Certificate of Insurance

ProtExPlan - Gold

A. AGREEMENT - Sirius International Insurance Corporation (publ) (the Company) promises and agrees to provide the Insured Person with the benefits described in the Master Policy, as outlined herein and coverage for which is certified hereunder by the Company. The Company makes this promise and agreement in consideration of the Assured's Application, the Insured Person's Application and payment of Premium, and subject to all of the Terms of the Master Policy and as contained therein, including any Riders. The Master Policy is effective as of January 1, 2012, and shall remain in effect until terminated in accordance with Section B(17), below. This Certificate shall be effective as of the Effective Date of Coverage shown on the Declaration, and shall remain in effect until terminated in accordance with Section B(18), below. This Certificate is not part of the insurance contract. The contract is the Master Policy, the Application, and any applicable Riders. This Certificate is merely a description of and evidence of the Insured Person's rights and benefits under the contract. The Declaration likewise is evidence of the coverage under the contract and a statement of the Effective Date of Coverage, subject always to the terms of coverage contained within the contract. The Company hereby recognizes International Medical Group®, Inc. as the Company's authorized agent and representative, and as the Plan Administrator of the Master Policy and this Certificate. Subject to the provisions of Section B(6), below, all communications, notices and payments to the Company that are required or permitted under the Master Policy and/or as described in this Certificate shall be transmitted through the Plan Administrator, and receipt of same by the Plan Administrator shall be considered receipt by the Company. THIS INSURANCE IS ISSUED PURSUANT TO APPLICABLE SURPLUS LINES LAW. PERSONS INSURED BY SURPLUS LINES CARRIERS DO NOT HAVE THE PROTECTION OF STATE INSURANCE GUARANTY LAWS TO THE EXTENT OF ANY RIGHT OF RECOVERY FOR THE OBLIGATION OF AN INSOLVENT UNLICENSED INSURER.

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

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

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

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

(b) prior to any Reinstatement under Section B(19), below; and

(c) on or before any renewal date as specified in Section B(23), below.

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

(3) PROOF OF CLAIM - When the Company receives notice of a claim for benefits under this insurance it will provide the Insured Person with forms ("Claim Forms") for filing Proof of Claim. The following items must be submitted to be considered a complete Proof of Claim eligible for consideration of coverage ("Proof of Claim"):

(a) a duly completed and signed Claim Form; and

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

(c) all original receipts for any expenses that have been incurred or paid by or on behalf of the Insured Person with respect to the claim.

The Insured Person shall have ninety (90) days from the date a claim is incurred to submit a complete Proof of Claim, and the Company may deny coverage for Proofs of Claim submitted thereafter or for incomplete Proofs of Claim.

(4) APPEALING A CLAIM - In the event the Company denies all or part of a claim, the Insured Person shall have ninety (90) days from the date that the notice of denial was mailed to the Insured Person's last known residence or mailing address to file a written appeal with the Company. Upon receipt of a written appeal, the Company will respond in writing as soon as reasonably practicable, and in any event within ninety (90) days from receipt thereof.

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

(6) SERVICE OF SUIT; VENUE; CHOICE OF LAW; TRIAL BY COURT - The contract of insurance represented by the Master Policy and evidenced by this Certificate shall be deemed issued, finalized and made in Indianapolis, Indiana, and sole and exclusive jurisdiction and venue for any court action or administrative proceeding relating to this insurance shall be in Marion County, Indiana, for which the Insured Person expressly consents. The subjects, risks and benefits of insurance covered by the Master Policy and evidenced by this Certificate are not intended or considered by the Insured Person or the Company (or the Plan Administrator) to be resident, located, or to be performed in any particular State of the United States. Indiana law shall govern all rights and claims raised under this Certificate of Insurance.

In the event of the failure of the Company to pay or reimburse any amount claimed to be due under this insurance, the Company, at the request of the Insured Person and upon receipt of lawful process or summons, will submit to the jurisdiction of a court of competent subject matter jurisdiction located in Marion County, Indiana, provided there exists an independent statutory and constitutional basis for *in personam* jurisdiction over the Company in said court and by said forum State. The Company consents to personal jurisdiction and venue in the Circuit and/or Superior Courts of Marion County, Indiana, and in the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful). All trials regarding any dispute under this insurance shall be exclusively presented to and determined solely by the court as the trier of fact, without a jury. In any suit instituted against the Company pursuant to the Terms of this Section B(6), the Company will abide by the final decision of such court or of any appellate court in the event of an appeal.

Nothing in this Section B(6) constitutes or should be understood to constitute a waiver of the Company's rights to: (i) oppose venue, procedural and/or substantive choice of law, personal jurisdiction, or subject matter jurisdiction in any forum other than the Circuit or Superior Courts of Marion County, Indiana, or the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful), (ii) commence an action in any court of competent jurisdiction in or outside of the United States, (iii) remove an action to a United States District Court, or (iv) seek transfer of a case to another court or forum as permitted by the laws of such forum or the laws of the United States or of any State in the United States, as applicable; all of which rights are expressly reserved and retained.

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

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

(7) MISREPRESENTATION - Any misstatement, omission, concealment or fraud, either in the Insured Person's Application which forms a part of the Master Policy and this Certificate, or in relation to any statement, certification or warranty made by the Insured Person or their representatives, agents or proxies, whether in writing or otherwise, to the Company or the Plan Administrator or their respective agents, employees or representatives, or in connection with the making of any claim under this insurance, shall render this Certificate null and void and all claims and benefits under this insurance shall be forfeited and waived.

