

**Global Medical
Superior Plan
Certificate of Insurance**
Underwritten by
Certain Underwriters at Lloyd's

INSURING CLAUSE

Certain Underwriters at Lloyd's, herein referred to as "the Company" hereby insures all persons whose Application has been Approved, by Global Assurance Group Inc., herein referred to as "the Administrator" on behalf of the Company and whose name is identified on the ID Card and/or recorded with the Administrator, subject to all of the Exclusions, Limitations and Provisions as set forth herein and in the Certificate of Insurance issued by the Company. Coverage is afforded only with respect to the named Insured Person(s), Coverage, amounts and limits specified herein and as identified in the Schedule of Benefits for the Insurance requested on the Application and for which the specified Premium has been paid to the Administrator.

SECTION 1: CERTIFICATE DEFINITIONS

The term "**Accident or Accidental**" shall mean an event, independent of Illness or self inflicted means, which is the direct cause of bodily Injury to an Insured Person.

The term "**Administrator**" shall mean Global Assurance Group, Inc. the organization contracted with the Company to provide underwriting, administrative and claims payment services under this Certificate.

The term "**Alcohol or Drug Abuse**" shall mean any pattern of pathological use of alcohol or drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

The term "**Application**" shall mean the official enrollment form issued by the Administrator, which must be completed, signed and dated by each applicant (or legal guardian for applicants who are minor children) and all accompanying and/or documents pertaining to underwriting information of each applicant listed on the Application.

The term "**Approved or Approval**" shall mean the final determination of the Administrator to issue coverage with or without Exclusionary Riders and/or an increase to the Premium to an Insured Person, after the Administrator has received and reviewed the Application and all underwriting information requested.

The term "**Baseline Mammogram**" shall mean a screening mammogram that is used as a comparison for future examinations.

The term "**Birth Defect**" or "**Congenital**" shall mean any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not.

The term "**Certificate**" shall mean the summary of the terms of Coverage, which includes this document, the Insured Person's Application and any endorsements, Exclusionary Riders or amendments that will attach during the Insured Person's Period of Coverage.

The term "**Child**" shall mean the Primary Insured Person's natural child, step-child or a Child under the Insured Person's legal guardianship, but only if such Child depends on the Primary Insured Person's support and maintenance and lives with the Primary Insured Person in a parent-child relationship.

The term Child does not include a foster Child who is eligible for benefits provided by a governmental program or law, unless required by the law of the State.

The term “**Class**” shall mean a group of Insured Persons defined by common characteristics selected by the Company, including but not limited to demographic group, geographic region, employer or industry classification.

The term “**Coinsurance**” shall mean the percentage amount of Eligible Benefits, after the Deductible, which are the responsibility of each Insured Person and must be paid by each Insured Person, before benefits under this Certificate are payable by the Company. The Coinsurance amount is stated in the Schedule of Benefits.

The term “**Company**” shall mean Certain Underwriters at Lloyd’s, the organization providing the Coverage under this Certificate.

The term “**Complications of Pregnancy**” shall mean any or all of the following conditions which are made worse by, occur during, or are caused by Pregnancy: acute nephritis, nephrosis, cardiac decompensation, missed abortion, hyperemesis gravidarum, ectopic Pregnancy that is ended, non-elective cesarean section, pre eclampsia, gestational diabetes, spontaneous end of Pregnancy which occurs when a viable birth is not possible, and other medical problems of similar severity.

The term “**Consultation**” shall mean either a visit or a session with a Physician or Service Provider.

The term “**Congenital**” or “**Birth Defect**” shall mean any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not and will include in the definition, Hereditary conditions, any abnormality, deformity, disease or illness which has been passed down through the generations of the insured person’s family that are not multifactorial or polygenic.

The term “**Convalescent**” shall mean Treatment, services and supplies provided to aid in the recovery of a patient to reach a degree of body functioning to permit self-care in essential daily living activities

The term “**Convalescent Care Facility**” shall mean an institution, or a distinct part of an institution meeting all of the following; a.) it is licensed to provide and is engaged in providing, on an Inpatient basis, for persons Convalescing from Injury or Disease, professional nursing services rendered by a Registered Nurse or by a licensed practical nurse under the supervision of a Registered Nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities, b.) its services are provided for compensation from its patients and which patients are under 24 hour, the full-time supervision of a Physician or Registered Nurse, c.) it maintains a complete medical record on each patient and has and effective utilization review plan. Convalescent Care Facility does not include a facility primarily for rest, the aged, drug abuse, Custodial Care, nursing care, or for care of Mental or Nervous disorders or the mentally incompetent.

The term “**Coverage**” shall mean the Eligible Benefits described in this Certificate, to which the Insured Person is eligible for reimbursement from the Company or payment for the Treatment and services paid directly to the Service Provider by the Company.

The term “**Coverage Period or Period of Coverage**” shall mean the period between the Individual Effective Date of Coverage and the Individual Termination Date of Coverage for this Certificate, which is stated on the Insured Person’s ID Card.

The term “**Covered Event**” shall mean the Covered Expenses for an Illness or an Accidental bodily Injury necessitating medical Treatment by a Service Provider as defined in this Certificate.

The term “**Covered Expenses**” shall mean expenses which are for Medically Necessary services, supplies, care, or Treatment; due to Illness or Injury, as described in the Certificate; prescribed, performed or ordered by a licensed Physician and/or Service Provider; Reasonable and Customary charges; incurred by the Insured Person during their Period of Coverage; and which are (1.) listed in the Schedule of Benefits, (2.) not excluded in the Exclusions and (3.) do not exceed the maximum limits stated in the Schedule of Benefits.

Any medical expenses incurred as a result of a non covered medical expense including but not limited to dental, plastic surgery or other procedures and expenses excluded in the Exclusions, will not be eligible for cover under this policy.

The term “**Custodial Care**” shall mean care primarily for the purpose of assisting a person in the activities of daily living or in meeting personal rather than medical needs, and which is not specific Treatment for an Illness or Injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value, whether or not totally disabled, in the activities of daily living.

The term “**Cytologic Screening**” shall mean a pap test to detect cervical cancer through the simple microscopic examination of cells scraped from the surface of the cervix.

The term "**Deductible**" shall mean the amount of Eligible Benefits which are the responsibility of each Insured Person and must be paid by each Insured Person, before benefits under this Certificate are payable by the Company. The Deductible amount is stated on the ID Card and/or in the Schedule of Benefits.

The term “**Disease**” shall mean any condition or Disease listed in the most recent edition of the International Classification of Diseases or a condition accepted and recognized as a know Illness or Injury by the American Medical Association.

The term "**Dentist**" shall mean a legally licensed doctor of dental surgery; dental medicine or dental science. A dental hygienist who works within the scope of his/her license, under the supervision of a Dentist, is a covered practitioner.

The term "**Dependant**" shall mean the spouse who is legally married to the Primary Insured Person; the Primary Insured Person's natural or legally adopted unmarried Child from fourteen (14) days old until his/her nineteenth (19th) birthday; or the Primary Insured Person's unmarried Child who is at least nineteen (19) years old but under twenty-four (24) years old and enrolled as a Full-Time Student at an accredited school or college and is not employed on a full-time basis.

The age limits that apply to Dependant Child(ren) will not apply to any insured Child of the Primary Insured Person who remains dependant on the Primary Insured Person for support and maintenance because he or she becomes incapable of working due to a physical handicap or mental retardation which occurs before reaching the age limit; and while insured under this Certificate.

The term “**Educational or Rehabilitative Care**” shall mean the care for restoration (by education or training) of one’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, physical therapy or occupational therapy.

The term “**Effective Date**” shall mean the date Coverage under this Certificate begins. After review and Approval of each Applicant by the Administrator, Coverage will become effective on the later of the following dates: (1.) The date requested on the Application, (2.) The date the appropriate premium and Application are received by the Administrator, or (3) The date the Applicant is Approved by the Administrator. The Insured’s ID Card will state the official Effective Date of coverage, as issued by the Administrator

The term "**Eligible Benefits**" shall mean expenses which are for Medically Necessary services, supplies, care, or Treatment; due to Illness or Injury; prescribed, performed or ordered by a licensed Physician and/or Service Provider; Reasonable and Customary charges; incurred by the Insured Person during their Period of

Coverage; and which are (1.) listed in the Schedule of Benefits, (2.) not excluded in the Exclusions and (3.) do not exceed the maximum limits stated in the Schedule of Benefits.

The term “**Emergency**” shall mean 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 24 hours.

The term “**Emergency Medical Evacuation / Repatriation**” shall mean: a) the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is Ill or Injured to the nearest adequate medical facility where medical Treatment can be obtained; or b) after being treated at a local medical facility as a result of an Emergency Medical Evacuation, the Insured Person's medical condition warrants transportation with a qualified medical attendant to his/her current Home Country to obtain further medical Treatment or to recover; or c) both a) and b) above.

The term “**Exclusionary Rider**” shall mean that the Applicant will be Approved for Coverage, but otherwise Covered Expenses for certain medical conditions or Treatment will be excluded from Coverage in written form from the Administrator.

The term “**Experimental/Investigational and/or for Research**” shall mean a Treatment, drug, device, procedure, supply or service and related services (or an portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists:

1. the Treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. the Treatment, drug, device, procedure, supply or service is not yet fully approved or recognized by a pertinent governmental agency or professional organization such as the National Cancer Institute or Food & Drug Administration.
3. the results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals to be of greater safety and efficacy than conventional Treatment, in both the short and long term.
4. the Treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state or Country where the Insured Person resides or as generally accepted throughout the relevant medical community by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.
5. the Treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or the like in any consent, release, or authorization which the Insured Person or someone acting on their behalf may be required to sign.

