referred to arbitration in accordance with the procedures of the American Arbitration Association. Any such arbitration shall be held within 50 miles of the Insured Person's residence, with the Company to pay costs and fees (not including any attorney fees) of the proceeding in excess of $500.00.

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

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

(9) SUBROGATION CLAUSE - The Insured Person shall undertake to pursue in his/her own name and stead, and to fully cooperate with the Company in the pursuit and prosecution of, any and all valid claims that the Insured Person may have against any third party who may be liable or responsible for any loss or damage arising out of any act, omission or occurrence which results or may result in a loss payment, provision of benefits, or coverage of claim by the Company under this insurance, and to fully account to the Company for any amounts recovered or recoverable in connection therewith, on the basis that the Company shall be reimbursed and entitled to recover first in full for any sums paid or to be paid by it before the Insured Person shares in any amount so recovered. The Insured Person further agrees and understands that the Company requires the Insured Person to complete a subrogation questionnaire, sign an acknowledgment of the Company's Subrogation rights and sign an agreement before the Company considers paying, or continues to pay, any claims. Should the Insured Person fail to so cooperate, account, or to prosecute any valid claims against any such third party or parties, and the Company thereupon or otherwise becomes liable or otherwise obligated to make payment under the Terms of this insurance, then the Company shall be fully subrogated to all rights and interests of the Insured Person with respect thereto and may prosecute such claims in its own name as subrogee. The Insured Person's submission of Proof of Claim or acceptance of coverage or benefits under this insurance shall be deemed to constitute an authorization, consent and assignment of such subrogation rights by the Insured Person to the Company. The Insured Person agrees the Company has a secured proprietary interest in any settlement proceeds the Insured Person receives or may be entitled to receive. The Insured Person understands and agrees the Company is entitled to a constructive trust interest in the proceeds of any settlement or recovery. The Insured Person agrees to include the Company as a co-payee on any settlement check or check from any third party or insurer. The Insured Person agrees he/she will not release any party or their insured without prior written approval from the Company, and will take no action which prejudices the Company's rights. The Insured Person is obligated to inform their legal representative of the Company's rights and lien and to make no distributions from any settlement or judgment which will in any way result in the Company receiving less than the full amount of its lien without the written approval of the Company. Any amount

recovered by the Company in accordance with the foregoing shall first be used to pay in full the costs and expenses of collection incurred by the Company, including reasonable attorneys' fees, and for reimbursement to the Company for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts recovered shall be paid to the Insured Person or other persons lawfully entitled thereto, as applicable. In the event that the Insured Person receives any form or type of settlement and either fails or refuses to abide by the terms of this insurance contract, in addition to any other remedies the Company may have, the Company retains a right of equitable offset against future claims.

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

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

After the Review Period, the Insured Person may request cancellation of the Declaration and this Certificate by giving the Company not less than sixty (60) days advance written request. Cancellation is at the sole option of the Company, except as provided in the RENEWAL; AMENDMENTS section, and the Company may request and/or require the Insured Person to execute a release of claims as a condition to and/or in consideration of granting such cancellation. If the Company grants cancellation, coverage for the Insured Person under this insurance shall terminate with effect from the cancellation date specified by the Company. The Company shall calculate the amount of Premium earned upon the Declaration and Certificate through the requested date of cancellation (Short Rate Earned Premium) in accordance with the Short Rate Cancellation Table in effect as of the date of the request for cancellation. If the Insured Person has paid more than the Short Rate Earned Premium, the Company shall refund the difference between the amount actually paid and the Short Rate Earned Premium. If the Insured Person has paid less than the Short Rate Earned Premium, the Insured Person shall remit to the Company the difference between the Short Rate Earned Premium and the amount actually paid as a condition to cancellation as of such requested date, or the cancellation date will be established retroactive to the date through which and for which Premiums have actually been paid.

(12) APPLICABLE CURRENCY - All benefit amounts, coverage, monetary limits and sub-limits, and other amounts stated in the Master Policy, the Application, the Declaration, this Certificate, and in any Riders, including Premium, are in U.S. dollars.

(13) COOPERATION - The Insured Person and his/her Physicians, Hospitals and other healthcare and medical service providers and suppliers shall undertake to cooperate fully with the Company and the Plan Administrator in reviewing, investigating, adjudicating, considering an appeal of, and/or administering any claim for benefits under this insurance, including granting full right of access to all relevant, pertinent or related records, medical documentation, medical histories, reports, lab or test results, x-rays, and all other available evidence relating to or affecting the review, investigation, adjudication or administration of the claim. The Company at its own expense shall have the right and opportunity to examine all evidence related to a claim when and as often as it may reasonably require during the pendency of a claim hereunder and to request an autopsy in case of death where it is not forbidden by law. The Company at its option may suspend or pend adjudication of a claim, and/or may deny benefits and/or coverage for a claim, when there has been: (i) a refusal to so cooperate, (ii) an unreasonable delay in such cooperation, and/or (iii) any other act or omission on the part of the Insured Person and/or his/her healthcare providers which hinders, delays, impairs, or otherwise prejudices the performance of the Company's obligations under this insurance.

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

intended to have or shall have any rights as a third-party beneficiary under this Certificate, the Declaration, or the Master Policy.

(15) FRAUDULENT CLAIMS - A person who knowingly and with intent to defraud the Company files a statement of claim containing any false, incomplete, or misleading information commits a felony. If any claim or request for benefits under this insurance shall be in any respect knowingly false, incomplete, misleading, concealing, fraudulent or deceitful, or if the Insured Person or anyone acting for or on his/her behalf under this insurance knowingly uses any false, incomplete, misleading, concealing, fraudulent or deceitful statements regarding the Insured Person, the insurance contract and all coverage thereunder may be cancelled, voided, rescinded and terminated by the Company in its sole and absolute discretion, and the Company shall have no obligation or liability for any such benefits, coverage or claims.

(16) ARBITRATION – With the exception of Florida residents' option to refer to arbitration, no claim for benefits for which liability, eligibility, or coverage under this insurance has been denied in whole or in part by the Company nor any other dispute or controversy arising under or related to this insurance shall be arbitrable or subject to arbitration under any circumstances or for any reason.

(17) TERMINATION OF MASTER POLICY - The Master Policy can be terminated at any time by either the Company or the Assured by giving at least thirty (30) days written notice to the other and to the Insured Person. Such termination will have no effect on this Certificate prior to the date of the termination, or on eligible coverage or benefits under this insurance accrued prior thereto. No additional Certificates will be issued or further Applications accepted for the plan after the date the Master Policy is terminated.

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

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

(b) the termination date as shown on the Declaration for this Certificate; or

(c) the date the Master Policy is terminated pursuant to the TERMINATION OF MASTER POLICY section; or

(d) the date the Insured Person first fails to meet or no longer meets the eligibility requirements for this insurance as set forth in the Master Policy and outlined in this Certificate; or

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

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

(g) the cancellation date specified by the Company pursuant to the CANCELLATION BY INSURED PERSON section; or

(h) the cancellation date specified by the Insured Person pursuant to the RENEWAL; AMENDMENTS section; or

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

Coverage for the Insured Person shall remain in full force and effect unless terminated pursuant to the provisions of this TERMINATION OF COVERAGE FOR INSURED PERSONS section, except as otherwise provided in the Master Policy, the Declaration, or this Certificate.

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

(a) a written request for Reinstatement; and

(b) a newly completed Reinstatement Application, which shall become a part of the Master Policy and any reinstated Certificate; and

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

since the Initial Effective Date under this insurance plan; and

(d) a written statement giving full details of the reason for the previous failure to pay Premium when due or to accept renewal terms in a timely manner; and

(e) payment of all Premium due.