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

(9) SUBROGATION CLAUSE - The Insured Person undertakes to pursue in his/her own name and stead, and to fully cooperate with the Company in the prosecution of, any and all valid claims that he/she may have against any third party who may be liable arising out of any act, omission or occurrence which results or may result in a loss payment or coverage of claim by the Company

under this insurance, and to account to the Company for any amounts recovered in connection therewith, on the basis that the Company shall be reimbursed and entitled to recover first in full for any sums paid by it before the Insured Person shares in any amount so recovered. Should the Insured Person fail to so cooperate, account, or to prosecute any valid claims against any such third party or parties, and the Company thereupon or otherwise becomes liable to make payment under the Terms of this insurance, then the Company shall be fully subrogated to all rights and interests of the Insured Person with respect thereto and may prosecute such claims in its own name as subrogee. The Insured Person's submission of Proof of Claim or acceptance of coverage or benefits under this insurance shall be deemed to constitute an assignment of such subrogation rights by the Insured Person to the Company. Any amount recovered by the Company shall first be used to pay the costs and expenses of collection incurred by the Company, including reasonable attorneys' fees, and for reimbursement to the Company for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts recovered shall be paid to the Insured Person or other persons lawfully entitled thereto, as applicable.

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

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

After the Review Period, the Insured Person may request cancellation of the Declaration and this Certificate by giving the Company not less than sixty (60) days advance written request. Cancellation is at the sole option of the Company, except as provided in Section B(23), below, and the Company may request and/or require the Insured Person to execute a release of claims as a condition to and/or in consideration of granting such cancellation. If the Company grants cancellation, coverage for the Insured Person under this insurance shall terminate with effect from the cancellation date specified by the Company. The Company shall calculate the amount of Premium earned upon the Declaration and Certificate through the requested date of cancellation (Short Rate Earned Premium) in accordance with the Short Rate Cancellation Table in effect as of the date of the request for cancellation. If the Insured Person has paid more than the Short Rate Earned Premium, the Company shall refund the difference between the amount actually paid and the Short Rate Earned Premium. If the Insured Person has paid less than the Short Rate Earned Premium, the Insured Person shall remit to the Company the difference between the Short Rate Earned Premium and the amount actually paid as a condition to cancellation as of such requested date, or the cancellation date will be established retroactive to the date through which and for which Premiums have actually been paid.

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

(13) COOPERATION - The Insured Person and his/her Physicians, Hospitals and other healthcare and medical service providers and suppliers shall undertake to cooperate fully with the Company and the Plan Administrator in reviewing, investigating, adjudicating and/or administering any claim for benefits under this insurance, including granting full right of access to all relevant or related medical documentation, medical histories, reports, lab or test results, x-rays, and other available evidence relating to or affecting the investigation, adjudication or administration of the claim. The Company may deny coverage for a claim when there has been a refusal or material failure to so cooperate.

(14) CLAIM SETTLEMENT - Eligible and covered claims under this insurance that have previously been paid by or on behalf of the Insured Person at the time of the Company's adjudication thereof will be reimbursed directly to the Insured Person, by check, at his/her last known residence or mailing address. While this insurance is in effect, the Insured Person shall undertake to promptly notify the Company of any change in such addresses subsequent to the Effective Date of Coverage. Eligible and covered claims that have not yet been paid by or on behalf of the Insured Person at the time of adjudication will be paid by check or wire transfer to the Insured Person at his/her last known residence or mailing address, or, at the sole option and discretion of the Company (but without obligation to do so), and as an accommodation to the Insured Person, directly to the provider(s). All claim settlements are subject to the applicable Deductible and Coinsurance, and to the benefit limits and sub-limits and all other Terms of this insurance. No provider or other third-party shall have any direct or indirect claim or right of action against the Company under this Certificate or the Master Policy, whether by purported assignment of benefits, subrogation of interests or otherwise, unless first expressly agreed and consented to in writing by the Company, and notwithstanding the Company's exercise or failure to exercise any option or discretion under this Section regarding the method of claim payment. No provider or other third-party is intended to have or shall have any rights as a third-party beneficiary under this Certificate or the Master Policy.

(15) FRAUDULENT CLAIMS - If any claim or request for benefits under this insurance shall be in any respect fraudulent or deceitful, or if the Insured Person or anyone acting for or on their behalf under this insurance uses any fraudulent or deceitful means or devices, all benefits and claims under this insurance shall be forfeited and waived, and the Company shall have no

liability for such benefits or claims.

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

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

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

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

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

(c) the date the Master Policy is terminated pursuant to Section B(17), above; or

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

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

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

(g) the cancellation date specified by the Company pursuant to Section B(11), above; or

(h) the cancellation date specified by the Insured Person pursuant to Section B(23), below; or

(i) the date specified by the Company in any notice of cancellation, forfeiture or rescission issued pursuant to or as a result of the circumstances described in Sections B(7) or (15), above, B(21), below, or as otherwise permitted by the Terms of this insurance.

Coverage for the Insured Person shall remain in full force and effect unless terminated pursuant to the provisions of this Section B(18), except as otherwise provided in the Master Policy or this Certificate.