The fact that a procedure, service, supply, treatment, drug, or device may be the only hope for survival will not change the fact that it is otherwise investigational, experimental, or for research.

The term “**Full-Time Student**” shall mean a person enrolled in at least 12 credit hours of study.

The term “**Hereditary**” shall mean any abnormality, deformity, disease or illness which has been passed down through the generations of the insured person’s family.

The term “**Home Country or Country of Residence**” shall mean the country where an Insured Person has for more the 180 days out of a policy year his or her fixed and permanent residence. Notification of change of country is the responsibility of the insured to notify the administrator within 30 days of when the change takes effect or policy may be canceled at the administrator discretion

The term “**Home Health Care Agency**” shall mean 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 by a Physician, in accordance with existing standards of medical practice. When Home Health Care is received in Trinidad it must be provided by Doctors or Nurses who are registered under the relevant Trinidad and Tobago legislation and must comply with the rules of good conduct as stipulated in Professions Related to Medicine Act Section 3 (3) (d).

The term “**Home Health Care**” shall mean services 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 provided in lieu of Medically Necessary Inpatient care in a Hospital. When Home Health Care is received in Trinidad it must be provided by Doctors or Nurses who are registered under the relevant Trinidad and Tobago legislation.

The term “**Hospice**” shall mean a coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The hospice must meet the licensing requirements of the locality in which it operates.

The term "**Hospital**" shall mean a place that 1.) is legally operated for the purpose of providing medical care and Treatment to Sick or Injured persons for which a charge is made that the Insured Person is legally obligated to pay in the absence of insurance 2.) provides such care and Treatment in medical, diagnostic, or surgical facilities on its premises, or those prearranged for its use; 3.) provides 24-hour nursing service under the supervision of a Registered Nurse at all times; and 4.) operates under the supervision of a staff of one or more Physicians. Hospital also means a place that is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals, American Osteopathic Association, or the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

Hospital does not mean:

- a Convalescent, nursing, or rest home or facility, or a home for the aged;
- a place mainly providing Custodial, Educational, or Rehabilitative Care; or
- a facility mainly used for the Treatment of drug addicts or alcoholics.

The term "**Ill or Illness**" shall mean Sickness or Disease of any kind listed in the most recent edition of the International Classification of Diseases.

The term “**Incident**” shall mean all Illnesses that exist simultaneously and which are due to the same or related causes are considered to be one Incident. Further, if an Illness is due to causes which are the same and are related to the causes of a prior Illness, the Illness will be deemed to be a continuation of the prior Illness and not a separate Incident. All Injuries due to the same Accident shall be deemed to be one Incident.

The term "**Injury**" shall mean bodily Injury listed in the most recent edition of the International Classification of Diseases and caused solely and directly by Accidental, external, and visible means occurring while this Certificate is in force and resulting directly and independently of all other causes resulting in a Covered Event under this Certificate.

The term "**Inpatient**" shall mean a person who is admitted or confined in an institution for a period of 24 hours or more and is charged for room and board.

The term "**Insurance**" shall mean the Coverage described and provided under this Certificate.

The term "**Insured Person(s)**" shall mean a person eligible for Coverage under the Certificate as stated on the ID Card, who has applied for Coverage and is named on the Application and for whom the Company has Approved for Coverage and accepted the corresponding Premium. This may be the Primary Insured Person or Dependant(s).

The term "**Intensive Care or Coronary Unit**" shall mean a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

The term "**Medically Necessary or Medical Necessity**" shall mean services, Treatment or supplies received by the Insured Person that are determined by the Company to be: 1.) appropriate and necessary for the symptoms, diagnosis, or direct care and Treatment of the Insured Person's medical conditions; 2.) within the standards the organized medical community deems good medical practice for the Insured Person's condition; 3.) not provided solely for educational purposes or primarily for the convenience of the Insured Person, the Insured Person's Physician or another Service Provider or person; 4.) not Experimental / Investigational and/or for Research; and 5.) not excessive in scope, duration, or intensity to provide safe and adequate, and appropriate Treatment.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kinds of services the Insured Person is receiving or the severity of the Insured Person's condition, in that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting.

The fact that any particular Physician may prescribe, order, recommend, or approve a service, Treatment, supply or level of care, does not of itself, make such Treatment Medically Necessary or make the charge a Covered Expense under this Certificate.

The term "**Medicine or Medications**" shall mean the drugs and/or anesthetics prescribed by a Physician and dispensed to the Insured Person, by a licensed pharmacist, as a result of a Covered Expense. Medicine or Medication shall mean the generic equivalent of a drug, or if the generic equivalent is not available, the brand name drug. Medicine or Medication shall mean only prescription drugs.

The term "**Mental Illness**" shall mean Mental, emotional, and psychiatric disorders, Illnesses or conditions (whether organic or non-organic, whether biological, non-biological, genetic, chemical or non-chemical in origin). Mental and nervous disorders include, but are not limited to psychoses; neurotic disorders; bipolar disorders; affective disorders; personality disorders; psychological or behavioral abnormalities, associated with transient or permanent dysfunction of the brain or related neurohormonal systems; and disorders, conditions, and Illnesses listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders IV-R or the most recent edition of the International Classification of Diseases on the date the medical care or Treatment is rendered to an Insured Person.

The term "**Outpatient**" shall mean a person who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for an Illness or Injury, but who is not admitted or confined to a 24 hour period and is not charged for room and board.

The term "**Participating Provider Network or Preferred Provider Organization (PPO)**" shall mean the approved Hospitals, Physicians, or other Service Providers who have entered into a contractual agreement with the Company to provide Hospital and medical services to Insured Persons at negotiated fees.

The term "**Permanent Residence**" shall mean the country where an Insured Person has his or her true, fixed and permanent home and principal establishment, and to which he or she has the intention of returning.

The term "**Physician**" shall mean a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform Surgery in accordance with the laws of the jurisdiction where such professional services are performed.

The term "**Pre-Existing Condition**" shall mean 1) A condition that would have caused a person to seek medical advice, diagnosis, care or Treatment prior to the Individual Effective Date of Coverage under this Certificate; 2) A condition for which medical advice, diagnosis, care or Treatment, including Medication, was sought, recommended or received prior to the Individual Effective Date of Coverage under this Certificate; 3) the symptoms which occurred prior to the Individual Effective Date of the Coverage under this Certificate would have allowed a person trained in medicine to make a diagnosis of the condition producing the symptoms; 4) a condition which manifested prior to the Individual Effective Date of Coverage under this Certificate; 5) Expenses for Pregnancy within twelve (12) months after the Individual Effective Date of Coverage under this Certificate.

Exclusionary Riders may be issued by the Administrator, for certain Pre-Existing Conditions. Pre-Existing Conditions that are fully and accurately disclosed on the Application and Approved and accepted by the Administrator, without an Exclusionary Rider or other restriction will be covered up to a lifetime maximum of US\$50,000 (US\$5,000 limit per Period of Coverage) after the Insured Person has been continuously insured for 24 months. At the time of application and at the Administrator discretion immediate benefits with higher limits may be offered.

The term "**Pregnancy or Maternity**" shall mean the physical condition of being pregnant, including Complications of Pregnancy.

The term "**Premium**" shall mean the corresponding monetary amount in United States Dollars charged by the Company and collected by the Administrator for the Coverage afforded in this Certificate, which applies to the Insured Person's age, gender, Deductible, maximum limit and any medical conditions of the Insured Person for which the Administrator periodically charges to maintain Coverage under this Certificate.

The term "**Primary Insured Person**" shall mean the person on the Application, who is listed as the Primary Insured, and whom may have Dependants, who are Insured Persons.

The term "**Pre-Notification and Pre-Notify**" shall mean that the Insured Person notify the Administrator in advance of any Hospital admission worldwide or of any Outpatient Surgery or Eligible Benefits which will exceed US\$1,000 in the United States. The Pre-Notification process will be complete after the Insured Person receives Treatment or services in a Participating Provider Network, to which the Insured Person may have access, and confirm that such confinement is Medically Necessary.

The term "**Reasonable and Customary**" shall mean the maximum amount that the Company determines is Reasonable and Customary for Eligible Benefits the Insured Person receives, up to but not to exceed charges actually billed. The Company's determination considers: 1.) amounts charged by other Service Providers for the same or similar service in the medical community where the services were received; 2.) any unusual medical circumstances requiring additional time, skill or experience; 3.) the cost to the Service Provider of providing the services or supplies or performing the procedure; and 4.) other factors the Company determines are relevant, including but not limited to, a resource based relative value scale.

For a Service Provider who has a reimbursement agreement with the Company, the Reasonable and Customary charge is equal to the amount that constitutes payment in full under any reimbursement agreement with the Company.

If a Service Provider accepts as full payment an amount less than the negotiated rate under a reimbursement agreement, the lesser amount will be the maximum Reasonable and Customary charge.

The Reasonable and Customary charge is reduced by any penalties for which a Service Provider is responsible as a result of that Service Provider's agreement with the Company.

The term “**Registered Nurse**” shall mean a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other jurisdictional authority, and who is legally entitled to place the letters “R.N.” after his or her name.

The term “**Relative**” shall mean spouse, parent, sibling, Child, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent, son, daughter, brother, or sister), aunt, uncle, niece, nephew, legal guardian, ward, or cousin of the Insured Person.

The term “**Repatriation**” shall mean transport to the Insured Person’s Home Country.