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

(20) PATIENT ADVOCACY - Neither the Company nor the Plan Administrator shall have any right, obligation, or authority of any kind to ultimately select Physicians, Hospitals, or other healthcare or health service providers for the Insured Person or to make any medical Treatment decisions for or on behalf of the Insured Person, and all such decisions shall be made solely and exclusively by the Insured Person and/or his/her guardians, family members and treating Physicians and other healthcare providers. Subject to the foregoing, the Company may determine that a particular claim, benefit, Treatment, or diagnosis occurring under or relating to this insurance may be placed under the Company's "Patient Advocacy" program to ensure that Medically Necessary Treatment and supplies are provided in the most cost effective manner. In the event the Company determines that a claim, benefit, Treatment, or diagnosis meets the Company's Patient Advocacy program guidelines, the Company will notify the Insured Person as soon as reasonably practicable, and a Patient Advocate will be assigned to the Insured Person. Thereafter, the Company's Patient Advocate may make evaluations and/or recommendations of Treatment settings and/or procedures and/or supplies that may be more cost effective for the Company and/or the Insured Person. Such recommendations will be made with input from the Insured Person and/or the Insured Person's guardians, family members and treating Physicians and other healthcare providers, and will be made only when it can be reasonably demonstrated that the Medically Necessary Treatment and/or supplies can be provided in a more cost effective manner to the Company and/or the Insured Person. The Company will use its best efforts to evaluate and recommend Treatment settings and/or procedures and/or supplies that can reasonably be expected to result in the same or better care of the Insured Person. The Insured Person is under no obligation to accept or follow any of the Company's recommendations. However, if the Insured Person accepts and follows any of the Company's recommendations, the Insured Person agrees to hold the Company and the Company's agents and representatives, including the Patient Advocate, harmless from same, and the Company shall not be held liable or otherwise responsible for any Treatment or supply provided to the Insured Person except for the payment of claims and benefits eligible for coverage under the Terms of this insurance. After the Insured Person has been notified that the claim, Treatment, benefit or diagnosis meets the Company's Patient Advocacy program guidelines, the Company reserves the right, at its option and in its sole discretion without liability, to:

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

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

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

(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 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 supplier; or

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

The Company shall have the right to 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, 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 the full extent of the refund due to the Company; and/or (ii) cancel this Certificate 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 at his/her last known residence or mailing address, and offset against the amount of any refund of Premium due the Insured Person to the full extent of the refund due to the Company.

(22) REINSTATEMENT OF MAXIMUM LIMIT - After each Period of Coverage, the Company will reinstate up to $5,000 of the Maximum Limit for the next Period of Coverage for the Insured Person. This does not apply to Mental or Nervous Disorders, Maternity and Newborn care or Pre-existing Conditions limits, and such reinstatement will not apply where coverage for the Insured Person lapses or terminates. In no event shall the Maximum Limit exceed $5,000,000.

(23) RENEWAL; AMENDMENTS - Subject to the Terms of the TERMINATION OF MASTER POLICY, TERMINATION OF COVERAGE FOR INSURED PERSONS, and REINSTATEMENT OF COVERAGE FOR INSURED PERSONS sections, the Insured Person can request coverage under this insurance plan to be renewed from year to year in accordance with and subject to the Terms of the plan then in effect (including the Terms of the then applicable Master Policy) and so long as renewal Premium is paid when due and the Insured Person otherwise continues to meet the applicable eligibility requirements of the plan. The Company's commitment and the Insured Person's ability to renew is also subject to termination upon thirty (30) days written notice to the other party prior to the expiration date of the then existing Period of Coverage. The Company reserves the right in its sole discretion to make changes, additions and/or deletions to the Terms of the Master Policy, this Certificate, renewals or replacements of either, and/or to the Global Medical Insurance plan (including the issuance of Riders to effectuate same) at any time or from time to time after the Effective Date of Coverage of this Certificate, upon no less than ninety (90) days prior written notice to the Assured and the Insured Person ("Notice of Amendment"). The Notice of Amendment shall include a complete description of the changes, additions and/or deletions to be made, the effective date thereof (the "Change Date"), and notice of the Insured Person's cancellation rights as set forth below, and shall be sent first class mail, postage pre-paid, to the last known residence or mailing address of the Insured Person. Upon issuance of the Notice of Amendment, the Assured and/or the Insured Person shall have the right to request cancellation of this Certificate above, at any time prior to the Change Date; provided, however that cancellation under this section shall be at the option of the Insured Person, and coverage under this insurance shall terminate with effect from the cancellation date specified by the Insured Person (subject to the provisions of the TERMINATION OF COVERAGE FOR INSURED PERSONS section. If the Insured Person does not elect to cancel this Certificate in accordance with the foregoing, the changes, additions and/or deletions as made by the Company and specified in said Notice of Amendment shall take effect as of the Change Date specified in the Company's Notice, and this insurance shall thereafter continue in effect in accordance with its Terms, as so amended and modified.

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

C. SCHEDULE OF BENEFITS/LIMITS - Subject to the Terms of this insurance, including without limitation the Deductible and Coinsurance (unless otherwise expressly set forth to the contrary), and the various limits and sub-limits set forth below, the Company promises to provide the Insured Person the following benefits and coverages arising out of Injury or Illness incurred while this Certificate is in effect:

Benefit/Other	**Limit/Sub-limit**
Area of Coverage	Area 2: Worldwide Excluding US, Canada, China, Hong Kong, Japan, Macau, Singapore and Taiwan Area 3: Worldwide as indicated on the Declaration If the "Area" is blank on the Declaration, the Area of Coverage is Worldwide
Deductible	$100, $250, $500, $1,000, $2,500, $5,000 or $10,000 per Insured Person per Period of Insurance, as indicated on the Declaration.

	For Eligible Medical Expenses incurred in the United States: Outpatient: PPO Provider: The Deductible will be reduced by 50% to a maximum reduction of $2,500 for Eligible Medical Expenses incurred within the Preferred Provider Network. Non PPO Provider: Subject to full Deductible Inpatient – Emergency Treatment: PPO Provider: The Deductible will be reduced by 50% to a maximum reduction of $2,500 for Eligible Medical Expenses incurred within the Preferred Provider Network. Non PPO Provider: Subject to full Deductible Inpatient – Non-Emergency Treatment: Medical Concierge Provider: The Deductible will be reduced by 50% to a maximum reduction of $2500 for Eligible Medical Expenses incurred from a Medical Concierge Provider. (see USA MEDICAL CONCIERGE SERVICE section for further details). PPO Provider: Subject to full Deductible Non PPO Provider: Subject to full Deductible
Emergency Room Deductible	An additional Deductible of $250 will be applied for each Emergency Room visit for treatment of an Illness which does not result in a direct hospital admission.
Deductible Carry Forward	If the Period of Insurance is not less than 12 months and the deductible has not been met, then Expenses incurred during the last 30 days of the Period of Insurance will be applied toward satisfaction of the Deductible for the next Period of Insurance.
Family Deductible Limit	2 Deductibles per Family per Period of Insurance
Coinsurance	For Treatment received outside the US & Canada: After the Deductible, the plan pays 100% of eligible expenses up to Policy Maximum For Treatment received with the US & Canada: In the PPO Network or Medical Concierge Provider: After the Deductible, the plan pays 100% of eligible expenses up to Policy Maximum Outside of the PPO Network: After the Deductible, the plan pays 90% of eligible expenses up to US$5000, then 100% up to Policy Maximum
Maximum Limit	$8,000,000 lifetime maximum benefit
Supplemental Accident Benefit	$500 per covered Accident
Mental or Nervous Disorders	$50,000 lifetime maximum (after 12 months of continuous coverage)
Local Ambulance Expense	Usual, Reasonable and Customary
Hospital Room & Board	The average private room rate, including nursing service
Intensive Care Unit	Usual, Reasonable and Customary
Physical Therapy	$50 maximum allowable charge per visit, limited to one visit per day
Maternity	Following a separate Maternity Deductible of $1,000, the plan will pay 100% of Eligible Medical Expenses up to a 50,000 lifetime maximum (after 10 months of continuous coverage)
Newborn Care & Congenital Disorders	$250,000 maximum for Treatment of Newborn, including any Medically Necessary Treatment for Congenital Disorders, for the first 31 days of life.
Newborn Wellness	$200 maximum for the first 12 months of life (not subject to Deductible or Coinsurance)