(19) REINSTATEMENT OF COVERAGE FOR INSURED PERSONS - In the event coverage under this insurance lapses or is terminated in accordance with Sections B(2) and/or B(18)(a) for failure to pay Premium, the Insured Person may apply to the Company for reinstatement ("Reinstatement"). Reinstatement is at the sole option of the Company, and shall be subject to the Company's retained right, without obligation or liability of any kind, to reassess and make determination of acceptable risk in its sole and absolute discretion. In order to be considered for Reinstatement, the Insured Person must submit all of the following to the Company:

(a) a written request for Reinstatement; and

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

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

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

(e) payment of all Premium due.

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

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

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

(b) deny coverage and/or benefits for any charges which exceed the amount the Company would have covered had the Insured Person accepted and followed the recommendations of the Patient Advocacy program.

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

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

(b) the Insured Person or any member of the Insured Person's family, whether or not the family member is or was an insured person under this insurance plan, is repaid or is entitled to be repaid for all or part of the claim by Other Coverage or by or from a source other than the Company; or

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

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

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

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

the Company shall have the right to a refund of and to recover the amount of overpayment from the Insured Person and/or the Hospital, Physician, or other provider of services or supplies, as the case may be. For overpayment of claims under paragraphs (c) and (d), above, the amount of the refund and recovery shall be the difference between: (i) the amount actually paid by the Company; and (ii) the amount, if any, that should have been paid by the Company under the Terms of this insurance. For all other overpayments, the amount of the refund and recovery shall be the amount overpaid. If the Insured Person or the Hospital, Physician or other provider of services or supplies does not promptly make any such refund to the Company, the Company may, in addition to any other rights or remedies available to it (all of which are reserved): (i) reduce or deduct from the amount of any future claim that is otherwise eligible for coverage or payment under this insurance, to the full extent of the refund due to the Company; and/or (ii) cancel this Certificate and all further coverage of the Insured Person under the Master Policy by giving thirty (30) days advance written notice by mail to the Insured Person's last known residence or mailing address, and offset against the amount of any refund of Premium due the Insured Person to the full extent of the refund due to the Company.

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

(23) RENEWAL; AMENDMENTS - Subject to the Terms of Sections B(17), (18), and (19), above, coverage under this insurance plan may be renewed from year to year in accordance with and subject to the Terms of the plan then in effect (including the Terms

of the then applicable Master Policy) and so long as renewal Premium is paid when due and the Insured Person otherwise continues to meet the applicable eligibility requirements of the plan. The Company's commitment and the Insured Person's ability to renew is also subject to termination upon thirty (30) days written notice to the other party prior to the expiration date of the then existing Period of Insurance. The Company reserves the right in its sole discretion to make changes, additions and/or deletions to the Terms of the Master Policy, this Certificate, renewals or replacements of either, and/or to the Global MedEX Insurance plan (including the issuance of Riders to effectuate same) at any time or from time to time after the Effective Date of Coverage of this Certificate, upon no less than ninety (90) days prior written notice to the Assured and the Insured Person ("Notice of Amendment"). The Notice of Amendment shall include a complete description of the changes, additions and/or deletions to be made, the effective date thereof (the "Change Date"), and notice of the Insured Person's cancellation rights as set forth below, and shall be sent first class mail, postage pre-paid, to the last known residence or mailing address of the Insured Person. Upon issuance of the Notice of Amendment, the Assured and/or the Insured Person shall have the right to request cancellation of this Certificate pursuant to the provisions of Section B(11), above, at any time prior to the Change Date; provided, however that cancellation under this Section B(23) shall be at the option of the Insured Person, and coverage under this insurance shall terminate with effect from the cancellation date specified by the Insured Person (subject to the provisions of Sections B(18)(a)-(f), and (i)). If the Insured Person does not elect to cancel this Certificate in accordance with the foregoing, the changes, additions and/or deletions as made by the Company and specified in said Notice of Amendment shall take effect as of the Change Date specified in the Company's Notice, and this insurance shall thereafter continue in effect in accordance with its Terms, as so amended and modified.

(24) UNDERWRITING DECISIONS; EXPLANATION OR VERIFICATION OF BENEFITS - In the event of any verbal or telephone inquiry, every attempt will be made to help the Insured Person and his/her healthcare providers understand the status, scope and extent of available benefits and coverages under this insurance; provided, however, that no statement made by any agent, employee or representative of the Company or the Plan Administrator will be deemed or construed as an estoppel or to create any liability against the Company or the Plan Administrator or be deemed or construed to bind the Company or to modify, replace, waive, extend or amend any of the Terms of the Master Policy or this Certificate, unless expressly set forth in writing. Actual eligibility and/or acceptance determinations, final coverage decisions, and benefit or claim payments can be determined and adjudicated only at the time a proper and complete Application and/or Proof of Claim is submitted (as the case may be), an opportunity for reasonable investigation and/or review is provided, cooperation required hereunder received, and all facts and supporting information, including relevant medical records, are presented in writing. The Terms of the Master Policy govern all available coverages and payments made or to be made. If a definite answer to a specific benefits or coverage question is required for any reason, the Insured Person or his/her provider may submit a written request to the Company, including all pertinent medical information and a statement from the attending Physician (if applicable), and a written reply will be sent by the Company and kept on file. If the Company elects to verify generally and/or preliminarily to a provider or the Insured Person that an Injury, Illness, diagnosis or proposed Treatment is or may be covered under this insurance, or that benefits for same are or may be available as outlined in this Certificate, any such verification of benefits does not guaranty either payment of benefits or the amount or eligibility of benefits. Final eligibility determinations, coverage decisions and actual reimbursement or payment of claims or benefits are subject to all Terms of this insurance, including without limitation filing a proper and complete Proof of Claim under Section B(3) and cooperation under Section B(13).