The term “**Rescind**” or “**Rescinding of a Certificate**” or “**Void**” shall mean termination of the Certificate retroactive to the original Individual Effective Date of Coverage as the result of inaccurate information provided on the Application or accompanying health statements, Regardless whether the inaccurate statement is related to the claim at hand or not, the company may choose to either return all the premium to the payer retroactive to the original Individual Effective Date of Coverage or issue a permanent exclusion for the particular pre existing condition and deny the claim. In the case that a policy is rescinded any claim payments made on the policy from the effective date until the date the policy is rescinded will be applied towards the return of premium.

The term “**Screening Mammogram**” shall mean a low dose x-ray used to visualize the internal structure of the breast.

The term “**Service Provider**” shall mean a Hospital, Hospice, Convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, Physician, Dentist, chiropractor, licensed medical practitioner, nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves to provide services under the Certificate.

The term “**Sickness**” shall mean Illness or Disease of any kind listed in the most recent edition of the International Classification of Diseases.

The term “**Surgery or Surgical Procedure**” shall mean an invasive diagnostic 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.

The term “**Termination Date**” shall mean Coverage will terminate upon the earlier of the following: (1.) The end of the period for which Premium has been paid, (2.) The date the Insured Person fails to meet the Eligibility Requirements described in SECTION 3, A; (3.) The date the Company cancels coverage for a specific Class of Insured Persons, which the individual Insured Person may be included. For cancellation of a specific class Company will send a 60 days advance written notice to the insured.

The term “**Treatment**” shall mean medical or surgical management of a patient designed to resolve the Illness or Injury based on standard and accepted medical practice. For purposes of this Certificate, the course of action will only include those scheduled and approved benefits, for which the Insured Person is eligible.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Check to see if any medical history has been omitted. Write to the Administrator immediately if any information shown is incorrect or incomplete. The Underwriters cannot distinguish between intentional and involuntary omissions. Consequently, any error or omission of any nature, will cause the rescission of the policy or the cancellation of all benefits assigned to the Assured under this contract. This policy is issued on the basis that the answers to all questions are correct and complete. Any omissions or incorrect statements could cause an otherwise valid claim to be denied.

SECTION 2: SCHEDULE OF BENEFITS

A. Deductible and Coinsurance

When a covered Illness or Injury is incurred by the Insured Person, the Company will pay for the Eligible Benefits in excess of the Deductible and Coinsurance as stated below.

Deductible choices: US\$250, US\$500, US\$1,000, US\$2,500, US\$5,000 and US\$10,000

Medical Benefits Deductible for each

Period of Coverage:

Per Insured Person: Amount stated on the ID Card

Per Insured Family Unit: 2x per person (or max. 2 per family)

When an Insured Person is admitted for Inpatient Hospital Treatment in the Insured Person's Country of Residence, no Deductible will be applied to Eligible Benefits submitted for payment when selecting deductible of \$250 to \$2,500. When a deductible of US\$5,000 to US\$20,000 has been selected; at the administrator's discretion the administrator may elect to waive all or part of the deductible upon advance request by the insured (this waiver does not apply to Maternity benefits).

When an Insured Person receives outpatient treatment in the United States (USA), no deductible will be applied to Eligible Benefits submitted for payment when selecting deductible of \$250 to \$2,500. This deductible waiver does not apply to well child care benefits, pregnancy benefit cesarean section delivery either elective or medically required or any complications thereof.

Eligible Benefit Percentage Payable after Deductible has been satisfied:

- 1.) The Coinsurance will be applied after the Insured Person meets the selected Deductible and shall be 10% of the next US\$10,000 of Eligible Benefits incurred outside the Insured Person's Home Country only. There shall be no Coinsurance after the selected Deductible within the Insured Person's Home Country.
- 2.) Claims occurring in the United States and not in an approved United States Preferred Provider Organization (PPO) Network Hospital will be paid at 70% of the Eligible Benefits after the Deductible and Coinsurance (if any) have been applied. Additionally, the selected Deductible will be applied two times if the claim occurs in the United States and not in a United States Preferred Provider Organization (PPO) Network Hospital. In the case of a true life-threatening emergency no penalties will be applied when taken to the nearest hospital, which is not part of the United States Preferred Provider Organization (PPO) network Hospital.
- 3.) Deductible credit: Any Eligible Benefits incurred and applied to your Coverage Period Deductible in the last 30 days prior to your Renewal Date, will carry over and be applied to the next Coverage Period Deductible.

B. Eligible Benefits and Maximum Limits

This Certificate will pay for Eligible Benefits, incurred up to the Maximum Limit depending on the insured's selected choice of annual cover, US\$1,000,000 respectively per Insured Person per Coverage Period for claims arising out of bodily Injury or Illness less the selected Deductible and Coinsurance (when applicable). The Maximum Amount Insured will stay level at US\$1,000,000 when the Insured Person becomes 70 years old. The ID Cards issued by the Administrator will state the Maximum Limit for each Insured Person.

- I. The Eligible Benefits of a Physician, a surgeon or other specialist to whom the Physician has referred the case.

- II. The Eligible Benefits for Medications or appliances prescribed by such Physician, surgeon or specialist mentioned in (I) above. Prescription Medications administered to the Insured Person on an Outpatient basis are limited to US\$5,000 per Insured Person per Coverage Period. After a covered inpatient surgery or treatment \$10,000 for the first six months.
- III. The Eligible Benefits of a private Hospital room and board.
- IV. The Eligible Benefits of Intensive Care.
- V. When a minor is admitted in a hospital \$100 per day to a maximum of 10 days to pay for a bed for a guardian
- VI. The Eligible Benefits performed on an outpatient basis for Oncology tests, drugs and consultant fees including cover for Chemotherapy and Radiotherapy.
- VII. The Eligible Benefits of Human Organ Tissue Transplants Expenses are limited to amounts and procedures listed as follows
 - a. Covered Transplant Procedures:
 - i. Any of the following Medically Necessary Human Organ and Tissue Transplants to a Lifetime Maximum of US\$500,000 per insured person:

Heart	Liver
Heart/Lung	Pancreas
Lung	Kidney/Pancreas
 - ii. Bone marrow transplants to a Lifetime Maximum of US\$350,000 per insured person.
 - b. Covered Transplant Services:
 - i. Inpatient and Outpatient Hospital services
 - ii. Services of a Physician for diagnosis, treatment, and Surgery for a Covered Transplant Procedure.
 - iii. Diagnostic services.
 - iv. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue; Eligible Benefits are limited to the actual procurement expenses, and the Eligible Benefits are subject to the amounts shown in the Maximums section.
 - v. Medically Necessary transportation costs for travel related to a Covered Transplant Procedure for the transplant recipient and one companion during a Benefit Period. Eligible Benefits for transportation are subject to the amounts shown in the Maximums section.
 - vi. If the recipient is a minor, transportation costs for two companions may be covered. Eligible Benefits for transportation are subject to the amounts shown in the Maximums section.
 - vii. Reasonable and necessary lodging and meal expenses incurred by the recipient and the recipients companion(s), related to a Covered Transplant Procedure, during the Benefit Period. Eligible Benefits for lodging and meals are subject to the amounts shown in the Maximums section.
 - viii. Rental of durable medical equipment for use outside the Hospital. Eligible Benefits are limited to the purchase price of the same equipment.
 - ix. Prescription Medication, including immunosuppressive drugs.
 - x. Oxygen.
 - xi. Speech Therapy, Occupational Therapy, Physical Therapy and Chemotherapy.
 - xii. Surgical dressings and supplies.
 - xiii. Services and supplies for and related to High Dose Chemotherapy and Bone Marrow Tissue transplantation when provided as part of a treatment plan which includes Bone Marrow transplantation and High Dose Chemotherapy.
 - xiv. Home Health Care.

- c. Transplant Maximum Amounts in Non-approved PPO Transplant Facilities. Eligible Benefit paid are the lesser of 80% of the billed charges or 80% of the amount stated below:

<u>Covered Transplant Procedure</u>	<u>Outside the USA</u>	<u>Within the USA</u>
Autologous Bone Marrow including High Dose Chemotherapy	US\$50,000	US\$100,000
Allogeneic Bone Marrow including High Dose Chemotherapy	US\$50,000	US\$100,000
High Dose Chemotherapy	US\$50,000	US\$100,000
Heart	US\$50,000	US\$100,000
Heart/lung	US\$50,000	US\$100,000
Lung	US\$50,000	US\$100,000
Liver	US\$50,000	US\$100,000
Pancreas	US\$50,000	US\$100,000
Simultaneous Kidney/Pancreas		US\$50,000US\$100,000

- d. Transportation/Lodging/Meals: A maximum of US\$200.00 per day for lodging and meals, per Covered Transplant Procedure. US\$10,000 for all transportation, lodging and meals per Covered Transplant Procedure. Itemized receipts in a form satisfactory to the Company shall be submitted by the Insured Person when claims are filed.
- e. Organ Procurement: The Company's payments for Procurement expenses for a donor organ or tissue will not exceed the following maximums, per Covered Transplant Procedure:

<u>Covered Transplant Procedure</u>	<u>Maximum Amounts</u>
Allogeneic BMT	US\$50,000
Heart	US\$50,000
Heart/lung	US\$50,000
Lung	US\$50,000
Liver	US\$50,000
Pancreas	US\$50,000
Kidney/Pancreas	US\$50,000

VII. The Eligible Benefits of treatment/consultation for vocational, occupational, rehabilitative, physical, speech, recreational therapy following an approved surgery or accident paid at a maximum cost of \$200 per session and a maximum of 60 sessions per insured person per policy period.