Prescription Drug Expense	Within the United States: MUST Utilize Universal RX Card Co-Pay (per each 34 day supply): $20.00 Generic/$40.00 Brand when Generic is unavailable *(certain monthly per prescription amounts limits may apply and require pre-approval by the Company)* Outside of the United States: Subject to Deductible, then Usual, Reasonable and Customary
High School Sports Coverage	Up to a $20,000 lifetime maximum
Eligible Medical Expenses	Usual, Reasonable and Customary
Emergency Medical Evacuation	Up to the Maximum Limit. Must be approved in advance and coordinated by the Company.
Remote Transportation	Limited to $5,000 per Period of Insurance and $20,000 lifetime maximum. Must be approved In advance and coordinated by the Company.
Political Evacuation and Repatriation	Limited to a US$10,000 lifetime maximum. Must be approved in advance and coordinated by the Company.
Return of Mortal Remains	$50,000 per Insured Person for return of the Insured Person's Mortal Remains or ashes to their Home Country. Must be approved in advance and coordinated by the Company.
Emergency Reunion	Limited to a $10,000 lifetime maximum. Must be approved in advance and coordinated by the Company.
Pre-certification	Transplants: No coverage if Pre-certification provisions are not met. All Other: 50% reduction of Eligible Medical Expenses if Pre-certification provisions are not met.
Transplant Expense	$2,000,000 lifetime maximum for eligible Covered Transplants, subject to special Transplant Pre-certification provisions, and only when Treatment is provided within the Company's approved independent Managed Transplant System Network. Covered Transplants are: heart, heart/lung, lung, kidney, kidney/pancreas, liver and allogenic and autologous bone marrow.
Wellness	Adult: $500 per Period of Insurance (after 6 months of continuous coverage) for Insured Persons age 18 and over. Not Subject to Deductible or Coinsurance. Child: $400 per Period of Insurance (after 6 months of continuous coverage). Not Subject to Deductible or Coinsurance.
Second Surgical Opinion	50% reduction of Eligible Medical Expenses for failure to obtain a Second Surgical Opinion when required by the Company.
Area 2 Out of Area Treatment:	Limited to 30 days per Insured Person per Period of Insurance for Accident or Emergency Treatment only. Treatment in the US must be received from a Physician, Hospital or other healthcare provider within the Preferred Provider Network.
Vision Care Expenses	Exam: Up to $100 every twenty-four (24) months for a Routine Eye examination. Not subject to deductible and coinsurance. Corrective: Up to $150 every twenty-four (24) months for corrective lenses, contacts to correct vision and frames. Not subject to deductible and coinsurance.
Dental Care Expenses	(after 6 months of continuous coverage)
Calendar Year Maximum Deductible	US$750 per Insured Person US$50 per Insured Person per Calendar Year with a maximum of two (2) Deductibles per Family per Calendar Year.

Coinsurance	Plan Pays
Class I Services	
Preventative and Diagnostic	90%; Deductible Waived
Emergency Palliative Treatment	90%; Deductible Waived

Class II Services	
Radiographs	70% after Deductible
Oral Surgery	70% after Deductible
Endodontics	70% after Deductible
Periodontics	70% after Deductible
Minor Restorative Services	70% after Deductible
Class III Services	
Prosthodontics	50% after Deductible
Major Restorative Services	50% after Deductible

With regard to the foregoing Schedule of Benefits/Limits, the references to "continuous coverage" mean continuous unbroken coverage under the Global Medical Insurance plan. The applicable benefits described will become first available to the Insured Person only at the end of the continuous coverage period so specified.

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

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

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

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

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

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

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

(7) (i) if a United States citizen, must be residing outside of the USA as of the Effective Date (or renewal date) and plan to reside outside of the USA for at least six (6) of the next twelve (12) months thereafter; or (ii) if not a United States citizen: (a) must reside outside the USA at time of Application (or renewal); or (b) must plan to reside outside of the USA continuously for at least six (6) months during the Period of Coverage with required departure from the USA not more than thirty (30) days after the Initial Effective Date or renewal Effective Date; or (c) if located inside the USA at the time of Application (or renewal), must not be eligible for any other medical insurance plan which is available to individuals similarly situated and located in the USA and must provide the Company an Affidavit of Eligibility.

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

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

(a) Inpatient Treatment and/or supplies of any kind.

(b) any Surgery or Surgical procedure.

(c) any Treatment in an Extended Care Facility.

(d) any Home Nursing Care.

(e) Durable Medical Equipment.

(f) artificial limbs.

(g) all Covered Transplant Treatment;

(h) Computerized Axial Tomography (CAT Scan).

(i) Magnetic Resonance Imaging (MRI).

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

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

Inside the United States:	1-800-628-4664
Outside the United States:	1-317-655-4500 (Collect if necessary)
E-mail:	acm@imglobal.com
Website:	www.akesocare.com; and

For transplant Pre-certification, contact the Company through the Plan Administrator as soon as possible but **always within seventy-two (72) hours of becoming a candidate** for a Covered Transplant.

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

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

(3) LOSS OF COVERAGE/BENEFITS FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS - Except as provided in this section below with respect to Covered Transplant Treatment, if the Insured Person or his/her healthcare providers do not comply with the foregoing Pre-certification requirements, all Eligible Medical Expenses incurred with respect to said Treatments and/or supplies will first be reduced by fifty percent (50%), the applicable Deductible will be subtracted from the reduced amount, the Coinsurance will then be applied to the remainder of the reduced amount as applicable, and further benefits, if any, will be available only for the remaining balance of the reduced amount thereafter.

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

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

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

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

F. UNITED STATES PREFERRED PROVIDER ORGANIZATION (PPO) REQUIREMENTS –

(1) Special Benefits

(a) If Outpatient or Emergency Inpatient Treatment or supplies eligible for coverage under this insurance are received directly from the Company's approved list of independent PPO providers while the Insured Person is in the United States: the Company will reduce by fifty percent (50%) any part of the Deductible applicable to such claims, and

(b) If Outpatient, Emergency Inpatient or Non-Emergency Inpatient Treatment or supplies eligible for coverage under this insurance are received directly from the Company's approved list of independent PPO providers while the Insured Person is in the United States the Company will waive any and all Coinsurance applicable to such claims.

However, all claims for Treatment or supplies received in the United States from a non-PPO provider will remain subject to the applicable Deductible and Coinsurance, whether or not the Insured Person may be eligible for the foregoing special benefit relating to Treatment or supplies received from PPO providers.

(2) PPO Information: The Company, through the Plan Administrator, endeavors to maintain a contractual arrangement with one or more independent Preferred Provider Organizations (PPO) that has established and maintains a network of U.S.-based Physicians, Hospitals and other healthcare and health service providers who are contracted separately and directly with the PPO and who may provide re-pricings, discounts or reduced charges for Treatment or supplies provided to the Insured Person. Neither the Company nor the Plan Administrator has any authority or control over the operations or business of the PPO, or over the operations or business of any provider within the independent PPO network. Neither the PPO nor provider within the PPO network nor any of their respective agents, employees or representatives has or shall have any power or authority whatsoever to act for or on behalf of the Company or the Plan Administrator in any respect, including without limitation no power or authority to: **(i)** approve Applications or enrollments for initial, renewal or reinstated coverage under this insurance plan or to accept Premium payments, **(ii)** accept risks for or on behalf of the Company, **(iii)** act for, speak for, or bind the Company or the Plan Administrator in any way, **(iv)** waive, alter or amend any of the Terms of the Master Policy or this Certificate or waive, release, compromise or settle any of the Company's rights, remedies, or interests thereunder or hereunder, or **(v)** determine Pre-certification, eligibility for coverage, verification of benefits, or make any coverage, benefit or claim adjudications or decisions of any kind. It is not a requirement of this insurance that the Insured Person seek Treatment or supplies exclusively from a provider within the independent PPO network. However, the Insured Person's use or non-use of the PPO network may affect the scope and extent of benefits available under this insurance, including without limitation any applicable benefit reduction, Deductible, Coinsurance and Extra Deductible, as set forth above. An Insured Person may contact the Company through the Plan Administrator and request a PPO Directory for the area where the Insured Person will be receiving consultation or Treatment (therein listing the Physicians, Hospitals and other healthcare providers within the PPO network by location and specialty), or may visit the Plan Administrator's website at http://www.imglobal.com to obtain such information.