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

Benefit/Other	**Limit/Sub-limit**
Area of Coverage	Area 1: Europe Only Area 2: Worldwide Excluding US, Canada, China, Hong Kong, Japan, Macau, Singapore and Taiwan Area 3: Worldwide Refer to Declaration of Insurance for applicable Area.
Deductible	$100, $250, $500, $1,000 per Insured Person per Period of Insurance, as indicated on the Declaration. The Deductible will be reduced by 50% for Eligible Medical Expenses incurred within the US Preferred Provider Network. An additional Deductible of $250 per Hospital admission (Extra Deductible) will be applied for each admission to a U.S. Hospital that is not within the Preferred Provider Network (see Section F, below).
Family Deductible Limit	3 Deductibles per Family per Period of Insurance
Maximum Limit	$5,000,000 lifetime maximum benefit
Mental or Nervous Disorders	$10,000 lifetime maximum (after 12 months of continuous coverage) Sub-limit: $5,000 per Period of Insurance

Maternity and Newborn Care	Benefits available after ten (10) months of continuous coverage Sub-limits: $3,500 per Pregnancy; provided, however, that a delivery by C-Section will be allowed an additional $2,500 sub-limit
Pre-Existing Conditions	$50,000 lifetime maximum (after 24 months of continuous coverage) Sub-limit: $5,000 per Period of Insurance
Local Ambulance Expense	Limited to $5000 per occurrence maximum. Subject to Deductible.
Hospital Room & Board	The average semi-private room rate, including nursing service
Hospital Cash Benefit	$100 per night payable where no charge is made by the hospital. Limited to 30 nights. (See Section K, below)
Parent Accommodation	Hospital accommodation costs for a parent or legal guardian for Insured Person under the age of 18 who is hospitalized as an inpatient.
Intensive Care Unit	Full Refund
Physical Therapy	$50 maximum allowable charge per visit, limited to one visit per day
Eligible Medical Expenses	Full Refund
Emergency Dental	$1000 maximum when due to a covered accident.
Emergency Medical Evacuation	Up to $50,000 Maximum Limit. Must be approved in advance and coordinated by the Company. (See Section M, below)
Return or Disposal of Mortal Remains	$25,000 per Insured Person for return of the Insured Person's Mortal Remains or ashes to their Home Country or for local burial or cremation. Must be approved in advance and coordinated by the Company. (See Section O, below)
Emergency Reunion	Limited to a $10,000 lifetime maximum. Must be approved in advance and coordinated by the Company. (See Section N, below)
Compassionate Emergency Home Visit	Up to $3000 per Period of Insurance (limited to 1 trip per Period of Insurance). Must be approved in advance and coordinated by the Company. (See Section P, below)
Pre-certification	
Transplants	No coverage if Pre-certification provisions are not met. (See Section J, below)
All Other	50% reduction of Eligible Medical Expenses if Pre-certification provisions are not met. (See Section E, below)
Wellness	$250 per Period of Insurance (after 24 months of continuous coverage) for Females over the age of 35 and Males over the age of 40. Not Subject to Deductible or Coinsurance. (See Section I, below)
Transplant Expense	$250,000 lifetime maximum for eligible Covered Transplants, subject to special Transplant Pre-certification provisions, and only when Treatment is provided within the Company's approved independent Managed Transplant System Network. Covered Transplants are: heart, heart/lung, lung, kidney, kidney/pancreas, liver and stem cell. (See Section J, below)
Second Surgical Opinion	50% reduction of Eligible Medical Expenses for failure to obtain a Second Surgical Opinion when required by the Company.

Area 1 & 2 Treatment outside of Area of Coverage	Limited to 30 days per Insured Person per Period of Insurance for Accident or Emergency Treatment only. Treatment in the US must be received from a Preferred Provider Organization.

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

D. ELIGIBILITY - If an Insured Person is not eligible, this policy is void *ab initio* and all premium paid will be refunded.

(1) Except as otherwise expressly provided below with respect to Newborns, in order to be eligible and qualified for coverage under this insurance, a person must:

(a) complete and sign an Application (or be listed thereon by proxy as an applicant and proposed Insured Person) with all questions answered truthfully and completely; and

(b) pay the required Premium on or before the Due Dates; and

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

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

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

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

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

(2) The Newborn Children of an Insured Person may be eligible for independent coverage under the Protexplan - Gold Insurance plan, and special eligibility requirements may apply. Any such coverage for a Newborn, if effected, will be evidenced by a separate insurance Certificate issued in the name of the Newborn ("Newborn's Certificate"), and will be subject to the Terms of the Master Policy in effect as of the date of issuance. Except for charges incurred for the pre- or post-natal care of a Newborn which may be covered under the Maternity and Newborn Care benefits available to the Insured Person-mother of the Newborn (as provided in Section C, Schedule of Benefits/Limits, above, and subject to the conditions, limits and sub-limits set forth therein), a Newborn shall have no independent coverage or rights under the mother's Certificate, or under the Master Policy, until such time as the Newborn qualifies for and obtains his/her own Newborn's Certificate.

In order for a Newborn to be eligible and qualified (under special eligibility requirements) for independent coverage under the Master Policy and the Protexplan -Gold:

(a) the Company must receive a separate Application for the Newborn (similar to the Application as defined herein) within thirty-one (31) days of the date of birth of the Newborn ("Newborn's Application"); and

(b) the Insured Person-mother of the Newborn must be covered by the Master Policy, and her Certificate must be currently in effect, as of the date of birth of the Newborn; and

(c) the delivery of the Newborn must be eligible for coverage and in fact covered under the Terms of the Master Policy and the mother's Certificate; and

(d) the Newborn must meet each of the eligibility requirements contained in sub-sections D(1)(a), (b), (c) and (g), above, and such other conditions and requirements as may be contained in the Master Policy in effect at the time of the Newborn's Application.

