Sirius International

INTERNATIONAL MEDICAL GROUP

Certificate of Insurance

MP INTERNATIONAL PLAN℠

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, U.S. 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 the insurance requirements that are applicable to you and the Company and its Administrator shall have no liability whatsoever, including for any penalties that you may incur, for your failure to obtain coverage required by any applicable law including without limitation PPACA.

A. SCHEDULE OF BENEFITS/LIMITS - Subject to the Terms of this insurance and the insurance plan shown in the Declaration, the following insurance plans are available to the Insured Person and offer the following benefits and coverage arising out of Injury or Illness incurred while the insurance plan shown in the Declaration is in effect:

LIMIT/OTHER	LIMIT/AMOUNT FOR ELIGIBLE MEDICAL EXPENSES
Period of Coverage	365 day Maximum Limit
Maximum Limit per lifetime	$1,000,000 per Insured Person
Deductible Per Calendar Year	Per Insured Person and as indicated on the Declaration. An additional Deductible of $250 will be applied for each Emergency Room visit for Treatment of an Illness which does not result in inpatient status.
Family Deductible	2 Deductibles per Family per Calendar Year.
Coinsurance per Calendar Year	For Treatment received outside the US: 0%. For Treatment received within the US: If **In the PPO Network**, 20% of Eligible Medical Expenses until reaching $5,000, then 0%. If **Utilizing Medical Concierge Provider** – 15% of Eligible Medical Expenses until reaching $5,000, then 0%. If **Outside the PPO Network**, the greater of $50 or 20% reduction of Eligible Medical Expenses until reaching $1,000 and then 20% of Eligible Medical Expenses.
The following benefits are subject to the Deductible and Coinsurance, as described above and cannot exceed the Maximum Limit. When the Eligible Medical Expense criteria are met, the benefits offered under the insurance plan shown in the Declaration shall be as follows:	
Charges for:	**Maximum Limits per Calendar Year or if indicated, per** lifetime
Eligible Medical Expenses	Usual, Reasonable and Customary.
Hospital Room & Board	Up to the average semi-private room rate, including nursing service.
Intensive Care Unit	**Maximum Limit** of 3 times (3x) average semi-private room rate.
Mental or Nervous Disorders	Outpatient Treatment: 50% of Eligible Medical Expenses and maximum of 40 visits per Insured Person per Calendar Year. Inpatient Treatment: Maximum of 30 days per Insured Person per Calendar Year.
Maternity	Usual, Reasonable and Customary
Newborn Care & Children's Congenital Disorders	$250,000 Maximum Limit per lifetime for Newborn Care and Children's Congenital disorders until age 18. 60 day waiting period for Children.
Physical Therapy	$2,500 Maximum Limit per Calendar Year
Chiropractic Care	50% of Eligible Medical Expenses up to $500 Maximum Limit per Calendar Year.
Hospice Care	$7,500 Maximum Limit per lifetime per Insured Person.
Home Nursing Care	Maximum Limit of 30 days per Calendar Year.

LIMIT/OTHER	LIMIT/AMOUNT FOR ELIGIBLE MEDICAL EXPENSES
Extended Care Facility	Maximum Limit of 60 days per Calendar Year.
Podiatry Expense	$750 Maximum Limit per Calendar Year.
Prescription Medication	Outside the U.S.: Usual, Reasonable, & Customary. Inside the U.S.: Maximum Limit of 90 day supply per prescription when using Universal Rx program along with the following copays: $15/Tier 1, $30/Tier 2, $60/Tier 3.
Transplant Expense	$500,000 Maximum Limit per lifetime; $10,000 Maximum Limit per lifetime for associated organ procurement & harvesting costs; $5,000 Maximum Limit per lifetime for associated travel & lodging expenses. 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: cornea, heart, heart/lung, lung, kidney, kidney/pancreas, liver or allogeneic or autologous bone marrow.

The following benefits are not subject to a Deductible or Coinsurance, but cannot exceed the Maximum Limit. The benefits offered under the insurance plan shown in the Declaration shall be as follows:

Benefit	Maximum Limits per Calendar Year, or if indicated, per lifetime
Wellness Expenses	$500 Maximum Limit every 12 months.
Hospital Indemnity	Private Hospitals: $400 per overnight and $4,000 Maximum Limit per Calendar Year. Public Hospitals: $500 per overnight and $5,000 Maximum Limit per Calendar Year when Other Coverage exists and Company is not obligated to pay any benefits.