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

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

(a) Cataract Removal; and
(b) Cholecystectomy; and
(c) Coronary Bypass; and
(d) Hemorrhoidectomy; and
(e) Herniorrhaphy; and
(f) Hysterectomy; and
(g) Knee Surgery; and
(h) Laminectomy; and
(i) Ligation and stripping of varicose veins; and
(j) Lithotripsy; and
(k) Submucous resection; and
(l) Septo-rhinoplasty; and
(m) Spinal Fusion; and
(n) Tonsillectomy and/or adenoidectomy; and
(o) any Covered Transplant.

(2) The Physician providing the second opinion must:

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

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

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

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

If the second opinion differs from the recommending Physician, the Insured Person may be required to consult with another Physician for a third opinion as to the Medical Necessity of the Surgery. The third Physician must also meet the requirements of subparagraphs 1 through 3 immediately above.

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

The Insured Person must notify the Company immediately in the event any one or more of the Surgeries listed above is recommended by a Physician. The Company will promptly advise the Insured Person whether or not it will require a second opinion. Upon receipt of a second opinion that differs from the recommending Physician, the Company will promptly advise the Insured Person whether or not it will require a third opinion.

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

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

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

H. USA Medical Concierge Service

The Medical Concierge Service is a proprietary service of IMG that helps an Insured Person navigate the U.S. healthcare system to identify the highest quality, most cost-effective providers for scheduled in-patient and certain out-patient Treatments. With Medical Concierge, an Insured Person scheduling Inpatient or Outpatient Treatment receives important information to help them choose their medical provider, including information on the number of procedures performed by the highest quality providers, the reported quality of the outcomes, the cost of the Treatment and other important information, thereby maximizing the benefits provided under this insurance plan.

For non-Emergency In-Patient Treatment incurred within the United States, use of USA Medical Concierge Service will provide the Insured Person with the ability to choose a Physician, other healthcare provider or Hospital from a list of high quality, yet competitively priced providers within the geographical area the Insured Person is located when Treatment is Medically Necessary.

Special Benefit When Using the USA Medical Concierge Service: When the Insured Person obtains Treatment and incurs Eligible Medical Expenses from a Physician, other healthcare provider or Hospital chosen by the Insured Person through use of our USA Medical Concierge Service, irrespective of whether the provider is within the US PPO Network - The Company will:

(1) Reduce by 50% the Deductible applicable to such claims, to a maximum reduction of $2,500; and

(2) Waive any and all Coinsurance applicable to such claim.

In order to qualify for these enhanced benefits, the Insured must contact the Company immediately upon the recommendation by a healthcare provider that the Insured Person seek any of the following Treatments:

(i) In-Patient Treatment or Surgery in Hospital
(ii) Out-Patient Surgery
(iii) CAT and MRI scans, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cystoscopy
(iv) Home nursing care
(v) Care in a hospice, Extended Care Facility or rehabilitation facility
(vi) Receiving Covered Transplant Treatment or supplies

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

Telephone (USA): +1 877-654-6229 (Toll Free within the USA)
Email: mcs@akesocare.com

I. ELIGIBLE MEDICAL EXPENSES - Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and the various limits and sub-limits set forth in the Schedule of Benefits/Limits, and the EXCLUSIONS, below, the Company will reimburse the Insured Person for the following costs, charges and expenses ("Charges") incurred by the Insured Person during the Period of Coverage or any applicable Benefit Period with respect to an Illness or Injury suffered or sustained by the Insured Person during the Period of Coverage and while this Certificate is in effect, so long as the Charges are Usual, Reasonable and Customary and are incurred for Treatment or supplies that are Medically Necessary ("Eligible Medical Expenses"):

(1) Charges incurred at a Hospital for:

(a) daily room and board and nursing services not to exceed the private room rate; and

(b) daily room and board and nursing services in Intensive Care Unit; and

(c) use of operating, Treatment or recovery room; and

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

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

(f) Emergency Treatment of an Illness; however an additional $250 deductible will be required unless the Insured Person is directly admitted to the Hospital as Inpatient for further Treatment of that Illness; and

(2) Charges incurred for Surgery at an Outpatient Surgical facility, including services and supplies; and

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

(4) Charges incurred for:

(a) dressings, sutures, casts or other supplies that are Medically Necessary; and

(b) diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, behavioral and educational testing are not included); and

(c) Implant devices that are Medically Necessary; however any Implants provided by a non-PPO provider are limited to payment of no more than 150% of the established invoice price and/or list price for that item; and

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

(e) reconstructive Surgery which is directly related to a Surgery which is covered under this insurance; and

(f) radiation therapy or Treatment, and chemotherapy; and

(g) hemodialysis and the charges by a Hospital for processing and administration of blood or blood components, but not the cost of the actual blood or blood components; and

(h) oxygen and other gasses and their administration; and

(i) anesthetics and their administration by a Physician; and

(j) drugs which require prescription by a Physician for Treatment of Illness or Injury, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, and for a maximum supply of ninety (90) days of any one prescription, however, prescriptions purchased at a USA Pharmacy are eligible only under the Universal RX Card Program and a maximum supply of thirty-four (34) days(certain monthly per prescription amount limits may apply and require re-approval by Company); and

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

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

(m) Emergency local ambulance transport necessarily incurred in connection with Illness or Injury resulting in Hospitalization; and

(n) Emergency Dental Treatment and Dental Surgery necessary to restore or replace sound natural teeth lost or damaged in an Accident that is covered under this insurance; and

(o) routine and Medically Necessary care of the Insured Person-mother and her Newborn during the first thirty-one (31) days of life, if the delivery of the Newborn and the charges incurred are eligible for coverage and are covered under the Terms of this insurance; and

(p) Treatment of Mental or Nervous Disorders, provided the Insured Person has been continuously insured under this insurance plan for not less than twelve (12) months immediately preceding Treatment; and

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

(r) the following Charges made by a Hospice:

(i) Room and board charged by the Hospice and part-time nursing by a Registered Nurse when the following conditions apply:

The Physician must certify that the Insured Person is terminally ill with 6 months or less to live; and services for the Insured Person must be received in an Inpatient Hospice facility or in the Insured Person's home.

(ii) Counseling for the patient and the patient's Family. Services must be rendered by a licensed social worker or a licensed pastoral counselor and are limited to $300 lifetime when the following conditions apply:

Services must be received prior to or within 6 months after the patient's death; and payment will be limited to a total of 15 visits per Family; and

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

(t) pre-natal care, delivery of a Newborn, and post-natal care, including complications thereof, provided the Insured Person-mother has been continuously insured under this insurance plan for not less than ten (10) consecutive months immediately preceding the incurring of such charges, and if the delivery of the Newborn and charges incurred are eligible for coverage and are covered under the Terms of this insurance unless the Pregnancy is a result of Invitro Fertilization, then all charges for pre-natal care, delivery, post-natal care, and care of Newborns are excluded from coverage; and

(u) routine and Medically Necessary care of the Newborn following the first thirty-one (31) days of life through the first 12 months of life, not to exceed $200, if the delivery of the Newborn and the charges incurred are eligible for coverage and covered under the Terms of this insurance.