In the event that all of the conditions and requirements for special eligibility of a Newborn as set forth in subparagraphs D(2)(a) through (d) above are fully met, and in the event the Company agrees to accept the Newborn's Application and issue the Newborn a separate Certificate in its own name, the Company will also agree at the time of issuance of the Newborn's Certificate to waive the Pre-existing Condition exclusion under the Newborn's Certificate. However, if any of the conditions or requirements for special eligibility as set forth in subparagraphs D(2)(a) through (d) above are not met in full, the Newborn shall not be entitled to the special eligibility provisions or such waiver. Rather, each and all of the eligibility requirements set forth in subsections D(1)(a) through (g) shall apply, and the Company will not agree to waive the Pre-existing Condition exclusion under any new separate Certificate issued to the Newborn.

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

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

(a) Inpatient Treatment of any kind; and

(b) any Surgery or Surgical procedure; and

(c) care in an Extended Care Facility; and

(d) Home Nursing Care generally; and

(e) Durable Medical Equipment; and

(f) artificial limbs; and

(g) all Covered Transplant Treatment.

(2) GENERAL REQUIREMENTS - To comply with the Pre-certification requirements of this insurance for the Treatment and services listed in Section E(1), above, the Insured Person or his/her Physician must:

(a) contact the Company through the Plan Administrator at the telephone numbers printed on the ID card, as follows:

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

(i) **As soon as possible before the Treatment is to be obtained; and**

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

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

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

(3) LOSS OF COVERAGE/BENEFITS FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS - If the Insured Person or his/her healthcare providers do not comply with the Pre-certification requirements:

(a) for the Treatment or supplies identified in subparagraph E(1)(a) through (f), above, or if such Treatment or supplies are not Pre-certified, Eligible Medical Expenses incurred with respect to said Treatment and/or supplies will be reduced by fifty percent (50%); and

(b) for the Treatment or supplies identified in subparagraph E(1)(g), above, or if such Treatment and/or supplies are not Pre-certified, all Covered Transplant benefits shall be forfeited and waived.

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

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

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

F. UNITED STATES PREFERRED PROVIDER ORGANIZATION (PPO)

Special Benefit. If Treatment or supplies eligible for coverage under this insurance are received directly from the Company's approved list of independent PPO providers while the Insured Person is in the United States: (1) the Company will reduce by fifty percent (50%) any part of the Deductible applicable to such claims, and (2) the Company will waive any and all Coinsurance applicable to such claims. However, all claims for Treatment or supplies received in the United States from a non-PPO provider will remain subject to the applicable Deductible, Extra Deductible, and Coinsurance, whether or not the Insured Person may be eligible for the foregoing special benefit relating to Treatment or supplies received from PPO providers.

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

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

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

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

(2) The Physician providing the second opinion must:

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

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

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

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

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

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

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

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

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

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

H. ELIGIBLE MEDICAL EXPENSES - Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the Schedule of Benefits/Limits, and the exclusions set forth in Section K, below, the Company will reimburse the Insured Person for the following costs, charges and expenses incurred by the Insured Person with respect to an Illness or Injury suffered or sustained by the Insured Person while this Certificate is in effect, so long as the costs, charges or expenses are Usual, Reasonable and Customary ("Eligible Medical Expenses"):

(1) Charges incurred at a Hospital for: (whether Inpatient or Day Patient – except items (e) and (g).)

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

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

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

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

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

(f) Emergency Treatment of an Illness; however charges for use of the Emergency room itself will not be covered unless the Insured Person is directly admitted to the Hospital as Inpatient for further Treatment of that Illness; and

(g) hospital accommodation costs for a parent or legal guardian staying with an Insured Person under the age of 18 who is admitted as an Inpatient.

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

(3) Charges by a Physician for professional services rendered, including Surgery; provided, however, that charges by or for an assistant surgeon will be limited and covered at the rate of twenty percent (20%) of the Usual, Reasonable and Customary charge

of the primary surgeon; and provided, further, that standby availability of a Physician or surgeon will not be deemed to be a professional service and is not eligible for coverage; and

(4) Charges incurred for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(s) the following Charges made by a Hospice:

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

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

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

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

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

I. WELLNESS EXPENSES - Provided the Insured Person has been continuously insured under this insurance plan for not less than 24 months and subject to the Terms of this insurance, the Company will reimburse the Insured Person for the following expenses incurred while this Certificate is in effect:

(1) for Males over the age of forty (40): one Routine Physical Exam, limited to $250 per Period of Insurance, provided at least twelve (12) months have elapsed since the Insured Person's most recent Routine Physical Exam; and

(2) for Females over the age of thirty-five (35): one Routine Physical Exam, limited to $250 per Period of Insurance, including expenses for mammography exams and pap smears, provided at least twelve (12) months have elapsed since the Insured Person's most recent Routine Physical Exam; and

J. TRANSPLANT EXPENSES - Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the Schedule of Benefits/Limits set forth in Section C, above, the Pre-certification and mandatory second opinion provisions set forth in Sections E and G, above, and the Exclusions set forth in Section K, below, the Company will reimburse the Insured Person for the following costs, charges and expenses incurred by the Insured Person with respect to a Covered Transplant obtained or received by the Insured Person while this Certificate is in effect, so long as such costs, charges or expenses are Usual, Reasonable, and Customary:

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

(2) organ procurement and harvesting costs, excluding acquisition or purchase of the actual organ or tissue, up to a lifetime maximum of $10,000; and

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

(4) reasonable travel and lodging expenses of the Insured Person if travel of more than fifty (50) miles is necessary to receive the Covered Transplant Treatment and supplies from a Managed Transplant System Network Provider, up to a lifetime maximum of $5,000.