Additional Provisions	Requirements
Pre-Certification	Transplants: No coverage if Pre-certification provisions are not met. All other Treatments and supplies: the greater of $50 or 20% reduction of Eligible Medical Expenses up to a maximum of $1,000 if Pre-certification provisions are not met.

B. 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 any Riders. The Master Policy is effective as of September 1, 2015, 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 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. 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.

C. CONDITIONS AND GENERAL PROVISIONS - The following Terms are conditions precedent to the Company's liability under the insurance provided to the Insured Person pursuant to and in accordance with the Terms of 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 or the 1st day of each month; and

(b) on or before any renewal date as specified in the Renewal; Amendments section; and

(c) prior to any reinstatement under the REINSTATEMENT OF COVERAGE FOR INSURED PERSONS section.

A grace period of thirty (30) 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 suppliers 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 maximum of two mandatory appeal levels to appeal the denial under which there will be a review of the claim and the determination. Insured Persons shall have ninety (90) days from the date that the notice of denial was mailed to the Insured Person's last known residence or mailing address within which to appeal the determination, 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 the Participating Organization or an Insured Person to recover on the contract of insurance prior to the later of (1) expiration of the later 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.

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, provided there exists an independent statutory and constitutional basis for *in personam* jurisdiction over the Company in said court and by said forum State. The Company and the Insured Person consent to personal jurisdiction and 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 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) commence an action in any court of competent jurisdiction in or outside of the United States, (iii) remove an action to a United States District Court, or (iv) seek transfer of a case to another court or forum as permitted by the laws of such forum or the laws of the United States or of any State in the United States, as applicable; all of which rights are expressly reserved and retained.

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., Locke Lord, 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 - 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 Participating Organization or any 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, the Participating Organization, 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.

Upon the Insured Person's attainment of eligibility for Medicare benefits or if Medicare does not pay all of the bill, the doctor or health care provider may submit a claim for Eligible Medical Expenses to the Company for secondary payment. However, under no circumstances shall this insurance offer any coverage for charges or benefits which are not payable as Eligible Medical Expenses or shall the Company be considered the primary payer unless the Medicare guidelines mandate Medicare is the secondary payer for those Charges If the individual is eligible for Medicare because of End-Stage Renal Disease ("ESRD"), the Insured Person may request payment of Eligible Medical Expenses for Charges for 30 months, whether or not enrolled in Medicare. At the end of the 30 months, Medicare becomes the primary payer. Medicare rules will apply to most people with ESRD, whether covered under this Certificate, or covered as a Family member.

(11) CANCELLATION BY INSURED PERSON - The Insured Person shall have five (5) 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 cannot cancel this insurance, and the Premium is fully earned and non-refundable.

(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 Participating Organization and 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 Participating Organization, the Insured Person and/or his/her healthcare providers which hinders, delays, impairs, or otherwise prejudices the performance of the Company's obligations under this insurance.

(14) CLAIM SETTLEMENT - Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have previously been paid by or on behalf of the Insured Person at the time of the Company's favorable adjudication thereof will be reimbursed by the Company directly to the Insured Person, by check, at his/her last known residence or mailing address. While this insurance is in effect, in order to effectuate proper administration, the Insured Person shall undertake to promptly notify the Company of any change in such addresses. Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have not been paid by or on behalf of the Insured Person at the time of adjudication will be paid by the Company by check or electronic funds transfer to the Insured Person at his/her last known residence or mailing address, or, at the sole option and discretion of the Company (but without obligation to do so), and as an accommodation to the Insured Person, directly to the provider(s), as applicable. All claim settlements, payments and reimbursements are subject to the insurance plan shown in the Declaration and all other Terms of this insurance. No healthcare or medical service provider or supplier, or any other third-party, shall have any direct or indirect interest, claim or right of action against the Company under this 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 knowingly be in any respect false, incomplete, misleading, concealing, fraudulent or deceitful, or if the Insured Person or anyone acting for or on his/her behalf under this insurance knowingly uses any false, incomplete, misleading, concealing, fraudulent or deceitful statements regarding the Insured Person, the insurance contract and all coverage thereunder may be cancelled, voided, rescinded and terminated by the Company in its sole and absolute discretion, and the Company shall have no obligation or liability for any such benefits, coverage or claims.