J. WELLNESS EXPENSES - Provided the Insured Person has been continuously insured under this insurance plan for not less than six (6) months and subject to the Terms of this insurance, the Company will reimburse the Insured Person for the following expenses incurred while this Certificate is in effect:

(1) for Males eighteen (18) years of age and older: one Routine Physical Exam, limited to $500 per Period of Insurance, provided at least six (6) months have elapsed since the Insured Person's most recent Routine Physical Exam; and

(2) for Females eighteen (18) years of age and older: one Routine Physical Exam, limited to $500 per Period of Insurance, including expenses for mammography exams and pap smears, provided at least six (6) months have elapsed since the Insured Person's most recent Routine Physical Exam; and

(3) for a Child up to eighteen (18) years of age, limited to $400 per Period of Insurance:

(a) one Routine Physical Exam per Period of Insurance, provided at least six (6) months have elapsed since the Child's most recent Routine Physical Exam; and

(b) routine inoculations and vaccinations commonly administered to children less than eighteen (18) years of age in accordance with standard medical practice.

K. TRANSPLANT EXPENSES - Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the SCHEDULE OF BENEFITS/LIMITS section, above, the Pre-certification and MANDATORY SECOND OPINION provisions sections, and the Exclusions section, the Company will reimburse the Insured Person for the following costs, charges and expenses incurred by the Insured Person with respect to a Covered Transplant obtained or received by the Insured Person while this Certificate is in effect, so long as such costs, charges or expenses are Usual, Reasonable, and Customary:

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

(2) organ procurement and harvesting costs, excluding acquisition or purchase of the actual organ or tissue, up to a lifetime maximum of $20,000; and

(3) Charges incurred for pre-transplant evaluation, the Covered Transplant procedure, re-transplantation (if incurred during the initial Covered Transplant Hospitalization), and post-transplant care; and

(4) reasonable travel and lodging expenses of the Insured Person if travel of more than fifty (50) miles is necessary to receive the Covered Transplant Treatment and supplies from a Managed Transplant System Network Provider, up to a lifetime maximum of $10,000.

Transplant Pre-certification - To become eligible for the transplant benefits under this insurance, the transplant must be a Covered Transplant, the Insured Person must receive all Covered Transplant Treatment and supplies from an independent

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

L. EXCLUSIONS - All charges, costs, expenses and/or claims (collectively "Charges") incurred by the Insured Person and directly or indirectly relating to or arising from or in connection with any of the following acts, omissions, events, conditions, charges, consequences, claims, Treatment (including diagnoses, consultations, tests, examinations and evaluations related thereto), services and/or supplies are expressly excluded from coverage under this insurance, and the Company shall provide no benefits and shall have no liability therefor:

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

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

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

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

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

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

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

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

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

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

(c) any act of Terrorism that takes place in a location, post, area, territory or country for which a Travel Warning becomes effective or is in effect on or after the Insured Person's date of arrival in said location, post, area, territory or country, and the Insured Person unreasonably fails or refuses to heed such warning and thereafter remains in said location, post, area, territory or country.

(3) Maternity and Newborn Care - Charges for pre-natal care, delivery, post-natal care, and care of Newborns, are excluded from coverage under this insurance until the Insured Person has maintained coverage under this insurance plan continuously for at least ten (10) months unless the Pregnancy is a result of Invitro Fertilization, then all charges for pre-natal care, delivery, post-natal care, and care of Newborns are excluded from coverage; and

(4) Mental or Nervous Disorders - Charges for Treatment of Mental or Nervous Disorders are excluded from coverage under this insurance until the Insured Person has maintained coverage under this insurance plan continuously for at least twelve (12) months; and

(5) Wellness - Charges for Routine Physical Exams are excluded from coverage under this insurance until the Insured Person has maintained coverage under this insurance plan continuously for at least six (6) months, and except as otherwise

expressly provided in ELIGIBLE MEDICAL EXPENSES section. In no event will the Company reimburse the Insured Person for more than one Routine Physical Exam during any twelve (12) month period; and

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

(a) not incurred, obtained or received by an Insured Person during the Period of Insurance; and/or

(b) incurred, obtained or received by an Insured Person for a Non-Disclosed Condition.

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

(d) not administered or ordered by a Physician or Dentist; and/or

(e) not Medically Necessary; and/or

(f) provided at no cost to the Insured Person or for which the Insured Person is not otherwise liable; and/or

(g) in excess of Usual, Reasonable, and Customary; and/or

(h) incurred by an Insured Person who was HIV + at the Initial Effective Date of this insurance; whether or not the Insured Person had knowledge of his/her HIV status at that time and whether or not the Charges are incurred in relation to or as a result of said status; and/or

(i) provided by or at the direction or recommendation of a chiropractor, unless ordered in advance by a Physician; and/or

(j) performed or provided by a Relative of the Insured Person; and/or

(k) not expressly included as Eligible Medical Expenses or Eligible Dental Expenses; and/or

(l) provided by a person who resides or has resided in the Insured Person's home; and/or

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

(7) Charges incurred for telephone consultations except Telemedicine consultations through an established Telemedicine protocol system will be considered individually based on medical necessity and appropriateness as determined by the Company under the plan; and

(8) Charges incurred due to a failure to keep a scheduled appointment; and

(9) Charges incurred for Surgeries or Treatment or supplies which are:

(a) Investigational, Experimental, or for Research Purposes, and/or

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

(c) for Congenital disorders and conditions arising out of or resulting therefrom which exceed the $250,000 Maximum and/or are incurred after the first 31 days of life; and

(10) Charges incurred while confined primarily to receive Custodial Care, Educational or Rehabilitative Care; and

(11) Charges incurred for any Surgery, Treatment or supplies relating to, arising from or in connection with, for, or as a result of:

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

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

(c) elective Surgery or Treatment of any kind; and/or

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

(e) any Injury or Illness sustained while taking part in: Amateur Athletics, Professional Athletics, or other athletic activity that is sponsored or sanctioned by the National Collegiate Athletic Association (and/or any other collegiate sanctioning or governing body), or the International Olympic Committee, and adventure sports and activities, including, without limitation the following (including any combination or derivative of the following): abseiling; mountaineering activities where specialized climbing equipment, ropes or guides are normally or reasonably should have been used; athletic or sporting activities (except for activities that are non-contact, non-professional, and engaged in by You solely for recreational, entertainment or fitness purposes); aviation (except when travelling solely as a passenger in a commercial aircraft);BMX; BASE jumping; bobsledding; bungee jumping; canyoning; caving; hang gliding; heli-skiing; high diving; hot air ballooning; inline skating; jet skiing; jungle zip lining; kiteboarding; kayaking; luge; motocross (MOTO-X); mountain biking; parachuting; paragliding; parascending; rappelling; racing of any kind including without limitation by horse, motor, motorcycle, automobile, or any other motorized or nonmotorized vehicle of any type or other means ; rock climbing; any rodeo activity; ski jumping; sky diving; snow skiing except for recreational downhill and/or cross country snow skiing (provided that there is no coverage for any Illness of Injury sustained while 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; spelunking; surfing; trekking; whitewater rafting; windsurfing; wildlife safaris; and sub-aqua pursuits involving underwater breathing apparatus below a depth of 30 meters. Practice or training in preparation for any excluded activity which results in Illness or Injury will be considered as activity while taking part in such activity; and/or

(f) 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

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

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

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

(j) any willfully Self-inflicted Injury or Illness; and/or

(k) any sexually transmitted or venereal disease; and/or

(l) any testing for the following: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS; and/or

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

(n) any Substance Abuse; and/or

(o) speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy; and/or

(p) orthoptics, visual therapy or visual eye training; and/or

(q) any Illness or Treatment of the feet, including without limitation: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; Treatment of weak, strained, flat, unstable or unbalanced feet; metatarsalgia, bone spurs, hammer toes or bunions; and any Treatment or supplies for corns, calluses or toenails; provided, however, that claims for Treatment or supplies for the feet may be eligible for coverage under this insurance at the sole option of the Company and subject to all other Terms of this insurance when related to:

(i) an Injury to the foot arising from an Accident covered hereunder; or
(ii) an Illness for which foot Surgery is Medically Necessary and determined to be the only appropriate method of Treatment; and/or

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

(s) any sleep disorder, including without limitation sleep apnea; and/or

(t) any exercise program, whether or not prescribed or recommended by a Physician; and/or

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

(v) any organ or tissue or other transplant or related services, Treatment or supplies, except for Covered Transplants as defined herein and covered pursuant to the Terms of this insurance; and/or

(w) any artificial or mechanical devices designed to replace human organs temporarily or permanently; and/or

(x) any efforts to keep a donor alive for a transplant procedure, whether or not the transplant procedure is a Covered Transplant; and/or

(y) any transplant expenses incurred outside the Company's approved independent Managed Transplant System Network; and/or

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

(aa) any Illness or Injury resulting from or sustained as a result of epidemics, pandemics, communicable diseases, global infections, public health emergencies, dangerous and emerging pathogen outbreaks, disease outbreaks, natural disasters, or other disease outbreak conditions that may affect a person's health and about which the World Health Organization, Centers for Disease Control & Prevention, or similar governmental agency of the Insured Person's Home Country had previously published, communicated or issued a restriction, notice, warning, alert, or watch informing the public about such health issues.

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

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

(14) Eyeglasses, contact lenses, hearing aids, hearing implants, or for any Treatment, supply, examination or fitting related to these devices, or for eye refraction for any reason except as provided for herein in the Vision Care Expenses section and/or the Schedule of Benefits/Limits; and

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

(16) Charges incurred for Treatment of the temporomandibular joint; and

(17) Charges incurred for any immunizations and/or routine physical exams except for the eligible benefits and covered expenses provided for under the WELLNESS EXPENSES section, or as otherwise expressly provided for hereunder; and

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

(19) Any taxes, assessments, charges, fees or surcharges imposed by any governmental agency or authority:

(a) arising out of or as a result of any Treatment or supplies received by the Insured Person, or

(b) based upon the Company's election hereunder, if any, to pay benefits directly to providers, or

(c) for any other reason; and

(20) Unless otherwise expressly included under the Complementary Medicine Benefit section, Charges or expenses incurred for nonprescription drugs, medicines, vitamins, food extracts, or nutritional supplements; IV vitamin or herbal therapy; drugs or medicines not approved by the U.S. Food and Drug Administration or which are considered "off-label" drug use; and for drugs or medicines not prescribed by a Physician.

(21) any drug purchased at a USA Pharmacy eligible under the Universal RX Card Program; and

(22) Services that are not determined as necessary and customary dictated by the standards of generally accepted dental practice, for which no valid dental need can be demonstrated or that are Experimental in nature; and

(23) Fees for treatment by other than a Dentist/Dental Provider, except for the scaling or cleaning of teeth and topical application of fluoride by a licensed dental hygienist under the supervision and guidance of a Dentist in accordance with generally accepted dental standards; and

(24) Charges for replacement of lost or stolen appliances of any type; and

(25) Appliances, restorations or surgical procedures for restoring occlusion, replacing tooth structure, correcting congenital malformations, for esthetics or implantology; and

(26) Sealants; and

(27) Hospitalization, general anesthesia and/or intravenous sedation for restorative dentistry or surgical procedures, unless specified need is shown; and

(28) Preventative control programs, including home care items; and

(29) Orthognathic surgery; and

(30) Charges for services and supplies (to include crowns, dentures and bridges) to replace extracted or missing teeth prior to coverage (Following 5 years of continuous coverage, these services or supplies will qualify as a covered benefit).

M. EMERGENCY MEDICAL EVACUATION BENEFIT - Subject to the applicable Maximum Limit set forth in the SCHEDULE OF BENEFITS/LIMITS, and the other Terms of this insurance, including the EXCLUSIONS and the Conditions and Restrictions set forth below, the Company will reimburse the Insured Person for the following transportation costs, when the Company or Plan Administrator arranges such transportation, and expenses incurred by the Insured Person arising out of or in connection with an Emergency Medical Evacuation occurring while this Certificate is in effect and during the Period of Coverage:

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

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

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

(a) Medically Necessary Treatment cannot be provided locally; and

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

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

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

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

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

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

(ii) was not a Non-Disclosed Condition; and

(g) The Company will cover reimbursement for the above-described costs and expenses and will arrange Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary Treatment to prevent the Insured Person's loss of life or limb. The Insured Person may select a different Hospital in his/her Home Country at his/her option, but in such event the Insured Person shall be solely responsible for all costs and expenses in excess of the amounts that would have been incurred had the Insured Person used the nearest qualified Hospital. If a Hospital other than the nearest qualified Hospital is selected by the Insured Person, then the attending physician, Insured Person, or a relative of the Insured Person shall certify to the Company the Insured Person's understanding and acknowledgement of such responsibility for excess costs and expenses in addition to the matters set forth in the Conditions and Restrictions, above. In all cases the Company will make the necessary arrangements for the Emergency Medical Evacuation, and will use its best efforts to arrange with independent, third-party contractors any Emergency Medical Evacuation within the least amount of time reasonably possible. By acceptance of this Certificate and request for Emergency Medical Evacuation benefits hereunder, the Insured Person understands, acknowledges and agrees that the timeliness, duration, occurrences during, and outcome of an Emergency Medical Evacuation can be directly and indirectly affected by events and/or circumstances which are not within the supervision or control of the Company, including but not limited to: the availability, limitations, physical condition, reliability, maintenance and training schedules and procedures, and performance or non-performance of competent transportation equipment, supplies and/or staff of such third-party contractors; delays or restrictions on flights or other modes or means of transportation caused by mechanical problems, government officials, telecommunications problems, non-availability of routes, and/or other

travel, geographical or weather conditions; and other acts of God and unforeseeable and/or uncontrollable occurrences. The Insured Person agrees to release and to hold the Company, the Plan Administrator and their agents and representatives harmless from, and agrees that the Company, the Plan Administrator and their agents and representatives shall not be held liable or responsible for, any delays, losses, damages, further injuries or illnesses, or any other claims that arise from or are caused in whole or in part by the acts or omissions of such independent third-party contractors or their agents, employees or representatives, or that arise from or are caused in whole or in part by any acts, omissions, events or circumstances that are not within the direct and immediate supervision and control of the Company, the Plan Administrator and/or their authorized agents and representatives, including without limitation the events and circumstances set forth above. The Insured Person further agrees that upon seeking an Emergency Medical Evacuation, he or she will cooperate fully as required by the COOPERATION section. Failure to so cooperate and/or failure to use or accept Emergency Medical Evacuation once it has been arranged by the Company or Plan Administrator will require the Insured Person to reimburse the Company for costs incurred for any Emergency Medical Evacuation that was arranged, but not used, by the Insured Person. Furthermore, the Insured Person may be required to arrange for payment of any subsequent Emergency Medical Evacuation and seek reimbursement thereafter for eligible costs associated with that subsequent Emergency Medical Evacuation.

N. EMERGENCY REUNION - Subject to the Terms of this insurance, including without limitation the Conditions and Restrictions set forth below, Emergency Reunion expenses will be reimbursed to an Insured Person as outlined in the Schedule of Benefits/Limits, in cases where there has been an Emergency Medical Evacuation covered under the Terms of this insurance. Subject to the applicable Deductible and Coinsurance and other limits and sub-limits as specified in the Schedule of Benefits/Limits, and subject to the Conditions and Restrictions set forth below, the following costs and expenses incurred in respect of travel by a Relative or friend of the Insured Person will be reimbursable to the Insured Person upon the recommendation and prior approval of the Company:

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

(2) reasonable and necessary travel costs, meals (maximum of $25 per day), transportation and accommodation expenses incurred in relation to the Emergency Reunion (but excluding entertainment).