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

K. HOSPITAL CASH BENEFIT - When you receive treatment for an eligible medical condition as an Inpatient and no costs are incurred for accommodation and treatment, you will be eligible to receive $100 per night as an Inpatient up to a maximum of 30 nights.

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

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

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

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

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

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

(e) Terrorism.

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

(2) Pre-existing Conditions - (i) For medical conditions existing at the time of Application which are fully disclosed on the Application and are not excluded or restricted through a Rider attached to this Certificate and for medical conditions which existed but that were unknown at the time of Application, charges resulting directly or indirectly from or relating to any such Pre-existing Condition are excluded from coverage under this insurance until the Insured Person has maintained coverage under this insurance plan continuously for at least twenty-four (24) months, and thereafter such Charges are limited in coverage as provided in Section C, Schedule of Benefits/Limits, above; and (ii) Any expenses incurred, obtained, or received by an Insured Person for any Non-Disclosed conditions will be excluded under this insurance; and

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

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

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

(6) Wellness - Charges for Routine Physical Exams are excluded from coverage under this insurance until the Insured Person has maintained coverage under this insurance plan continuously for at least twenty-four (24) months, and except as otherwise expressly provided in Section I, above. In no event will the Company reimburse the Insured Person for more than one Routine Physical Exam during any twelve (12) month period; and

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

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

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

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

(d) not Medically Necessary; and/or

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

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

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

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

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

(j) not expressly included as Eligible Medical Expenses as defined in Section H, above; and/or

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

(l) required or recommended as a result of complications or consequences arising from or related to any Treatment, Illness, Injury,

or supply excluded from coverage or which is otherwise not covered under this insurance; and

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

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

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

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

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

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

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

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

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

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

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

(d any Injury or Illness sustained while taking part in: Amateur Athletics, Professional Athletics and adventure sports and activities, including, without limitation the following (including any combination or derivative of the following) abseiling, mountaineering activities where specialized climbing equipment, ropes or guides are normally or reasonably should have been used, , aviation (except when traveling solely as a passenger in a commercial aircraft), kiteboarding, hang gliding and parachuting, bicycle motorcross or BMX, BASE jumping, bobsledding, bungee jumping, canyoning, caving, high diving, heli-skiing, hot air ballooning, inline skating, jet skiing, jungle zip lining, kayaking, luge, mountain biking, paragliding, parascending, rappelling, rock climbing, rodeo, racing of any kind including by horse, motor vehicle (of any type) or motorcycle, snow skiing except for recreational downhill and/or cross country snow skiing (no cover provided whilst skiing in violation of applicable laws, rules or regulations; away from prepared and marked in-bound territories; and/or against the advice of the local ski school or local authoritative body), snowboarding, snowmobiling, ski jumping, sky diving, spelunking, surfing, trekking, windsurfing, wildlife safaris, whitewater rafting and subaqua pursuits involving underwater breathing apparatus (except as otherwise expressly set forth in Section R. Recreational Underwater Activities). Practice or training in preparation for any excluded activity which results in injury will be considered as activity while taking part in such activity; and/or

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

(f) any Illness or Injury sustained while participating in any activity where such activity is undertaken against medical advice; and/or

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

(h) any Injury or Illness sustained while operating a moving vehicle after consumption of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician. For purposes of this exclusion, “vehicle” shall include both motorized devices for which a driver or operator license is required (including watercraft and aircraft) and non-motorized bicycles and scooters for which no permit or license is required; and/or

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

(j) any venereal disease; and/or

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

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

(m) any Substance Abuse; and/or

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

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

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

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

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

(r) any sleep disorder; and/or

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

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

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

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

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

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

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

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

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

(15) Charges incurred for Dental Treatment, except for Emergency Dental Treatment necessary to repair or replace sound natural teeth lost or damaged in an Accident covered hereunder; and

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

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

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

(19) Charges incurred by the Insured Person for the Treatment of his/her Newborns (or for supplies related thereto) after the first thirty-one (31) days of birth, except as otherwise expressly provided for in this insurance; and

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

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

this insurance; and

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

(a) arising out of or as a result of any Treatment or supplies received by the Insured Person, or
(b) based upon the Company's election hereunder, if any, to pay benefits directly to providers, or
(c) for any other reason; and

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

M. EMERGENCY MEDICAL EVACUATION BENEFIT - Subject to the applicable Maximum Limit set forth in the Schedule of Benefits/Limits set forth in Section C, above, and the other Terms of this insurance, including the Exclusions set forth in Section L and the Conditions and Restrictions set forth below, the Company will reimburse the Insured Person for the following transportation costs, when the Company or Plan Administrator arranges such transportation, and expenses incurred by the Insured Person arising out of or in connection with an Emergency Medical Evacuation occurring while this Certificate is in effect:

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

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

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

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

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

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

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

(e) Emergency Medical Evacuation is approved in advance and all arrangements are coordinated by the Company; and

(f) the condition, Illness, Injury or occurrence giving rise to the Emergency Medical Evacuation occurred suddenly and/or spontaneously, and without: (i) advance warning, (ii) advance Treatment, diagnosis or recommendation for Treatment by a Physician, or (iii) prior manifestation of symptoms or conditions which would have caused a prudent person to seek medical attention prior to the onset of the Emergency.