(16) ARBITRATION - 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 date the Master Policy is terminated pursuant to the Termination of Master Policy section

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

(d) the date the Participating Organization or 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 date the Participating Organization or Company, at its sole option, elects to cancel from the MP International[sm] plan (sometimes referred to herein as "the insurance plan") provided the Participating Organization or 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

(f) the cancellation date specified by the Company following a written request for cancellation from the Insured Person or Participating Organization; or

(g) the cancellation date specified by the Insured Person pursuant to the Renewal; Amendments section; or

(h) the date the Insured Person returns to his/her Home Country; or

(i) the next day following the maximum number of days shown in the Schedule of Benefits/Limits section; or

(j) 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 section, or Fraudulent Claims section, Right of Recovery section, or as otherwise permitted by the Terms of this insurance; or

(k) the 30th day after the Effective Date, if the Insured Person is a citizen of the USA, 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.

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) EXTENSION OF COVERAGE DUE TO DISABILITY OR DEATH- (a) If an Insured Person becomes Totally Disabled after his/her Effective Date, the Insured Person shall be entitled to continue coverage hereunder, subject to all Terms of this insurance, for a period not to exceed 90 days after the first day of Total Disability. If on the 91st day the Employee is not Actively at Work, then insurance for the Employee, his/her Spouse, and his/her Dependents shall terminate as of that date. Concurrent periods of Total Disability shall be considered one period of Total Disability beginning on the first day of the initial Total Disability. Successive periods of Total Disability shall be considered separate periods of Total Disability, each beginning on the first day of said Total Disability provided that such periods of Total Disability are separated by a period greater than 30 days during which the Insured Person maintained Actively at Work status. If successive periods of Total Disability are not separated by at least 30 days, then the period of Total Disability shall, for purposes of this insurance, be considered one

period of Total Disability beginning on the first day of the initial Total Disability. If the Insured Person has Dependent(s) covered hereunder as of the first day of Total Disability, then the insurance for said Dependent(s) shall also be extended for the same period as that of the Insured Person. (b) In the event of the death of an Insured Person, the Spouse and Dependents of the Employee shall be entitled to continue coverage hereunder, subject to all Terms of this Insurance for a period not to exceed sixty (60) days from the beginning of the month following the Employee's death.

(20) 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 Participating Organization 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 determinations of acceptable risk in its sole and absolute discretion. In order to be considered for Reinstatement, the Participating Organization 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 the 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 belonging to the Insured Person.

(21) 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.

(22) 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, for defective equipment or medical devices covered under a warranty, 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.

(23) RENEWAL; AMENDMENTS - Subject to the Terms of the Termination of Master Policy and Termination of Coverage for Insured Persons sections, a Participating Organization whose initial Period of Coverage is at least twelve (12) months can on behalf of Insured Persons request coverage under this insurance plan to be renewed monthly for up to 12 month periods 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 Participating Organization and Insured Person otherwise continue to meet the applicable eligibility requirements of the plan.

The Company's offer and the Participating Organization's ability to request renewal 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 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 and complying with the Cooperation section.

D. ELIGIBILITY:

(1) PARTICIPATING ORGANIZATIONS - A legal entity engaged in trade, traffic, commerce, transportation, or communication within any state or political subdivision and any place outside the United States of America is eligible to apply to participate in the insurance plan as a Participating Organization if it promptly meets all of the following requirements:

(a) it completes and submits to the Company, through the Plan Administrator, an Application to participate or renew participation under this insurance as a Participating Organization on a form approved and provided by the Company; and

(b) it is accepted as a Participating Organization by the Company and receives a Certificate issued by the Company; and

(c) it agrees to receive premium invoices on behalf of Insured Persons and remit an up-to-date and accurate census along with one payment per month for all Insured Persons' Premium; and

(d) it will at all times allow Employees, Spouses, and Dependents to apply for and Insured Persons to maintain coverage under this insurance plan for at least two (2) of its eligible Employees during the entire Period of Coverage; and

(e) it agrees and understands no percentage of the population of Insured Persons can reside and work in (1) the U.S. if they are required to meet the individual responsibility requirement under the Affordable Care Act or (2) Canada if eligible for public health insurance in Canada at any one time; and

(f) it will require that all eligible Employees, and their respective Spouses and Dependents provide the Company with completed, signed applications; and

(g) it will provide each and every Insured Person a copy of this Certificate of Insurance.