VIII. The Eligible Benefits of reconstructive Surgery, after a Covered Accident (Lifetime maximum US\$40,000 per Insured Person.)

IX. The Eligible Benefits for Treatment relating to birth defects (excluding hereditary conditions), premature birth, and congenital illness, shall be reimbursed at 80% of Eligible Expenses up to a US\$500,000 Lifetime Maximum. (Please refer to Section 6, Certificate Provisions, #13 - Data Furnished by Insured Person(s) for the provisions for adding a newborn to the Certificate.)

X. The Eligible Benefits of normal delivery, including prenatal consultations, birth and postnatal care for the mother and the newborn child. In country of residence Covered at 100% and the selected Certificate Deductible will not apply. Out of the country of residence Covered at 80% and the selected Certificate Deductible will not apply. To be eligible for maternity benefits under this policy the mother and her legally married husband or the single mother and another adult who is not a dependent must apply on the same Application and be covered continuously under this Certificate for 12 months prior to delivery. Medically

necessary Cesarean Section delivery will be covered as a normal delivery. Elective Cesarean Section delivery will be covered as an operation benefit with deductible and 20% co insurance applied, waiver of deductible in country of residence does not apply for any maternity or cesarean benefit.

This Pregnancy Benefit or any complications thereof including a cesarean section and coverage for the new born do not apply to

- a. An Insured Person's who has selected deductibles of US\$5,000 and/or higher
- b. Any Pregnancy not covered under the policy.

When selecting a single mother maternity rider the Eligible Benefits of a normal delivery, including prenatal consultations, delivery, medically necessary cesarean section delivery, birth complications and postnatal care for the mother and the newborn child. In country of residence Covered at \$4,000 and the selected Certificate Deductible will not apply. Out of the country of residence there is no cover in the single mother maternity rider. The single mother of the child must be continuously covered under this Certificate for 12 months prior to delivery. Elective cesarean section delivery, including pre and postnatal care for the mother and the newborn child or complications thereof will be covered with the policy deductible and 20% co insurance first applied with a maximum total of \$3,000. Waiver of deductible in country of residence does not apply. The Maternity Benefit does not apply to an Insured Person's who has selected deductibles of US\$5,000 or higher.

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| XI. | Dental Benefit (due to Accident only) | US\$20,000 per Coverage Period subject to a US\$50.00 per occurrence Deductible. |
| XII. | Preventive Benefits adults | US\$700 per Coverage Period Maximum 12 month waiting period |
| XIII. | Emergency Medical Evacuation Benefit | US\$100,000 per Coverage Period |
| XIV. | Return of Mortal Remains Benefit | US\$10,000 |
| XV. | Emergency Medical Reunion Benefit | US\$10,000 per Coverage Period |
| XVI. | The Eligible Benefits of emergency ground transportation necessarily incurred in connection with the events covered by this Insurance within the country where the event occurs. (Maximum US\$3,000 per Insured Person per Policy year.) | |
| XVII. | A Cash Benefit of US\$200 per night for electing to receive Inpatient Treatment of Eligible Benefits in a Hospital located outside the USA or Canada. (Maximum of 10 nights per Insured Person per Policy Year) This benefit is not applicable for maternity or maternity complications. This benefits only applies to a maximum of two main insured's adults in the policy and does not apply to any other dependents under age 24. | |
| XVIII | In case of death of the primary insured, policy premiums for the family will be paid for a maximum of two years for insureds who are enrolled in the policy at the time when this benefit is paid. | |

SECTION 3: INSURANCE PROVISIONS

A. Eligibility Requirements

For all Applicants / Insured Persons: Primary and named Dependant Insured Persons must be at least fourteen (14) days old and have not yet reached their 70th birthday at the date of original inception for cover. Dependents would comprise of the Primary Insured's Spouse and his/her natural or legally adopted unmarried children between the age of fourteen (14) days and nineteen (19) years old; and, between nineteen (19) years old and twenty three (23) years old in the case of a full time student at an accredited school or college who is not employed on a full time basis.

For US Citizens: Applicants / Insured Persons must be outside the United States at the time of application / renewal. In addition, the Insured Person must reside outside the United States at least 6 months during any given 12-month Certificate Period to meet the Eligibility Requirements of an Insured Person. Should any Insured Person reside in the United States longer than 6 months during any given 12-month Certificate Period, their Coverage shall immediately terminate retroactively from the date the Eligibility Requirements were not met regardless to the reason. The Administrator will issue a refund of premium if any, prorated to the date the Eligibility Requirements were not met. Any claims occurring after the date the Eligibility Requirements were not met will be denied.

For Non-US Citizens: Applicants / Insured Persons must be outside the United States at the time of application / renewal. In addition, the Insured Person must reside outside the United States at least 6 months during any given 12-month Certificate Period to meet the Eligibility Requirements of an Insured Person. Should any Insured Person reside in the United States longer than 6 months during any given 12-month Certificate period, their Coverage shall immediately terminate retroactively from the date the Eligibility Requirements were not met regardless to the reason. The Administrator will issue a refund of premium if any, prorated to the date the Eligibility Requirements were not met. Any claims occurring after the date the Eligibility Requirements were not met will be denied.

It is the Insured Persons responsibility to maintain all records and provide them to administrator upon requests all Eligibility Requirements including but not limited to, residence status, travel history, age and student status, and send to the Administrator the relevant information which changed at the date the change occurred and to provide any documents to the Administrator, which would verify the Eligibility Requirements. Should the insured at any time not meet the Eligibility Requirements and did not advise the Administrator of such material changes then the policy will be canceled retroactively from the date the Eligibility Requirements were not met. The Administrator will issue a refund of premium if any, prorated to the date the Eligibility Requirements were not met. Any claims occurring after the date the Eligibility Requirements were not met will be denied. Failure to provide within 30 days from date of request, eligibility requirements documents requested by the administrator will result in the automatic cancellation of the policy.

B. Individual Effective Date of Coverage

After review and Approval of each Applicant by the Administrator, Coverage will become effective on the later of the following dates: (1.) The date requested on the Application, (2.) The date the appropriate premium and Application are received by the Administrator, or (3) The date the Applicant is Approved by the Administrator. The Insured's ID Card will state the official Effective Date of coverage, as issued by the Administrator.

C. Individual Termination Date of Coverage

Coverage will terminate upon the earlier of the following: (1.) The end of the period for which Premium has been paid, (2.) The date the Insured Person fails to meet the Eligibility Requirements described in SECTION 3, A; (3.) The date the Company cancels coverage for a specific Class of Insured Persons, which the individual Insured Person may be included with a 60 days advance written notice sent to the insured.

D. Commencement of Benefits

No benefits will be payable for expenses of any medical conditions which manifests itself within 90 days of the Individual Effective Date of the Certificate or any complications and/or medical expenses resulting thereof; with the exception of medical conditions caused by Accidents and/or Infectious Diseases. The Company may elect to waive this provision if an international medical insurance Certificate was in force with another insurance company for the Insured Person for twelve (12) consecutive months immediately prior to the Effective Date of this Certificate. Waiver of the Commencement of Benefits provision is subject to receipt of a copy of the Certificate of Coverage, Schedule of Benefits and dates of Coverage from the prior insurance company at the time of application, with a 120 days waiver rider issued simultaneously with the policy. Having an international health policy in force at the time of application does not guarantee the waiver of this provision.

SECTION 4: SCOPE OF COVERAGE

A. Description of Coverage

Covered Expenses arising from valid claims will be settled according to Eligible benefits

Eligible Benefits shall be payable to either the Insured Person or the Service Provider for Eligible Benefits incurred by the Insured Person worldwide. **Hospital admissions whether worldwide, or for expenses incurred in the United States must utilize the Pre-Notification Program. Failure to utilize the Pre-Notification Program will result in a 30% reduction of the Eligible Benefits stated in the Schedule of Benefits.**

The charges enumerated herein shall in no event include any amount of charges, which are in excess of Reasonable and Customary charges. A charge incurred by an Insured Person shall be deemed a Reasonable and Customary charge for the services and supplies for which the charge is made if it is not in excess of the average charge for such services and supplies in the locality where received, considering the nature and severity of the bodily Injury or Illness in connection with which such services and supplies are received. If the charge incurred is in excess of such average charge, such excess amount shall not be recognized as a Covered Expense. All charges shall be deemed to be incurred on the date such services or supplies, which give rise to the expense charged, rendered or obtained.

B. Medical Benefits

The Company will pay Eligible Benefits, as per the limits stated in the Schedule of Benefits. Coverage is limited to Eligible Benefits incurred subject to the Exclusions, Limitations and Provisions of this Certificate. All bodily disorders existing simultaneously, which are due to the same or related causes shall be considered as one Covered Event. If a Covered Event is due to causes which are the same or related to the cause of a prior Covered Event (including complications arising there from), the Covered Event shall be considered a continuation of the prior Covered Event and not a separate Covered Event.

When a covered expense incurred by the Insured Person, the Company will pay Reasonable and Customary medical expenses in excess of the Deductible and Coinsurance as stated in the Schedule of Benefits. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits.