The Company will cover reimbursement for the above-described costs and expenses and will arrange Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary Treatment to prevent the Insured Person's loss of life or limb. The Company will use its best efforts to arrange with independent, third-party contractors any Emergency Medical Evacuation within the least amount of time reasonably possible. The Insured Person understands, acknowledges and agrees that the timeliness, duration, occurrences during, and outcome of an Emergency Medical Evacuation can be directly and indirectly affected by events and/or circumstances which are not within the supervision or control of the Company, including but not limited to: the availability, limitations, physical condition, reliability, maintenance and training schedules and procedures, and performance or non-performance of competent transportation equipment, supplies and/or staff of such third-party contractors; delays or restrictions on flights or other modes or means of transportation caused by mechanical problems, government officials, telecommunications problems, non-availability of routes, and/or other travel, geographical or weather conditions; and other acts of God and unforeseeable and/or uncontrollable occurrences The Insured Person agrees to release and to hold the Company, the Plan Administrator and their agents and representatives harmless from, and agrees that the Company, the Plan Administrator and their agents and representatives shall not be held liable or responsible for, any delays, losses, damages, further injuries or illnesses, or any other claims that arise from or are caused in whole or in part by the acts or omissions of such independent third-party contractors or their agents, employees or representatives, or that arise from or are caused in whole or in part by any acts, omissions, events or circumstances that are not within the direct and immediate supervision and control of the Company, the Plan Administrator and/or their authorized agents and representatives, including without limitation the events and circumstances set forth above. The Insured Person further agrees that upon seeking an Emergency Medical Evacuation, he or she will cooperate fully as required by Section (B)(13). Failure to so cooperate and/or failure to use or accept Emergency Medical Evacuation once it has been arranged by the Company or Plan Administrator will require the Insured Person to reimburse the Company for costs incurred for any Emergency Medical Evacuation that was arranged, but not used, by the Insured Person. Furthermore, the Insured Person may be required to arrange for payment of any subsequent

Emergency Medical Evacuation and seek reimbursement thereafter for eligible costs associated with that subsequent Emergency Medical Evacuation.

N. EMERGENCY REUNION - - Subject to the Terms of this insurance, Emergency Reunion expenses will be reimbursed to the Insured Person as outlined in the Schedule of Benefits/Limits in cases where there has been an Emergency Medical Evacuation covered under the Terms of this insurance. Subject to the Deductible and Coinsurance and other limits as specified in the Schedule of Benefits/Limits, and subject to the Conditions and Restrictions set forth below, the following expenses incurred in respect of travel by a Relative or friend of the Insured Person, will be reimbursable to the Insured Person upon the recommendation and prior approval of the Company:

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

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

Conditions and Restrictions:

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

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

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

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

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

O. RETURN OR DISPOSAL OF MORTAL REMAINS - In the event of the death of the Insured Person as a result of an Illness or Injury covered under this insurance while the Insured Person is outside of his/her Home Country, the Company will reimburse the estate of the Insured Person up to US $25,000 for the costs and expense incurred to return the Insured Person's Mortal Remains to his/her Home Country (but not including any costs of burial or other disposition); or the local burial or cremation of the Insured Person's Mortal Remains, provided, however, that the Company must coordinate and approve all costs and expenses related to the return of the Insured Person's Mortal Remains in advance as a condition of this benefit.

P. COMPASSIONATE EMERGENCY HOME VISIT – Subject to the Terms of this insurance and the limits specified in the Schedule of Benefits/Limits, costs incurred by an insured person for an economy class return airfare to travel to and from an insured person's home country in the event of an accident or sudden and unexpected, injury, illness, sickness or disease of a Close Family Member aged 75 years or younger, resulting in that Close Family Member being in Critical Care, or the death of a Close Family Member. Travel for home visit must commence within 15 days of the qualifying event for coverage. Travel must be approved in advance by the Company.

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

(1) Schedule and Limits of Complementary Medicine Benefit

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

Vitamin Therapy	Up to $100 per Period of Insurance per Insured Person.
Chiropractic Therapy	Up to $150 per Period of Insurance per Insured Person.

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

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

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

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

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

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

Special Exclusions and Limitations:

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

1. Diving by the Insured Person without holding a recognized certificate issued by an Authoritative Diving Body for the type of diving being undertaken, or not under professional instruction;
2. Diving without proper and well-maintained equipment in good working order and/or contrary to the guidelines, codes of good practice and/or recommendations as laid down by the Authoritative Diving Body under which the Insured Person has been certified;
3. Diving to depths greater than thirty (30) meters, or diving requiring decompression stops;
4. Solo diving;
5. Any form of cave diving;
6. Flying within twenty-four (24) hours of the last dive or diving within ten (10) hours of flying;
7. Diving for hire, reward, or treasure;
8. Diving while suffering from a cold, influenza or any other condition, Illness or Injury causing an obstruction of the sinuses or ears, or diving while otherwise medically unfit to dive;
9. Diving by an Insured Person under twelve (12) years of age or over sixty-five (65) years of age;
10. Willfully self-inflicted Injury or Illness, the effects of alcohol or drugs (other than as prescribed by a licensed Physician in full awareness of the Insured Person's sub-aqua activities) and any self exposure to needless peril (unless in an attempt to save human life);
11. Any condition for which the Insured Person was undergoing, recovering from or awaiting Treatment immediately prior to the sub-aqua activities;
12. Diving with artificial or other underwater breathing apparatus containing any gas other than compressed air.