(2) INSURED PERSONS - 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:

(a) be an Actively At Work Full Time Employee, the Spouse or Dependent of an Employee traveling with the Employee, and residing outside his/her Home Country; and

(b) at the time of the Effective Date and on subsequent renewals must be physically residing in Host Country with the intent to reside there for at least six of the next twelve months; and

(c) 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

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

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

(f) be at least thirty one (31) days old; and

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

(h) not have a permanent residence in the Host Country; and

(i) if located inside the United States at the time of Effective Date or renewal Effective Date, not be eligible for any other medical insurance plan which is available to individuals similarly situated and located in the United States and legally depart the Home Country within thirty (30) days; and

(j) for Employees, Spouses, and/or Dependents who become eligible for coverage on or after the Participating Organization's initial Effective Date of this Certificate, submit to the Company a properly completed Application which may include questions related to evidence of insurability, and proof of any Creditable Coverage within thirty (30) days of becoming eligible for coverage under this insurance; and

(k) for Employees, Spouses, and/or Dependents who do not enroll timely, be considered a Late Enrollee and submit to the Company a completed Application which may include questions related to evidence of insurability, and proof of any Creditable Coverage.

(3) NEWBORNS - Newborns of an Insured Person will be covered from the moment of birth for Injury or Illness, provided the child is properly enrolled as a Dependent of the Insured Person within thirty (30) days of the child's date of birth, the mother is an Insured Person, and the mother is entitled to Maternity benefits under this insurance. If a child is acquired other than at the time of birth, due to a court order, decree, or marriage, that child will be considered an eligible Dependent from the date of such court order, decree or marriage, provided that this new child is properly enrolled as such Dependent of the Employee within thirty (30) days of the court order, decree, or marriage.

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 up to the amount shown in the Schedule of Benefits/Limits incurred in relation thereto, subject to all Terms of this insurance and the insurance plan shown in the Declaration. Eligibility for and payment of benefits are subject to all of the Terms of this insurance and the insurance plan shown in the Declaration.

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

(a) Inpatient status.

(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.

(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 and 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:	http://www.myimglobal.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; and

(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 and 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 the amount shown in the Schedule of Benefits/Limits, 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 under the insurance plan shown in the Declaration, 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) PROVISION:

(1) Special Benefits

If 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 adjust the Coinsurance applicable to such claims according to the amount shown in the Schedule of Benefits/Limits.

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. Additionally and if the Insured Person receives Treatment or supplies in the United States from a non-PPO provider, all Eligible Medical Expenses incurred with respect to said Treatments and/or supplies will first be reduced by the amount shown in the Schedule of Benefits/Limits, 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 under the insurance plan shown in the Declaration, will be available only for the remaining balance of the reduced amount thereafter.

(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 Deductible, Coinsurance and benefit reduction, as set forth above. An Insured Person may contact the Company through the Plan Administrator and request a PPO Directory for the area where the Insured Person will be receiving consultation or Treatment (therein listing the Physicians, Hospitals and other healthcare providers within the PPO network by location and specialty), or may visit the Plan Administrator's website at http://www.myimglobal.com to obtain such information.

G. 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, non-emergency inpatient and certain outpatient Treatments. With Medical Concierge, an Insured Person scheduling Inpatient or Outpatient Treatment receives important information to help them choose their medical provider of Eligible Medical

Expenses, including information on the cost and quality of hospitals, thereby maximizing the benefits provided under the insurance plan.

For non-emergency Inpatient Treatment incurred within the United States, use of USA Medical Concierge Service will help provide the Insured Person with a list of qualified, cost effective 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 under the insurance plan shown in the Declaration 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 U.S. PPO Network, the Company will adjust the Deductible or Coinsurance to the amount shown in the Schedule of Benefits/Limits.

In order to qualify for these benefits, the Insured must contact the Company immediately upon the recommendation by a healthcare provider that the Insured Person be admitted or receive any of the following:

(a) Inpatient status on non-emergency Treatment or Surgery.

(b) Outpatient Surgery.

(c) CAT and MRI scans.

(d) Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cystoscopy.

(e) Home nursing care.