Conditions and Restrictions:

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

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

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

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

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

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

P. POLITICAL EVACUATION AND REPATRIATION - If the United States Department of State, Bureau of Consular Affairs or similar government organization of the Insured Person's Home Country orders the evacuation of all non-emergency government personnel from the Host Country, due to political unrest, that becomes effective on or after the Insured Person's date of arrival in the Host Country, the Company will pay up to the amount set forth in the Schedule of Benefits/Limits section for transportation to the nearest place of safety or for repatriation to the Insured Person's Home Country or country of residence provided that:

(1) the Insured Person contacts the Company within 10 days of the United States Department of State, Bureau of Consular affairs or similar government organization of the Insured Person's Home Country issuing the evacuation order; and

(2) the evacuation order pertains to persons from the same Home Country as the Insured Person; and

(3) Political Evacuation and Repatriation is approved and coordinated by the Company.

In no event will the Company pay for a Political Evacuation if there is a Travel Warning in effect on or within six (6) months prior to the Insured Person's date of arrival in the Host Country. This coverage will provide the most appropriate and economical means of travel consistent under the circumstances with the Insured Person's health and safety.

Q. REMOTE TRANSPORTATION BENEFIT- Subject to the Maximum Limit set forth in the Schedule of Benefits/Limits, and the other Terms of this insurance, including the Conditions and Restrictions set forth below, the Company will reimburse the Insured Person for the following expenses incurred by the Insured Person arising out of or in connection with a Remote Transportation expenses occurring while this Certificate is in effect:

(1) Direct costs and other Reasonable and Customary Expenses arising out of travel to the nearest Qualified Facility where the Insured Person will receive Treatment; and

(2) Accommodation charges with respect to the Insured Person's transportation to the Qualified Facility.

Conditions and Restrictions - To be eligible for coverage for Remote Transportation benefits the Insured Person must be in compliance with all Terms of this insurance. The Company will provide Remote Transportation benefits only when the condition, Illness, Injury or occurrence giving rise to the Remote Transportation is covered under the Terms of this insurance. The Company will provide Remote Transportation benefits only when all of the following conditions are met:

(1) If, after the Insured Person receives the first Treatment required to stabilize or diagnose the medical situation in a Hospital or a clinic, the Insured Person's condition is still considered to be:

(a) life-threatening by the treating Physician; or

(b) a critical medical situation which is not necessarily immediately life-threatening, but is severe enough to result in death or a permanent disability if not treated right away; or

(c) a critical medical situation for which no official diagnosis can be obtained at the current facility.

(2) Remote Transportation is recommended by the attending Physician who certifies to the matters in subparagraphs (1)(a) thru (c), above; and

(3) Remote Transportation is agreed to by the Insured Person or a Relative of the Insured Person; and

(4) Remote Transportation is approved in advance and all arrangements are coordinated by the Company; and

(5) The severity of the critical medical situation, the absence of a Qualified Facility, and the necessity of the Remote Transportation must be confirmed by both the local treating Physician and the Company.

R. COMPLEMENTARY MEDICINE BENEFIT - Subject to the Deductible and Coinsurance and the other Terms of this insurance, including without limitation the Conditions and Limitations set forth below, the Company will reimburse the Insured Person up to the amounts indicated below for charges incurred by the Insured Person for the following ("Complementary Medical Services"):

(1) Schedule and Limits of Complementary Medicine Benefit

Acupuncture	Up to $150 per Period of Coverage per Insured Person.
Magnetic Therapy	Up to $75 per Period of Coverage per Insured Person.
Herbal Therapy	Up to $50 per Period of Coverage per Insured Person.
Massage Therapy	Up to $150 per Period of Coverage per Insured Person.
Aroma Therapy	Up to $50 per Period of Coverage per Insured Person.
Vitamin Therapy	Up to $100 per Period of Coverage per Insured Person.

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

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

(b) submit a written plan approved by the attending Physician for Complementary Medical Services to the Company in advance of obtaining any Complementary Medical Service; and

(c) have the plan for Complementary Medical Services approved by the Company in writing in advance of obtaining any Complementary Medical Service; and

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

S. SUPPLEMENTAL ACCIDENT BENEFIT - In the event of an Accident which gives rise to benefits covered under the Terms of this insurance, as a supplemental benefit the Company will also reimburse the Insured Person for the first $500 of Eligible Medical Expenses related to the Treatment of an Injury resulting from such Accident, before applying any Deductible.

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

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

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

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

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

(4) Solo diving;

(5) Any form of cave diving;

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

(7) Diving for hire, reward, or treasure;

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

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

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

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

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

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

U. HIGH SCHOOL SPORTS COVERAGE – Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the Schedule of Benefits/Limits, and the Exclusions section, the Company will reimburse the Insured Person for Eligible Medical Expenses incurred with respect to Injury or Illness suffered or sustained by the Insured Person while engaged in interscholastic sports activities.

V. VISION CARE EXPENSES - Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the Schedule of Benefits/Limits, and the Exclusions section, the Company will reimburse the Insured and/or covered Dependents a maximum of:

(1) Exam - Up to $100.00 every twenty-four (24) months for a routine eye examination; and/or

(2) Corrective – Up to $150.00 every twenty-four (24) months for corrective lenses, contacts to correct vision and frames.

W. ELIGIBLE DENTAL EXPENSES - Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and the various limits and sub-limits set forth in the Schedule of Benefits/Limits section, and the Exclusions, and subject to the Conditions and Restrictions below, the Company will reimburse the Insured Person for the following costs, charges and expenses ("Charges") incurred by the Insured Person during the Period of Coverage or any applicable Benefit Period while this Certificate is in effect, so long as the Charges are Usual, Reasonable and Customary and are incurred for Treatment or supplies that are Medically Necessary ("Eligible Dental Expenses"):

Class I Benefits: (Preventive and Diagnostic services not subject to the Deductible and payable at 90%)

(1) Prophylaxis, diagnostic exam and bitewing x-rays (limited to 4 bwx per year) covered twice in any calendar year with at least a six month period between visits; and

(2) Palliative treatment; and

(3) Fluoride treatment once per calendar year for children under age 19.

Class II Benefits: (Subject to Deductible and payable at 70% of Usual, Reasonable and Customary fees)

(1) Radiographs Full mouth x-rays, including panographic x-rays covered once in a three year period; and
(2) Amalgams, plastic and synthetic restorations; and
(3) Relines and repairs to prosthetic appliances; and
(4) Oral surgery, extractions; and
(5) Endodontics, including root canals; and
(6) Periodontic services, treatment for gum disease; and
(7) Re-cementing crowns, inlays, and bridges; and
(8) Local and/or General anesthesia determined upon the level or degree of dental procedures being performed

Class III Benefits: (Subject to Deductible and payable at 50% of Usual, Reasonable and Customary fees)

(1) Prosthodontic services, including appliances, bridges, full and partial dentures that replace missing natural teeth that were extracted while the person is covered with this Plan. No more than one full upper and lower denture shall be covered in any five year period; and

(2) Partial dentures, fixed bridge or removable bridge will not be covered for any one patient more than once in a five year period except where loss of additional teeth requires construction of a new appliance; and

(3) Replacement of denture base material or reline is covered once in any 36 month period; and

(4) Major restorations such as crowns, jackets, gold-related services required when teeth cannot be restored using other filling material. Crowns, jackets or inlays on the same tooth covered once in any 5-year period. Porcelain crowns, porcelain fused to metal or resin processed to metal type crowns is not covered for patients under 12 years of age.

Conditions and Restrictions - For the purpose of this Certificate, the below time limitations are to be measured from the date on which those services were last supplied under this GMI® Dental plan.

(1) Benefits for prophylaxes and oral exams are payable twice in any period of 12 consecutive months; and

(2) Benefits for bitewing X-rays are payable once in any period of 12 consecutive months. Benefits for full mouth X-ray (which include bitewing x-rays) are payable once in any three-year period. A panographic X-ray (include bitewings) is considered a complete mouth X-ray and is paid as such.