For the purpose of this section, only expenses, incurred as the result of a Covered Event, which are specifically enumerated in the following list, and which are not listed in the Exclusions, shall be considered as Eligible Benefits:

- 1.) Charges made by a Hospital for room and board, Inpatient floor nursing and other services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for private room and board accommodation.
- 2.) Charges made for Intensive Care or Coronary Care charges and Inpatient nursing services.
- 3.) Charges made for diagnosis, treatment and Surgery by a Physician. Charges for a second surgeon will be paid at a maximum of 50% of the primary surgeon fee. Charges for a third surgeon or more will not be an eligible medical benefit.
- 4.) Charges made for an operating room.
- 5.) Charges made for Outpatient treatment, same as any other treatment covered on an Inpatient basis. This includes ambulatory Surgical centers, Physicians' Outpatient visits/examinations, clinic care, and Surgical opinion consultations.
- 6.) Charges made for the cost and administration of anesthetics. Charges for the anesthesiologist will be paid at a maximum of 50% of the surgeons fees.
- 7.) Charges for Medication, x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, chemotherapy, oxygen, blood, transfusions, and iron lungs.
- 8.) Charges for physiotherapy, if recommended by a Physician, for the treatment of a specific Covered Event and administered by a licensed physiotherapist.
- 9.) Hotel room charge, when the Insured Person would otherwise be confined in a Hospital, shall be under the care of a duly qualified Physician in a hotel room owing to unavailability of a Hospital room by reason of capacity or distance or to any other circumstances beyond control of the Insured Person.
- 10.) Dressings, Medications, and Medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
- 11.) Local transportation to the nearest Hospital or to the nearest Hospital with facilities for required treatment. Such transportation shall be by licensed ground ambulance only, within the metropolitan area in which the Insured Person is located at that time the service is used. If the Insured Person is in a rural area, then licensed ground ambulance transportation to the nearest metropolitan area shall be considered a Covered Expense.
- 12) Acute medical conditions are covered as per the table of benefits.

C. Pregnancy Benefits

When a covered Pregnancy is incurred by an Insured Person, who is not a Dependant Child, the Company will pay Reasonable and Customary medical expenses, excess of the Deductible and Coinsurance as stated in the Schedule of Benefits. Pregnancy expenses incurred during the first 12 months of the Coverage Period are not considered Eligible Benefits. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Benefits during any one Pregnancy.

The Insured Person or their representative must pre-notify the Administrator of a Pregnancy within the first one hundred and twenty (120) days of the Pregnancy.

FAILURE TO PRE-NOTIFY THE ADMINSTRATOR OF A PREGNANCY WITHIN 120 DAYS WILL RESULT IN A 30% REDUCTION OF THE ELIGIBLE BENEFITS STATED IN SECTION 1:

SCHEDULE OF BENEFITS. IN ADDITION, THE PRE-NOTIFICATION PROGRAM MUST BE FOLLOWED, AS STATED IN SECTION 4, K. PRE-NOTIFICATION PROGRAM.

Benefits will be payable for Eligible Benefits incurred before, during, and after delivery of a Child, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Insured Person and her newborn Child in a Hospital will, at a minimum, be for the length of stay recommend by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Prenatal Care, but not to exceed a maximum of 31 days. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Benefits during any one Pregnancy.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Insured Person's attending Physician determines further Inpatient postpartum care is not necessary for the Insured Person or her newborn Child provided the following are met:

- 1.) In the opinion of the Insured Person's attending Physician, the newborn Child meets the criteria for medical stability in the guidelines for Prenatal Care prepared by the Academy of pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of: (a) the antepartum, intrapartum, postpartum course of the mother and infant; (b) the gestational stage, birth weight, and clinical condition of the infant; (c) the demonstrated ability of the mother to care for the infant after discharge; and (d) the availability of post discharge follow up to verify the condition of the infant after discharge; and
- 2.) One (1) at-home post delivery care visit is provided to the Insured Person at her residence by a Physician or nurse performed no later than forty-eight (48) hours following discharge of the Insured Person and her newborn Child from the Hospital. Coverage for this visit includes, but is not limited to: (a) parent education; (b) assistance in training in breast or bottle feeding; and (c) performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Insured Person or newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At the Insured Person's discretion, this visit may occur at the Physician's office.

D. Well-Child Care Benefits

This benefit applies to Dependant Children, who have been underwritten and Approved, by the Administrator as Insured Persons. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Benefits during any one Period of Coverage. The benefit includes: the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity. In addition, it includes Coverage for preventive and primary care services, including physical examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include a maximum of five (5) visits per year for Dependant Children under nineteen (19) years of age. Deductible and co insurance apply. Any applied Preventive and primary care services shall also include, as recommended by the Physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

E. Adult Preventive Benefits

The Company will pay expenses, as per the limits stated in the Schedule of Benefits, for the following Eligible Benefits. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Benefits during any one Period of Coverage.

Coverage is limited to the following expenses incurred subject to any Exclusions listed. These Preventative Benefits are not subject to Deductible or Coinsurance.

Covered Preventive Benefit expenses include:

1. Routine physical examinations:
 - a. Females must be over the age of 30 and have been continuously covered under the Certificate for 12 consecutive months prior to receiving treatment.
 - b. Males must be over the age of 30 and have been continuously covered under the Certificate for 12 consecutive months prior to receiving treatment.

2. Female preventive examinations. Females must be over the age of 30 and have been continuously covered under the Certificate for 12 consecutive months prior to receiving treatment.
 - a. Mammogram:
 - i. A baseline mammogram for women.
 - ii. An annual screening for mammogram for women.
 - b. Cervical Cytologic:
 - i. An annual cervical cytologic screening for women.

F. Dental Benefit

When covered Dental expenses are incurred by the Insured Person the Company will pay Reasonable and Customary expenses in excess of the Deductible as stated in the Schedule of Benefits. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Benefits during any one Period of Coverage.

For the purpose of this section, only such expenses, incurred as the result of an eligible Dental condition, in which services or Medications are prescribed, performed, or ordered by a Dentist and enumerated below, and which are not listed in the Exclusions, shall be considered as Eligible Benefits.

1. An eligible Dental condition shall mean emergency dental repair or replacement to sound, natural teeth damaged as a result of a covered Accident.
2. Treatment must be completed within 12 months of the Accident.

G. Emergency Medical Evacuation/Repatriation Benefit

The Company shall pay benefits for Eligible Benefits incurred up to the maximum stated in the Schedule of Benefits, if any covered Illness or Injury commencing during the Insured Person's Period of Coverage results in the Medically Necessary Emergency Medical Evacuation or Repatriation of the Insured Person. The decision for an Emergency Medical Evacuation or Repatriation must be ordered by the Company's appointed Administrator in consultation with the Insured Person's local attending Physician.

Emergency Medical Evacuation or Repatriation means: a) the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is Ill or Injured to the nearest adequate medical facility where medical treatment can be obtained; or b) after being treated at a local medical facility as a result of an Emergency Medical Evacuation, the Insured Person's medical condition warrants transportation with a qualified medical attendant to his/her current Home Country to obtain further medical treatment or to recover; or both a) and b) above.

For the purpose of this section, only such expenses, incurred as the result of a Covered Event, which are specifically enumerated in the following list, and which are not listed in the Exclusions, shall be considered as an Eligible Benefits:

1. Eligible Benefits are expenses, up to the maximum stated in the Schedule of Benefits for transportation, medical services and medical supplies necessarily incurred in connection with an Emergency Medical Evacuation or Repatriation of the Insured Person. All transportation arrangements must be by the most direct and economical route.
2. Expenses for special transportation and medical supplies and services must be: (a) pre-approved and ordered by the Company's appointed Administrator representative and (b) required by the standard regulations of the conveyance transporting the Insured Person. Transportation means any land, water or air conveyance required to transport the Insured Person. Special transportation includes, but is not limited to, licensed ground and air ambulances, commercial airlines, and private motor vehicles.
3. All transportation in connection with an Emergency Medical Evacuation or Repatriation must be pre-approved and arranged by an Administrator representative appointed by the Company.

H. Return of Mortal Remains Benefit

The Return of Mortal Remains Benefit shall only apply when the Insured Person is traveling outside of their current Home Country. The Company shall pay benefits for Eligible Benefits incurred up to the maximum stated in the Schedule of Benefits, if any covered Illness or Injury commencing during the Insured Person's Period of Coverage results in Return of Mortal Remains of the Insured Person. The Company will pay the reasonable Eligible Benefits incurred to return the Insured Person's remains to his/her then current Home Country, if he or she dies.

For the purpose of this section, only such expenses, incurred as the result of a Covered Event, which are specifically enumerated in the following list, and which are not excluded in the Exclusions, shall be considered as an Eligible Benefits:

1. Eligible Benefits include, but are not limited to, expenses for embalming, a container appropriate for transportation, shipping costs, and the necessary government authorizations.
2. All Eligible Benefits in connection with a Return of Mortal Remains must be pre-approved and arranged by an Administrator representative appointed by the Company.

I. Emergency Medical Reunion Benefit

The Emergency Medical Reunion Benefit shall only apply when the Insured Person is traveling outside of his current Home Country. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Benefits during any one Period of Coverage. When an Insured Person is eligible for a covered Emergency Medical Evacuation or Repatriation under this Certificate and the Administrator representative, and the attending Physician determine that Emergency Medical Evacuation or Repatriation is necessary and prudent for the Insured Person, an Emergency Medical Reunion Benefit shall apply.

For the purpose of this section, only such expenses, incurred as the result of a Covered Event, which are specifically enumerated in the following list, and which are not excluded in the Exclusions, shall be considered as an Eligible Benefits:

1. The cost of a round trip economy air fare for one individual selected by the Insured Person, from the Insured Person's Home Country to the location where the Insured Person is hospitalized and return to the current Home Country;
2. Reasonable travel and accommodation expenses incurred in relation to the Emergency Medical Reunion up to the maximum stated in the Schedule of Benefits, not to exceed US\$200 per day.
3. The period of Emergency Medical Reunion is not to exceed 10 days, including travel.
4. All transportation in connection with an Emergency Medical Reunion must be pre-approved and arranged by an Administrator representative appointed by the Company.