(f) Inpatient care in a Hospice, Extended Care Facility or rehabilitation facility.

(g) 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)
Telephone (Outside USA): 1-317-655-4500 (Collect if necessary)
Email: mcs@akesocare.com

H. ELIGIBLE MEDICAL EXPENSES - Subject to the Terms of this insurance, and the insurance plan shown in the Declaration, the Company will reimburse the Insured Person up to the amount shown in the Schedule of Benefits/Limits for the following costs, charges and expenses ("Charges") incurred by the Insured Person during the Period of Coverage or any applicable Treatment 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 average semi-private room rate or the average cost of a Private Room, if (i) the Insured Person's Physician documents the necessity of isolation for the safety and welfare of the Insured Person or other patients or (ii) the Hospital only offers Private Rooms; and

(b) daily room and board and nursing services in an 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 an 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 deductible shown in the Schedule of Benefits/Limits for the insurance plan shown in the Declaration 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 up to twenty percent (20%) of the Usual, Reasonable and Customary charge of the primary surgeon; and provided, further, that the standby availability of a Physician or surgeon will not be deemed to be a professional service and is not eligible for coverage; and

(4) Charges incurred for:

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

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

(c) Implant devices that are Medically Necessary; however any Implants provided outside the PPO network are limited to a maximum of 150% of the manufacturer's 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 when the Surgery is incidental to or follows Surgery which was covered hereunder (including Surgery and reconstruction of both breasts following a required mastectomy); and

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

(g) hemodialysis for the Treatment of acute renal failure only 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 gases and their administration; and

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

(j) drugs purchased at a participating pharmacy within the Universal Rx program or from a pharmacy located outside the United States which require prescription by a Physician for Treatment of Illness or Injury up to the amount shown in the Schedule of Benefits/Limits, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs; 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) Local Ambulance Transport necessarily incurred in connection with an (i) Injury or (ii) Illness resulting in Hospital confinement as an Inpatient; 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) pre-natal care, delivery of a Newborn, and post-natal care, including complications thereof, provided by a Physician or certified nurse midwife or a certified direct entry midwife assuming (i) the Insured Person is the Newborn's mother and she became insured under this plan prior to the Pregnancy, (ii) the charges incurred for the Newborn's birth are covered under the Terms of this insurance, (iii) the Pregnancy is not as a result of artificial insemination; and

(r) Treatment of Mental or Nervous Disorders; and

(s) 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

(t) Medically Necessary rental of Durable Medical Equipment, up to the purchase price paid by the Insured Person; and

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

(v) the following Charges made by Hospice:

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

(ii) Counseling for the Insured Person and the Family. Services must be rendered by a licensed social worker or a

licensed pastoral counselor and are limited to $300 Maximum Limit per lifetime when the following conditions apply: Services must be received prior to or within six (6) months after the patient's death; and payment will be limited to a total of fifteen (15) visits per Family; and

(5) speech therapy services to restore speech lost or impaired due to one of the following:

(a) covered Surgery, radiation therapy or other Treatment that affects the vocal chords; and

(b) cerebral thrombosis (cerebrovascular Accident); and

(c) the Insured Person suffers Accidental Injury while covered under this Insurance; and

(6) for Charges made by a chiropractor for Treatment or manual manipulation of subluxations and all related services, including, but not limited to, office visits, x-rays, and laboratory tests ordered by a chiropractor.

(7) for Charges for care of the feet, including Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, bone spurs, hammer toes or bunions. In addition, Charges for Treatment or supplies may be eligible for coverage under this insurance subject to all other Terms of this insurance when related to:

(a) an Injury to the foot due to an Accident covered hereunder; or

(b) an Illness for which foot Surgery is Medically Necessary and the only Treatment option available.

I. WELLNESS EXPENSES - Subject to the Terms of this insurance and the insurance plan shown in the Declaration, the Company will reimburse the Insured Person up to the amount shown in the Schedule of Benefits/Limits 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, up to the amount shown in the Schedule of Benefits/Limits 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 and expenses for mammography exams and pap smears up to the amount shown in the Schedule of Benefits/Limits, 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 the amount shown in the Schedule of Benefits) and includes:

(a) one Routine Physical Exam every 12 months, 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 that Child in accordance with standard medical practice.