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

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

Accident: A sudden, unintentional, and unexpected occurrence caused by external, visible means and resulting in physical Injury to the Insured Person.

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

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

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

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

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

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

Certificate: This document as issued to the Insured Person, which describes and provides an outline and evidence of eligible coverages and benefits payable to or for the benefit of the Insured Person under the Master Policy, and which includes the Insured Person's Application and any Riders.

Child; Children: An Insured Person who is less than eighteen (18) years of age.

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

Congenital disorder: Physical abnormality that is present at birth.

Close Family Member: A spouse, son, daughter, parent, step-parent, parent-in-law, grandparent, grandchild, brother, sister, son-in-law, daughter-in-law, or guardian.

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

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

Critical Care: The medical condition of the individual is unstable and serious where the outcome of the injury, illness, sickness or disease cannot be medically predicted, prognosis is uncertain and the individual is in danger of dying.

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

Day Patient: A person who is admitted to a hospital bed but does not stay overnight.

Declaration: The Declaration of Insurance issued by the Company to the Insured Person contemporaneously with this Certificate (and/or upon renewal or Reinstatement hereof) evidencing the Insured Person's insurance coverage under the Master Policy as evidenced by this Certificate, which Declaration shall be incorporated in and become a part of this Certificate.

Deductible: The dollar amount of Eligible Medical Expenses, specified in the Declaration, that the Insured Person must pay per Period of Insurance prior to receiving benefits under this insurance, and exclusive of Coinsurance.

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

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

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

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

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

Eligible Medical Expenses: As defined in Section H, above.

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

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

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

EST: U.S. Eastern Standard Time.

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

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

Family: An Insured Person and his/her spouse who is covered as an insured person under this insurance plan and his/her natural Child or Children who are under the age of eighteen (18) and covered as insured persons under this insurance plan.

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

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

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

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

Home Nursing Care: Services, 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 in lieu of Medically Necessary Inpatient care.

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

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

home, a place for the aged, drug addicts, alcoholics or runaways; or similar establishment.

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

Illness: A sickness, disorder, illness, pathology, abnormality, ailment, disease or any other medical, physical or health condition. Illness does not include learning disabilities, or attitudinal or disciplinary problems.

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

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

Injury: Bodily injury resulting from an Accident.

Inpatient: A person who is an overnight resident patient of a Hospital, using and being charged for room and board.

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

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

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

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

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

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

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

Mental or Nervous Disorders: A mental, nervous, or emotional Illness which generally denotes an Illness of the brain with predominant behavioral symptoms; or an Illness of the mind or personality, evidenced by abnormal behavior; or an Illness or disorder of conduct evidenced by socially deviant behavior. Mental or Nervous Disorders include without limitation: psychosis; depression; schizophrenia; bipolar affective disorder; and those psychiatric Illnesses listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association. Mental or Nervous Disorder does not include learning disabilities, or attitudinal or disciplinary problems. For purposes of this insurance, Mental or Nervous Disorder does not include Substance Abuse.

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

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

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

Other Coverage: As defined in Section B(10), above.

Outpatient: A person who receives Medically Necessary Treatment by a Physician or other healthcare provider that does not require an overnight stay in a Hospital.

Period of Insurance: The period beginning on the Effective Date of Coverage of this Certificate and ending on the earliest of the following dates: (a) the termination date specified in the Declaration, or (b) the termination date as determined in accordance with

Section B(18), above. The Period of Insurance can be no more than twelve (12) consecutive months.

Physician: A duly licensed practitioner of the medical arts. A Physician must be currently licensed by the state or country in which the services are provided, and the services must be within the scope of that license.

Plan Administrator: International Medical Group®, Inc., 2960 N. Meridian Street, Indianapolis, Indiana, 46208, Telephone Number 317/655-4500, or 1-800-628-4664, Fax Number 317/655-4505, Website: http://www.imglobal.com, Email: info@imglobal.com and IMG Europe Limited, 36-38 Church Road, Burgess Hill, West Sussex, RH15 9AE, United Kingdom. As the Plan Administrator, International Medical Group, Inc., acts solely as the disclosed and authorized agent and representative for and on behalf of the Company, and has and shall have no direct, indirect, joint, several, separate, individual, or independent liability or obligation of any kind under the Master Policy or this Certificate to the Insured Person or to any other person or entity.
Pre-certification; Pre-certify: A general determination of Medical Necessity, only, made in reliance and based upon the completeness and accuracy of the information provided at the time thereof. Pre-certification is not an assurance, authorization, or verification of coverage, a verification of benefits, or a guarantee of payment. See Section E, above, for further details.

Pre-existing Condition: Any Illness, Injury or Mental or Nervous Disorder that, with reasonable medical certainty, existed on or at any time prior to the Initial Effective Date of this insurance, whether or not previously manifested or symptomatic, diagnosed, treated or disclosed on the Application or on any Claim Form or otherwise, including any chronic, subsequent or recurring complications or consequences associated therewith or arising or resulting therefrom.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Specialist referral services which typically involves of a specialist assisting a general practitioner in rendering a diagnosis

to guide Treatment.

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

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

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

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

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

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