J. Pre-Notification Program

The Pre-Notification Program requires that the Insured Person (or someone on his behalf) obtain Pre-Notification by contacting the Administrator as soon as possible, but not less than 48 hours prior to the date of a scheduled Hospital admission or within 48 hours after an Emergency Hospital admission anywhere in the world. Additionally, Outpatient services to be rendered in the United States which will exceed US\$1,000 must be Pre-Notified in the same manner as a Hospital admission. The Pre-Notification Program also requires that the Insured Person utilize an approved Preferred Provider Organization (PPO) Service Provider for services and Treatments received in the United States.

Pre-Notification requires the Insured Person to comply with the following protocol:

1. Contact the Administrator

Acceptable methods of contacting the Administrator include phone, fax, and e-mail. In order to complete Pre-Notification, The Administrator will need to obtain the following from the Insured Person: Certificate Number, patient name, patient's telephone number (and/or email address), name and telephone number of the Hospital, the name and telephone number of the referring Physician and the diagnosis and approximate number of days to be confined.

The Administrator can be contacted at:
Global Assurance Group
7491 West Oakland Park Blvd 2nd Floor
Fort Lauderdale, Florida 33162 USA
Phone 954-749-1025
Fax 954-749-1027
Email info@glmed.net

2. Contact the Assistance Company

GMMI Phone

3. Utilize an approved PPO Service Provider within the United States

Services and Treatment in the United States must be received at an approved PPO Service Provider facility, if one exists within a 75 mile radius of where the Insured Person is located. To obtain a list of approved PPO Service Providers contact the Administrator

Failure to follow the protocol outlined in number 1 and 3 above of the Pre-Notification Program will result in a 30% reduction of the Eligible Benefits stated in the Schedule of Benefits.

Benefits payable under the Certificate are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Certificate. Pre-Notification does not guarantee or confirm benefits under the Certificate.

4. Pre-Notification Appeal

Upon request by the Insured Person or Service Provider, the Administrator will review expenses which were not Pre-Notified. Upon the presentation of evidence of extraordinary circumstances or of medical information justifying the expenses, which were not available to the Insured Person or Service Provider at the time of admission or when the Treatment and services were rendered, the Administrator may upon review agree to the expenses retroactively if justified.

SECTION 5: EXCLUSIONS

A. Medical Benefit Exclusions

This Insurance does not cover any Treatment, Medication, charges or the consequences thereof, related to the following Exclusions, unless specifically included or modified on the Schedule of Benefits numbers I through XVII in this Certificate. With regards to Medical Benefits this Insurance does not cover expenses from, related to or in connection with:

1. 1.Pre-Existing Conditions are any Injury or Illness which meets the following criteria: 1) A condition that would have caused a person to seek medical advice, diagnosis, care or Treatment prior to the Individual Effective Date of Coverage under this Certificate; 2) A condition for which medical advice, diagnosis, care or Treatment, including Medication, was sought, recommended or received prior to the Individual Effective Date of Coverage under this Certificate; 3) the symptoms which occurred prior to the Individual Effective Date of the Coverage under this Certificate would have allowed a person trained in medicine to make a diagnosis of the condition producing the symptoms; 4) a condition which manifested prior to the Individual Effective Date of Coverage under this Certificate; 5) Expenses for Pregnancy within twelve (12) months after the Individual Effective Date of Coverage under this Certificate. Exclusionary Riders may be issued by the Administrator, for certain Pre-Existing Conditions. Pre-Existing Conditions that are fully and accurately disclosed on the Application and Approved and accepted by the Administrator, without an Exclusionary Rider or other restriction will be covered up to a lifetime maximum of US\$50,000 (US\$5,000 limit per Period of Coverage) after the Insured Person has been continuously insured for 24 months. At the time of application and at the Administrator discretion immediate benefits with higher limits may be offered.
2. Injury or Illness which is not presented to the Company for payment within ninety (90) days immediately following the Incident, which gave rise to the expenses.
3. Treatment which is not Medically Necessary.
4. Services provided at no cost to the Insured Person.
5. Treatment which exceed Reasonable and Customary charges.
6. Surgeries, Medications or Treatments which are Investigational, Experimental, or for research purposes.

7. Services, supplies or Treatment, including any period of Hospital confinement, which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician.
8. Suicide or any attempt there at, while sane or self destruction or any attempt there at, while insane;
9. War, hostilities or warlike operations (whether war be declared or not), Invasion, Act of an enemy foreign to the nationality of the insured person or the country in, or over, which the act occurs, Civil war, Riot, Rebellion, Insurrection, Revolution, Overthrow of the legally constituted government, Civil commotion assuming the proportions of, or amounting to, an uprising, Military or usurped power, Explosions of war weapons, Utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined, Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the insured person whether war be declared with that state or not, Terrorist activity or radioactive contamination.

For the purpose of this Exclusion #9;

- i) Terrorist activity means an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organisation(s) or governments(s).
- ii) Utilization of Nuclear weapons of mass destruction means the use of any explosive nuclear weapon or device or the emission, discharge, dispersal, release or escape of fissile material emitting a level of radioactivity capable of causing incapacitating disablement or death amongst people.
- iii) Utilization of Chemical weapons of mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people.
- iv) Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesised toxins) which are capable of causing incapacitating disablement or death amongst people.

Also excluded hereon is any Loss or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, or suppressing any, or all, of the situations described above. In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

10. Injury sustained while participating in organized, professional or an amateur sport event
11. Unless otherwise provided for under the plan, Vaccinations, inoculations, routine physicals, preventative medical examinations, check-ups or health screening or other examinations where there are no objective indications or impairment in normal health, and laboratory diagnostic or x-ray examinations, except in the course of a Covered Event established by a prior call or attendance of a Physician;
12. Treatment of the Temporomandibular Joint (TMJ).
13. Vocational, occupational, rehabilitative, physical, speech, recreational, or music therapy whether inpatient or outpatient
14. Treatment given by a doctor, general medical practitioner (GP), physician, specialist or consultant who is in any way related to the insured person or who is unrecognized by the relevant authorities in the country in which the treatment takes place as having specialized knowledge or, or expertise in the treatment of the disease, illness or injury being treated.

15. Cosmetic or plastic Surgery, whether for psychological reasons or otherwise, and any related consequences thereof and or medical expenses related to, except as the result of a covered Accident. For the purposes of this Insurance, Treatment of a deviated nasal septum shall be considered a cosmetic condition.
16. Treatment, purchase and fitting of false teeth or dentures. Claims for hearing examinations, hearing aids, ear and body piercing. Claims for the supply or fitting of physical aids or devices not forming a permanent part of the body.
17. Eye refractions or eye examinations for the purpose of prescribing corrective lenses or eye glasses or for the fitting thereof and radial keratotomy, unless caused by Accidental bodily Injury incurred while insured hereunder; Treatment to correct short or long sight, including eyeglasses, spectacles, lenses and contact lenses.
18. Treatment costs incurred as a result of complications directly caused by a disease, illness, injury or treatment for which cover has been restricted or excluded..
19. Telephone consultations or failure to keep a scheduled appointment.
20. Treatment while confined primarily to receive Custodial Care, educational or rehabilitative care and nursing services in a long term care facility, spa, hydroclinic, weight loss clinic, sanatorium, nursing home or similar facilities.
21. Services and supplies which are non-medical in nature.
22. The Insured Person's unused airline ticket for the transportation back to the Insured Person's Home Country, where an Emergency Medical Evacuation or Repatriation and/or Return of Mortal Remains benefit is provided.
23. Intentionally self-inflicted Injury or Illness;
24. Commission of a felony offense;
25. Injury sustained while taking part in mountaineering where ropes or guides are normally used, hang gliding, parachuting, bungee jumping, racing by horse, motor or motorcycle, scuba diving, involving underwater breathing apparatus - unless PADI or NAUI certified;
26. Treatment paid for or furnished under any other individual or group policy or other service or medical pre-payment plan arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for Treatment without cost to any individual; regardless as to when any other policy issue date was before or after the issuance of this policy; In all instances this policy will pay medical expenses last and in excess only after all valid and existing policies benefits are fully paid out and exhausted.
27. Injuries for which benefits are payable under any no-fault automobile insurance policy;
28. Treatment of venereal disease, sexually transmitted disease, or expenses for a sex change;
29. Unless otherwise provided for under the plan Routine Dental Treatment, preventative dental examinations, prophylaxis treatment, check-ups, scraping, cleaning or polishing of teeth, services for Dental care of the teeth or periodontium or the surrounding tissue or structure, except as the result of Injury to sound, natural teeth caused by Accident; Any medical expenses which are the consequences thereof and or related to treatments under this exclusion including but not limited to infections are not an eligible medical expenses under this policy
30. Treatment of any condition, which in the opinion of our medical advisors, is hereditary.
31. Pregnancy expenses incurred by a Dependant Child;
32. Treatments, Medications or procedures that either promotes or prevents conception, or prevents childbirth, including but not limited to: Claims for any type of contraception or fertilization, treatment for sexual problems (including impotence, whatever the cause), assisted reproduction (e.g. IVF treatment), termination of pregnancy, artificial insemination, in vitro fertilization, gamete intra fallopian transfer (GIFT), Treatment for infertility or impotency, sterilization or reversal thereof, or abortion. Maternity and childbirth costs as a result of any form of assisted reproduction and any birth defects, congenital or hereditary conditions which are present at birth, whether or not diagnosed.
33. Treatment in connection with addictive conditions or disorders; misuse of drugs or alcohol or substance or solvent abuse whether or not it is related to prescription drugs or treatment for any injury sustained whilst under the influence wholly or party to the effects of misuse of drugs, alcohol, substance or solvent.
34. Any Mental and Nervous disorders or rest cures, unless otherwise covered in this Certificate.