J. TRANSPLANT EXPENSES - Subject to the Terms of this insurance, the insurance plan shown in the Declaration, and the Conditions and Restrictions set forth below, the Company will reimburse the Insured Person up to the amount shown in the Schedule of Benefits/Limits 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, including donor preparation, excluding acquisition or purchase of the actual organ or tissue, up to the amount shown in the Schedule of Benefits/Limits; and

(3) Charges incurred for pre-transplant evaluation, the Covered Transplant procedure, re-transplantation (if incurred during the initial Hospital confinement as an Inpatient for the Covered Transplant), and post-transplant care; 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 the amount shown in the Schedule of Benefits/Limits.

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 and the insurance plan shown in the Schedule of Benefits.

K. HOSPITAL INDEMNITY - Subject to the Terms of this insurance and in the event the Insured Person has been Hospitalized in a facility outside the United States, during the Period of Coverage, the Company will reimburse the Insured Person up to the amount shown in the Schedule of Benefits/Limits for each overnight as an Inpatient in the Hospital, so long as the Treatment received during the overnight Hospitalization is considered to be an Eligible Medical Expense.

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

(1) War; Military Action; Terrorism - The Company shall not be liable for and will not provide coverage or benefits in excess of the Maximum Limits shown in the Schedule of Benefits/Limits for any claim or charges incurred with respect to any Illness, Injury, death or dismemberment, 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 the Insured Person's active and voluntary planning or coordination of or participation in 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).

(f) any 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 he/she was a victim, innocent bystander, and there was no contributory fault chargeable to the Insured Person.

(3) Pre-existing Conditions - For medical conditions existing at the time of Application and are not accepted through a Rider attached to this Certificate and for medical conditions which existed but that were unknown at the time of Application, charges resulting directly or indirectly from or relating to any Pre-existing Condition are excluded from coverage under this insurance until the earlier of the following dates: (a) 365 continuous days after the Effective Date during which no Treatment is sought, recommended or received (including prescription medication or drugs); (b) 365 continuous days after the Effective Date offset by the number of days of Creditable Coverage; or (c) for Late Enrollees, 546 continuous days after the Effective Date offset by the number of days of Creditable Coverage; and

(4) for Charges resulting directly or indirectly from or relating to any Congenital disorders diagnosed or Treated before age nineteen (19) and conditions arising out of or resulting therefrom except as otherwise expressly set forth; and

(5) Maternity and Newborn Care - Charges for pre-natal care, delivery, post-natal care, and care of Newborns, are excluded from this insurance when the mother is not the Employee or his/her Spouse and/or the Pregnancy is not the result of natural insemination; and

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

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

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

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

(d) not Medically Necessary; and/or

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

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

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

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

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

(j) 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

(10) Charges incurred for psychometric, behavioral, and educational testing or 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) 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

(d) any Illness or Injury 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-collision and engaged in by the Insured Person 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 non-motorized 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

(e) 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

(f) 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

(g) 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

(h) 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

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

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

(k) any testing for the following when not Medically Necessary: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS; and/or

(l) 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

(m) any Substance Abuse except as otherwise expressly set forth; and/or

(n) biofeedback, acupuncture, recreational, sleep or music therapy; and/or

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

(p) any Illness or Treatment of the feet, including without limitation: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; Treatment or supplies for corns, calluses or toenails except as otherwise expressly set forth; and/or

(q) 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

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

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

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

(u) any organ or tissue or other transplant or related services, Treatment or supplies except as otherwise expressly set forth; and/or

(v) any artificial or mechanical devices designed to replace human organs temporarily or permanently after termination of Inpatient status; and/or

(w) any efforts to keep a donor alive for a transplant procedure; and/or

(x) any Illness or Injury resulting from or sustained after entering the Host Country and as a result of epidemics, pandemics, public health emergencies, natural disasters, or other disease outbreak conditions that may affect a person's health and about which the World Health Organization has issued an Emergency Travel Advisory, U.S. Centers for Disease Control & Prevention has issued a Warning Level 3 (avoid nonessential travel), or similar governmental agency of the Insured Person's Country of Residence had published, communicated or issued a Travel Warning restriction or official declaration informing the public about such health issues before the Insured Person traveled to the Host Country; and

(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) Charges incurred for Dental Treatment, except as otherwise expressly set forth; and

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

(16) 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

(17) Charges incurred for Treatment or supplies for temporomandibular joint TMJ syndrome, craniomandibular syndrome, chronic TMJ pain, orthognathic Surgery, Le-Fort Surgery or splints; and

(18) Charges incurred for any immunizations and/or routine physical exams except as otherwise expressly set forth; and

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

(20) Any taxes, involuntary or forced contributions, 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; and/or

(b) based upon the Company's election hereunder, if any, to pay benefits directly to providers as an accommodation to the Insured Person; and/or

(c) for any other reason; and

(21) 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; and

(22) any drug purchased at a USA Pharmacy which is not through and is required under the Universal RX Card Program.