(3) Benefits for full porcelain, porcelain/resin processed to metal, full cast or three-quarter cast crowns are not payable for eligible dependents under 12 years of age; and

(4) Benefits for root planting are payable once in any two-year period. Benefits for periodontal surgery, including subgingival curettage, are payable once in any three-year period; and

(5) Optional treatment: In all cases in which the Insured Person selects a more expensive service than is customarily provided, or for which a valid dental need is shown, the Company will pay only the applicable percentage of the fee for the service, if any, that is customarily provided; and

(6) Prosthodontic benefits:

(a) Benefits for one complete upper and once complete lower denture are payable once in any five-year period for any individual; and

(b) Benefits for a partial denture, fixed bridge or removable bridge for any individual are payable only once in any five-year period unless the loss of additional teeth requires the construction of a new appliance; and

(c) Benefits for fixed bridges and removable cast partials are not payable for people under 16 years of age; and

(7) Benefits for a reline or the complete replacement of denture base materials are payable once in any three-year period for any individual.

X. DEFINITIONS - Certain words and phrases used in this Certificate are defined below. Other words and phrases may be defined elsewhere in this Certificate, including where they are first used.

Accident: An Unexpected occurrence directly caused by external, visible means and no other cause, which directly, without any intervening cause, results in physical Injury to the Insured Person.

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

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

Amateur Athletics: An amateur or other non-professional sporting, recreational or athletic activity that is organized, sponsored and/or sanctioned, and or involves regular or scheduled practices, games and/or competitions. This definition does NOT include athletic activities that are non-contact and engaged in by the Insured Person solely for recreational, entertainment or fitness purposes or that are interscholastic or club sports participated in by a high school student.

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

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

Assured: The Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN.

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

Child; Children: An Insured Person who is at least fourteen (14) days old but less than eighteen (18) years of age.

Coinsurance: The payment by or obligations of the Insured Person for payment of Eligible Medical Expenses at the percentage specified in the Schedule of Benefits/Limits contained herein, and exclusive of the applicable Deductible.

Company: The "Company," as referred to in the Master Policy and this Certificate, is Sirius International Insurance Corporation (publ), headquartered in Stockholm, Sweden. This insurance and its risks are underwritten by the Company as the insurer and carrier, and the Company is solely obligated and liable for the coverage and benefits provided by this insurance.

Congenital Disorder: Physical abnormality that is present at birth.

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

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

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

Deductible: The dollar amount of ELIGIBLE MEDICAL EXPENSES, as selected on the Application and specified in the Declaration, that the Insured Person must pay per Period of Coverage prior to receiving benefits or coverage under this insurance, and exclusive of Coinsurance.

Dental Treatment: The procedures and care rendered by licensed Dentists/Dental Providers for diagnosis or treatment of dental disease, injury or abnormal condition. These dental services are based on a valid dental need according to accepted standards of dental practice.

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

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

Durable Medical Equipment (DME): Durable Medical Equipment shall mean exclusively the following items: a standard basic hospital bed; and/or a standard basic wheel chair.

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

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

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

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

- a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within twenty-four (24) hours; and
- where Medically Necessary Treatment cannot be provided locally, either in the facility of the attending Physician or another local facility.

EST: United States Eastern Standard Time.

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

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

Family: An Insured Person and his/her spouse who is covered as an Insured Person under this insurance plan and his/her Child or Children who are covered as Insured Persons under this insurance plan.

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

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

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

Home Health Care Agency: A public or private agency or one of its subdivisions, which operates pursuant to law; and is regularly engaged in providing Home Nursing Care under the supervision of a Registered Nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation and Treatment prescribed by a Physician.

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

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

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

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

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

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

Initial Effective Date: The date (most recent, if more than one) the Insured Person first obtains coverage under the Global Medical Insurance plan and maintains continuous unbroken coverage thereafter.

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

Inpatient: A person who has been admitted to and charged by a Hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if billed by the Hospital for Charges as an inpatient, and formally admitted as an inpatient with the expectation he will occupy a bed and (1) remain at least overnight or (2) is expected to need hospital care for 24 hours or more.

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

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

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

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

Master Policy: The applicable Master Policy for Global Medical Insurance® issued on an annual basis by the Company to the Assured, and under which insurance coverage and benefits are provided by the Company to the Insured Person, subject to the Terms thereof, and as outlined and evidenced by this Certificate and subject to the Terms hereof. The Company, as insurance carrier and underwriter of the Master Policy, is solely liable and responsible for the coverage and benefits provided thereunder.

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

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

Mental or Nervous Disorders: Any mental, nervous, or emotional Illness which generally denotes an Illness of the brain with predominant behavioral symptoms; or an Illness of the mind or personality, evidenced by abnormal behavior; or an Illness or disorder of conduct evidenced by socially deviant behavior. Mental or Nervous Disorders include without limitation: psychosis; depression; schizophrenia; bipolar affective disorder; any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases as published by the U.S. Department of Health and Human Services; and those psychiatric and other mental Illnesses listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders published by the American Psychiatric Association. For purposes of

this insurance, Mental or Nervous Disorder does not include Substance Abuse, learning disabilities, and attitudinal or disciplinary problems.

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

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

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

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

Period of Coverage: The period beginning on the Effective Date of Coverage of this Certificate and ending on the earliest of the following dates: (a) the termination date specified in the Declaration, or (b) the termination date as determined in accordance with the TERMINATION OF COVERAGE FOR INSURED PERSONS section. The Period of Coverage can be no more than twelve (12) consecutive months.

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

Plan Administrator: International Medical Group®, Inc., ATTN: Platinum Claims Team, 2960 North Meridian Street, Indianapolis, Indiana, 46208, Telephone Number 317/655-4500, or 1-800-628-4664, Fax Number 317/655-4505, Website: http://www.imglobal.com, Email: info@imglobal.com. As the Plan Administrator, International Medical Group, Inc., acts solely as the disclosed and authorized agent and representative for and on behalf of the Company, and has and shall have no direct, indirect, joint, several, separate, individual, or independent liability or obligation of any kind under the Master Policy or this Certificate to the Insured Person or to any other person or entity.

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

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

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

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

Qualified Facility: A medical facility that can perform the needed procedure or Treatment.

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

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

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

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

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

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

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

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

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

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

- Specialist referral services which typically involves of a specialist assisting a general practitioner in rendering a diagnosis to guide Treatment.
- Patient consultations using telecommunications to provide medical data, which may include audio, still or live images, between a patient and a Physician or other healthcare provider for use in rendering a diagnosis and Treatment plan. This might originate from a remote clinic to a Physician's office using a direct transmission link or may include communicating electronically.
- Remote patient monitoring uses devices to remotely collect and send data from a medical facility to a monitoring station for interpretation. Such applications might include a specific vital sign, such as blood glucose or heart ECG**.**

Terms: Terms, provisions, conditions, definitions, limits, sub-limits, limitations, wordings, restrictions, qualifications and/or exclusions.

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

Travel Warning: Published statement or web-site document issued by the United States Department of State, Bureau of Consular Affairs or similar government agency of the Insured Person's Home Country, warning that travel to specific identified countries, regions, or locations is hazardous and is not advised.

Treated; Treatment; Treatments: Any and all undertakings, services and/or procedures rendered or employed with respect to the management and/or care of an Insured Person for the purpose of identifying, testing for, analyzing, diagnosing, treating, curing, resolving, preventing, monitoring, attending to, caring for, controlling and/or combating any Illness or Injury or the symptoms or manifestations thereof, including without limitation: verbal or written advice, consultation, examination, discussion, diagnostic or laboratory testing or evaluation of any kind, pharmacotherapy or other medication, and/or Surgery.

Unexpected: Sudden, unintentional, not expected, and unforeseen.

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