35. Treatment which is incurred by Insured Persons who were HIV Positive at the time of Application for this Insurance, or testing for the following: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, or AIDS.
36. Treatment for the AIDS virus, AIDS related Illness, ARC Syndrome, AIDS, and/or any Illness arising as complications from these conditions.
37. Treatment for Chronic Fatigue Syndrome, including but not limited to diagnostic workups.
38. Service or Treatment for any form of food supplement or augmentation or for any program for weight control, whether for obesity or any diagnosis, by diet, injection of any fluid, or use of any Medications or Surgery of any kind, including smoking cessation programmes.
39. Chiropractic care, unless otherwise covered under this Certificate.
40. Purchase or rental of durable medical equipment outside of a Hospital, including but not limited to wheelchairs, oxygen tanks and walkers.
41. Land and/or sea rescues.
42. Treatment for Illness or Injury resulting from or in the course of any employment for wage or profit by the Insured Person.
43. Treatment, services and supplies for flat feet, fallen arches, corns, bunions, callouses and care of toenails.
44. Treatment, services and supplies for Convalescent, Hospice and Home Health Care.
45. Treatment and costs of a life support machine or similar device and the costs of care and treatment associated with the use of such life support machine or similar device beyond the first 14 days of use
46. Claims for chronic end stage renal failure dialysis manifested during the first ten (10) years of coverage. All other dialysis are covered.
47. Non-emergency transportation costs, other than inter-Hospital ambulance transportation and in particular costs arising from trips specifically made for the purpose of obtaining medical treatment are excluded.
48. Any claim arising from assignment(s) undertaken against the advice of a physician when the insured person has received a terminal prognosis or is suffering from a chronic condition.
49. Hormone replacement therapy (HRT), unless carried out as part of, or immediately after a surgical procedure which is covered under the Table of Benefits which attaches to this plan.
50. Treatment for sleep apnea (temporarily stopping breathing during sleeping), snoring or any other sleep related breathing disorders.
51. Treatment of an allergic condition or any other disorder or discomfort that the insured person was aware of at the time of application and did not declare it.
52. Treatment for learning difficulties and developmental problems.

SECTION 6: CERTIFICATE PROVISIONS

1. **Entire Contract; Changes:** The Certificate, including the, Application, Schedule of Benefits, Exclusionary Riders, endorsements and the attached papers, if any, constitutes the entire contract of Insurance. No change in the Certificate shall be valid until Approved by an executive officer of the Administrator and unless such approval is endorsed hereon. No agent has authority to change this Certificate or to waive any of its provisions.
2. **Notice of Claim:** Written notice of claim must be given to the Company within ninety (90) days after the occurrence or commencement of any Covered Event covered by the Certificate, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Administrator, or to any authorized agent of the Company, with information sufficient to identify the Insured Person shall be deemed notice to the Company.

An insured person can claim benefit from start of treatment until the time when it is medically confirmed that the treatment is no longer necessary, or until the plan is no longer in force, whichever is the earlier. If the insured person subsequently claims for a new course of treatment, which is not in any way

connected with the former treatment; or after a 6 month gap in treatment, the subsequent claim will be regarded as a new claim.

In the written Notice of Claim the insured or the insured authorized agent shall give notice to the administrator if the insured does not have a Global Medical Claim Form and / or in the USA the HIPPA claims authorization form. If such forms are not furnished to the insured within fifteen (15) days after the giving of such notice requesting the forms, the claimant shall be deemed to have complied with the requirements of the Certificate as to Proof of Loss.

3. **Proof of Loss:** The burden of proof is on the claimant. Written Proof of Loss in the form of a duly signed Global Medical claim form and for claims in the USA a signed HIPPA claims authorization form must be furnished to the Administrator, at its said office, within ninety (90) days after the date of such Covered Event. Failure to furnish such proof will invalidate the claim. However failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. Where the Company deems a consequence is not covered under the plan by reasons of an exclusion, the burden of proof to the contrary shall be upon the insured person.
4. **Payment of Claims:** Once an insured person has received pre-authorization and approval for eligible in-patient treatment for accident, injury, sickness, disease or illness, eligible costs are directly settled with the treatment provider/s. Should the insured pay directly to the provider it will be the responsibility of the insured to get a refund from the provider
5. **Physical Examination and Autopsy:** The Company at its own expenses shall have the right and opportunity to examine the person of any individual whose Injury or Illness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.
6. **Legal Actions:** The parties hereon agree that any and all disputes, claims, controversies arising out of or relating to this Certificate, or its alleged breach, that are not resolved by the parties hereon, shall be subject to the laws of England and Wales. Wherewith may be served by personal delivery or registered mail to the Company at its office at Certain Underwriters at Lloyd's, One Lime Street London EC3M 7HA and on the Insured Person at the most current address appearing on the records of the Company, with the same effect as if personally served in such City. The Company's liability in any such legal action shall be limited to such amounts as the courts may determine are due under this Certificate, with such interest thereon and such cost of the courts proceeding, if any, as the courts may direct. In no event shall the Company be liable for any extra-contractual damages, whether characterized, without limitation, as consequential, exemplary, punitive or tort damages, for any alleged breach of this Certificate.

No action at law, or in equity, shall be brought by an insured person to recover under the plan prior to the expiration of sixty (60) days after the Company or the medical co-ordinator have been furnished with proof of loss in accordance with the requirements. Nor shall any such action be brought at all unless commenced within twelve (12) months from the date of the original claim.

7. **Grace Period:** A Grace Period of thirty-one (31) days will be granted for the payment of each Premium falling due after the first Premium, during which Grace Period the Certificate will continue in force, but the Insured Person shall be liable to the Company for the payment of the Premium accruing for the period the Certificate continues in force.
8. **Reinstatement:** If the Company terminates Coverage for non-payment of Premium or for premium which is not received at the office of the administrator within the allotted time period, at the Company's discretion it may chose to consider reinstatement of Coverage only after receiving proof of good health and payment of Premium. Reinstatement is not guaranteed and the company is not under any

obligation to accept the reinstatement. The reinstated Certificate shall cover only Covered Events resulting from Injuries that are sustained after the date of reinstatement and those Covered Events due to Illness that manifests not less than ten (10) days after the date of reinstatement. No reinstatement will be considered by the Company sixty (60) days after the Certificate has been terminated for non-payment of Premium.

9. **Effective Date of Individual Insurance:** After review and Approval of each Applicant by the Administrator, Coverage will become effective on the later of the following dates: (1.) The date requested on the Application, (2.) The date the appropriate premium and Application are received by the Administrator, or (3) The date the Applicant is Approved by the Administrator. The Insured's ID Card will state the official Effective Date of coverage, as issued by the Administrator.

The Company reserves the right to refuse enrolment based on an individual application or application including dependants without giving any reason, or to accept the applicant and/or dependants on any special terms, which it may require, and which will be specified on an endorsement.

10. **Termination Date of Individual Insurance:** Coverage will terminate upon the earlier of the following: (1.) The end of the period for which Premium has been paid (2.) The date the Insured Person fails to meet the Eligibility Requirements described in SECTION 2, A; (3.) The date the Company cancels coverage for a specific Class of Insured Persons, which the individual Insured Person may be included. For cancellation of a specific class Company will send a 60 days advance written notice to the insured.

11. **Not in Lieu of Worker's Compensation:** This Insurance is not in lieu of and does not affect any requirements for Coverage by Worker's Compensation Insurance.

12. **Certificate of Insurance:** The Company shall issue to each Insured Person an individual Certificate of Insurance, which shall state the essential features of Insurance to which such person is entitled and to whom benefits are payable.

13. **Data Furnished by Insured Person(s):** Insured Person shall furnish all information requested on the Application and any additional information requested by the Company. Failure to provide information requested by the administrator will be cause for a denial of an application, a claim and /or will void the policy. All newborn Children of the Main Insured Person, who are not reported on the initial Application and not currently covered under this Insurance, shall be underwritten by the Administrator, not before age of fourteen (14) days old.

Failure on the part of the Main Insured Person to furnish an Application for a newborn Child to the Company for underwriting shall not constitute valid Insurance under this contract for the newborn Child. A Dependant Child can not be added to this Certificate of Insurance, without a complete Application and approval of the Administrator.

The refusal or failure of the insured or Physician or Hospital to make all medical reports and records available to the Company could cause an otherwise valid claim or Application to be denied or the file to be closed due to lack of or limited reply from the Insured Person and the Insured Person's medical providers.

14. **Cancellation:** The Certificate is an annually renewable for the life of the Insured Person or until the Termination Date of Individual Insurance. Renewals will be subject to the definitions, terms and conditions in force at the time of each renewal. The company reserves the right to alter and/or amend by Class the terms, conditions, premium rates, discounts and/or surcharges at each policy renewal date and apply such alteration/s and or amendment/s to all new and renewal policies. The Company may cancel an entire class of Insured Persons including but not limited to a class within a certain region, gender, age or category.

The Insured Person may cancel the Certificate by giving the Company 30 days notice, in writing, at which time the Company shall make a short rate calculation on the remaining Premium (if any) and reimburse the Insured Person accordingly.