M. 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 resulting in physical Injury to the Insured Person.

Actively At Work Full-time: The Employee's performance of assigned duties and principal activity as a missionary outside the United States while on the Participating Organization's premises, on duty, or at a prescribed work place for at least thirty (30) hours per work week during each week of a calendar year. Averaging of hours over two or more weeks is not permitted. Actively At Work Full-time does not include absence from work, use of paid, unpaid, sick, or family leave, non-productive status due to conditions unrelated to employment, conditions which render the worker unable to work, or performance of assigned duties for less than thirty (30) hours per week during each week of a Period of Coverage, or any individual classified by the Participating Organization as an independent contractor, Part-time, temporary, or seasonal.

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

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

Application: The fully answered and signed Participating Organization, individual, or Family Application/enrollment form submitted by or on behalf of the Insured Person for acceptance into, renewal of coverage under 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, Indiana.

Calendar Year: The twelve months beginning on January 1 and ending on December 31, annually.

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 thirty one (31) days old but less than nineteen (19) 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.

Creditable Coverage: Health insurance coverage not interrupted by a significant break in coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); Children's Health Insurance Program (CHIP); or, a state health insurance high risk pool. Creditable Coverage does not include non-medical coverages or coverage consisting solely of "excepted benefits" such as coverage solely for limited-scope dental, vision, specified disease, workers compensation benefits. Days in a waiting period during which an individual has no other coverage are not considered creditable coverage, nor are these days taken into account when determining if there is a significant break in coverage. A significant break in coverage generally occurs when an individual has no health coverage for 63 days or more. Any health coverage an individual had before a significant break in coverage is not counted to reduce any exclusion period.

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 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, specified in the Declaration, that the Insured Person must pay prior to receiving benefits or coverage under this insurance, and exclusive of Coinsurance.

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

Dependent: A Child who meets all of the following conditions is: (a) under age 19 at the end of the Period of Coverage and younger than the Insured Person (or spouse if filing jointly), (b) under age 26 at the end of the Period of Coverage, a Full time student, and younger than the Insured Person (or spouse if filing jointly), or (c) any age if Totally Disabled and such incapacity occurred prior to attaining nineteen (19) years of age or while a covered Dependent under this plan of insurance. The Child must have lived with the Insured Person for more than half of the year, the Child must not have provided more than half of his or her own support for the year, and the Child must does not plan on filing or did not file a joint return for any tax year (unless that joint return is filed only to claim a refund of withheld income tax or estimated tax paid). Proof of eligibility must be furnished upon request to the Company, or its designee at the beginning of the Period of Coverage, and additional proof may be required to show eligibility for coverage. The term "Dependent" excludes an individual for whom an exemption cannot be claimed on the Insured Person's federal tax return; any person on active military duty or who is eligible for military medical care benefits; and/or any person who is also an Insured Person.

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

Educational Institution: An accredited college or university, technical trade, mechanical, or other post-secondary educational institution.

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

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. Immediate medical intervention and attention is required as a result of severe, life threatening or potentially disabling condition.

Employee: A paid or unpaid worker who the Participating Organization controls or has the right to control what the worker does and how the worker does his job; a worker whose business aspects of the job are controlled by the Participating Organization (e.g. how worker is paid, whether expenses are reimbursed, who provides tools/supplies, etc.); a worker who may have entered into a written employment or volunteer contract with the Participating Organization; a worker who is entitled to employee type benefits (i.e. pension plan, insurance, vacation pay, etc.); a worker whose relationship will continue indefinitely; and the worker performs services that are a key aspect of the Participating Organization's business.

Employee Organization: Any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with missionary organizations concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

EST: United States Eastern Standard Time.