15. **Renewal of Individual Insurance:** The Certificate will be renewed each year on the anniversary of the Effective Date of Individual Insurance subject to the provisions of the Certificate in force at the time of the renewal. The initial Period of Coverage cannot exceed twelve (12) months. The Insured Person, however, may apply for renewal of Coverage. The renewal Period of Coverage may not total more than twelve (12) months. Renewal premiums will be charged at the rates applicable to the class of persons insured under the plan at the date of each renewal. Renewal(s) will be contingent upon the Insured Person submitting within the allotted time and the administrator receiving at its office the applicable renewal Premiums for their class, as determined by the Company. The Company can not cancel an Insured Person, unless that Insured Person is included in a class that is canceled in its entirety by the Company.

16. **Excess Benefits:** All Coverage shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted. Regardless as to when any other policy issue date was before or after the issuance of this policy; In all instances this policy will pay medical expenses last and in excess only after all valid and existing policies benefits are fully paid out and exhausted.

Other valid and collectible insurance for which benefits may be payable are insurance programs provided by:

- 1.) Individual, group or blanket insurance or coverage;
- 2.) Other prepayment coverage provided on a group or individual basis;
- 3.) Any coverage under labor management trustee plans, union welfare plans, employer organizational plans, employee benefit organization plans, or other arrangement of benefits for individuals of a group;
- 4.) Any coverage required or provided by any statute, socialized insurance program; or
- 5.) Any no-fault automobile insurance;
- 6.) Any third party liability insurance.

17. **Subrogation:** The Company has the right to full subrogation and reimbursement of any and all amounts paid by the Company to or on behalf of, an Insured Person, if the Insured person receives any sum of money from any person, plan or legal entity which is legally obligated to make payments arising out of any act or omission of any person whether a third party or another covered person under the Certificate, which directly or indirectly caused a physical or mental condition, in connection with which payment of any benefits under the Certificate to, or on behalf of, such Insured Person was made. The Company shall have a lien against such sum of money received from third parties or other persons described above or their insurers, or the insurer of the Insured Person, and shall be reimbursed there from. The Insured Person further agrees to notify other persons described above in writing, of the Company's subrogation and lien rights before the receipt of any payment from said parties or other persons.

The Insured Person shall be responsible for all expenses of recovery from such parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such payments or payments by other persons, which fees and expenses shall not reduce the amount of reimbursement to the Company required of the Insured Person. The Insured Person agrees to reimburse the Company for any benefit paid hereunder, out of any monies recovered from such party or other persons as a result of judgment, settlement or otherwise, even though such monies are not characterized as amounts paid for medical expenses or claims. The Insured Person agrees to furnish such information and assistance, and to execute and deliver all necessary instruments, as the Company or its designee may request to facilitate the enforcement of these subrogation rights, including but not limited to the execution of a subrogation agreement prior to payments of benefits under the Certificate to, or on behalf of the Insured Person.

The Insured Person shall not release or discharge any party from his or her obligation to the Insured Person or the Company or take any other action which could impair the Company's subrogation rights. The Company's exercise of its rights to take whatever action it sees fit against any third party or other persons shall not affect the Insured Person's right to pursue other forms of recovery.

If the Insured Person or any one acting on his or her behalf has not taken action to pursue his or her rights against such parties or other persons to obtain a judgment, settlement or other recovery, the Company or its designee, upon giving thirty (30) days written notice to the Insured Person shall have the right to take such action in the name of the Insured Person to recover that amount of benefits paid under the Certificate; provided, however, that any action taken without the consent of the Insured Person shall be without prejudice to such Insured Person.

The Company's right to reimbursement as set forth herein shall be payable first from sums received from the parties or other persons and such reimbursement shall continue until the Insured Person's obligations hereunder to the Company are fully discharged, even though the Insured Person does not receive full compensation or recovery for his/her injuries, damages loss or debt. This right to subrogation pro tanto shall exist in all cases.

If an Insured Person fails to comply with these requirements, the Insured Person shall not be eligible to receive any benefits, services or payments under the Certificate until there is compliance regardless of whether such benefits are related to the act or omission of such party or other persons.

18. **Change of Residence:** The Certificate will become null and void unless the Company is notified of any change in the Home Country of the Insured Person, within thirty (30) days of the change. All terms and conditions are subject to review and revision upon a change in the Insured Person's Home Country.
19. **Monetary Limits:** The monetary limits stated in this Certificate and the Premium shall be in United States dollars. For services outside of the territorial limits of the United States, the exchange rate used to determine the amount of United States dollars to be paid is the exchange rate effective for the date the claims expense was incurred.
20. **Assignment:** The Insurance provided hereunder is not assignable, but benefits may be assigned in accordance with #5, Payment of Claims.
21. **Modification of Medical Condition Prior to Issuance of Certificate:** Any conditions which manifest themselves between the date the Application is signed and the date the Coverage is issued, shall be considered Pre-existing and not covered for the entire Certificate Period. Additionally, some conditions which manifest themselves between the date the Application is signed and the date the Coverage is issued may affect your eligibility for Insurance.
22. **Group Plans:** When this certificate is part of a group plan or employee benefit plan, which receives special group rates, retired individuals and their dependants are covered at terms to be agreed by the Company
23. **The purpose of this plan:** is to cover non - manual individuals and groups and their dependants (if applicable) as insured persons during a period of insurance for medical expenses incurred for treatment of medical, surgical and acute conditions by medical practitioners and specialists
24. **Representations in Application:** Any statement or description made by or on behalf of the Insured Person on the Application for Insurance Coverage is a representation and is not a warranty. A misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the Certificate if either one of the following apply; a.) the misrepresentation, omission, concealment, or statement is false and/or fraudulent, whether material or not to the Approval of the Coverage for the

Insured Person, b.) if the facts had been known to the Administrator or Company prior to issuance of Coverage, the Administrator or Company would not have issued Coverage, would not have issued Coverage at the same Premium, or would have issued an Exclusionary Rider to the Coverage under this Certificate.

When a misrepresentation, omission, concealment of fact, or incorrect statement occurs on the application or accompanying health statements, regardless whether the misrepresentation, omission, concealment of fact, or incorrect statement is related to the possible claim at hand or not, the company may choose to either rescind and void the certificate and return all the premium to the payer retroactive to the original Individual Effective Date of Coverage or issue a permanent exclusion for the particular pre-existing condition and deny the claim. In the case that a policy is rescinded any claim payments made on the policy from the effective date until the date the policy is rescinded will be applied towards the return of premium which is retroactive to the Effective Date.

Section 7: Travel Benefits

All sections of the policy included but not limited to definitions, benefits, exclusion and certificate provisions apply unless specifically specified in the travel benefit section below.

Travel benefits apply while traveling internationally outside your country of residence up to a maximum of 60 days at a time.

24 hours/ 7 days a week / 365 days a year

Emergency illness or accident medical and hospital expense benefit of \$10,000 per policy period, deductible and co insurance do not apply. For benefits above this \$10,000 benefit the applicable deductible and co insurance will apply first and then the remainder of the policy benefits will be paid as a regular claim.

Emergency illness or accident prescription medicine of \$300 per policy period deductible and co insurance do not apply.

Round trip economy air travel cost of family member to assist insured when admitted in a hospital for a period of over 48 hours up to \$1,000 per insured person per policy period

Cost of hotel room only for family member to assist insured when admitted in a hospital for period of over 48 hours up to \$100 per day with a 10 day maximum per insured person per policy period not including food or any other hotel expenses aside from actual room cost.

Repatriation of an accompanying minor of the insured when insured is admitted in hospital for over 48 hours and no other family member is with minor up to \$2,500 per insured person per policy period

Legal assistance of \$1,500 when the insured is arrested, detained, or in an automobile accident while traveling outside your country of residence per insured person per policy period

Complete and total lost baggage benefit of up to a maximum \$1,200 per insured person per policy period to be calculated as follows. Paid at \$60 per KG up to a maximum of 20 KG. There are no reimbursements or benefits paid for items with specific values. Bags must be checked with an international airline traveling from one country to another through the authorized personal of the airline. Insured must travel as a passenger on the same flight with the bags. In order to receive this benefit, the airline who received the bags must approve and pay for the complete loss of the bags with proof of payment documents and proof of weight document submitted in originals to the company. Partial lose or partial damage to bags do not qualify for any benefits under this Travel Benefit.

Unlimited Transmission of urgent messages.

Unlimited Medical consultation, information and referrals.

Emergency illness is defined as a medical condition that manifested itself after leaving your country of residence. Any other illness or medical condition that manifested before leaving your country of residence or travel against doctor orders will receive regular claim review based on the plan policy and not the travel benefit.

Emergency accident is defined as an external cause for a medical condition that occurred after leaving your country of residence. Any other accident that occurred before leaving your country of residence will receive regular claim review based on the plan policy and not this travel benefit.

Complaints procedure.

Global Assurance Group, Inc will at all times endeavor to provide the highest standards of service.

If at any time you are not completely satisfied with any aspect of our service, including the handling of claims, please write to our Customer Services Manager at our head office address below, quoting your policy number. We will fully investigate your claim and try to put matters right.

If you are unsatisfied with our response, please write to our Managing Director's office at our head office address:

Global Assurance Group
7491 West Oakland Park Blvd
2nd Floor
Fort Lauderdale
FL 33162 USA

Telephone 954-749-1025

If you are still not satisfied with our responses to your complaint, you may write to the Chairman's office at the following address:

Certain Underwriters at Lloyd's
One Lime Street
London
EC3M 7HA

Telephone +44 (0)20 7327 1000

Complaints that we cannot settle can be referred to the Financial Ombudsman Service. They can be contacted at:

Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London
E14 9SR

Telephone: 0845 080 1800