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

Extended Care Facility: An institution, or a distinct part of an institution, which is licensed as a Hospital, Extended Care Facility or rehabilitation facility by the state or country in which it operates; and is regularly engaged in providing 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, 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.

Full-Time Student: A person who is enrolled in a program that leads to a degree, certificate, or other recognized educational credential and regularly attends an Educational Institution for the minimum number of credit hours required by the Education Institution in order to maintain a full-time student status. On-the-job training courses, correspondence schools, or schools offering courses only through the internet do not qualify as an Education Institution.

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

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

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

Home Country: For 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 country of residence on the Application.

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

Home Nursing Care: Services and/or Treatment provided by a Home Health Care Agency and supervised by a Registered Nurse, 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.

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

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

Illness: A sickness, disorder, illness, pathology, abnormality, malady, morbidity, affliction, disability, defect, handicap, deformity, birth defect, congenital defect, symptomatology, syndrome, malaise, infection, infirmity, ailment, disease of any kind, or any other medical, physical or health condition. Provided, however, that Illness does not include learning disabilities, or attitudinal 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.

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 U.S. 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 the insurance plan issued 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. 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; learning disabilities and attitudinal or disciplinary problems; 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** include Substance Abuse.

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

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.

Participating Organization: The plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of this insurance and is named in the group Application for coverage, which the Application forms part of this Certificate.

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 the number of days shown in the Schedule of Benefits/Limits.

Physician: A practitioner who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid, unlimited license to practice medicine or osteopathic medicine. Commissioned medical officers, and individuals licensed and legally authorized to provide health care or professional services including a: (a) psychologist; (b) psychiatrist; (c) dentist; (d) registered or licensed practical nurse; (e); (g) optometrist; (h) podiatrist; or (i) chiropractor may be considered a Physician. A practitioner 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. A person who is not authorized or able to prescribe controlled substances, drugs, medicine, or treatment by the jurisdiction in which the person is acting in the usual course of professional practice; unfit to practice; and/or violates any statue, rule, regulation regulating the profession, or engages in the unlawful or unauthorized practice of medicine or osteopathic medicine is not a Physician.

Plan Administrator: The Plan Administrator for this insurance is International Medical Group®, Inc., 2960 N. Meridian Street, Indianapolis, Indiana, 46208, Telephone Number +1-317-655-4500, or +1-800-628-4664, Fax Number +1-317-655-4505, Website: http://www.imglobal.com, Email: insurance@imglobal.com. As the Plan Administrator, International Medical Group, Inc., acts solely as the disclosed and authorized agent and representative for and on behalf of the Company, and does not have, and shall not be deemed, considered or alleged to have any, direct, indirect, joint, several, separate, individual, or independent liability, responsibility or obligation of any kind under the Master Policy, the Declaration, or this Certificate to the Insured Person or to any other person or entity, including without limitation to any Physician, Hospital, Extended Care Facility, Home Health Care Agency, or any other health care or medical service provider or supplier.

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

Pre-existing Condition: Any Illness, Injury, sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment for which 1) medical advice, diagnosis, care or Treatment was recommended or received at any time during the six (6) months prior to the Insured Person's initial Effective Date or 2) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the six (6) months immediately preceding the Insured Person's initial Effective Date.

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.

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.

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

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, deductibles, coinsurance, limits, sub-limits, limitations, wordings, restrictions, requirements, 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.

Totally Disabled/Total Disability: The inability, due to Illness or Injury, of an individual to work or earn income. The medical condition must significantly limit the ability to do basic work activities, prevent the individual from being able to do the work he or she did before the Illness or Injury, or prevent the individual from being able to do other work. With respect to children, it is the inability, due to Illness or Injury, to engage in any substantial gainful activity because of a physical or mental condition. A qualified Physician must certify that the child's condition has lasted or can be expected to last continuously thru the end of the Period of Coverage or more, or that the condition can be expected to result in death.

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

Treated; Treatment: Any and all 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; whether the services or supplies were unbundled or should have been included in the allowance of another service; the amount reimbursed by other payors for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or service as compared to the length of time required to perform other similar services; the length of time required to perform the procedure or service as compared to national standards and/or benchmarks; the severity or nature of the Illness or Injury being treated; and such other factors as the Company, in the reasonable exercise of its discretion, determines are appropriate.