

Reside[®] Prime Worldwide Medical Plan Certificate of Insurance

Underwritten by:
Certain Underwriters at Lloyd's, London

INSURING CLAUSE

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

SECTION 1: CERTIFICATE DEFINITIONS

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

The term "**Administrator**" shall mean Specialty Risk International, Inc. or SRI Administrators, Inc. the organization contracted with the Company to provide underwriting, administrative and claims payment services under this Certificate.

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or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

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

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

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

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

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

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

The term "**Chiropractic**" shall mean services as provided by a licensed Chiropractor for manipulation or manual modalities in treatment of the spinal column, neck, extremities or other joints other than for treatment of a fracture or surgery.

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

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

The term "**Common Carrier**" shall mean any public air conveyance operating under a valid license providing for the transportation of passengers for hire.

The term "**Company**" shall mean Certain Underwriters at Lloyds, London, the organization providing the Coverage under this Certificate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The term "**Educational or Rehabilitative Care**" shall mean the care for restoration (by education or training) of one's ability to function in a normal or near normal manner following an Illness or Injury. This type of care includes, but is not limited to, physical therapy or occupational therapy.

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

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

The term "**Emergency**" shall mean a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger, if medical attention is not provided within 24 hours.

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

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

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

1. the Treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. the Treatment, drug, device, procedure, supply or service is not yet fully approved or recognized by a pertinent governmental agency or professional organization such as the National Cancer Institute or Food & Drug Administration.
3. the results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals to be of greater safety and efficacy than conventional Treatment, in both the short and long term.

4. the Treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state or Country where the Insured Person resides or as generally accepted throughout the relevant medical community by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.
5. the Treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or the like in any consent, release, or authorization which the Insured Person or someone acting on their behalf may be required to sign.

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

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

The term "**Home Country**" shall mean the country where an Insured Person has his or her true, fixed and permanent residence.

The term "**Home Health Care Agency**" shall mean a public or private agency or one of its subdivisions, which operates pursuant to law; and is regularly engaged in providing Home Nursing Care under the supervision of a Registered Nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice.

The term "**Home Health Care**" shall mean services provided by a Home Health Care Agency and supervised by a Registered Nurse, which are directed toward the personal care of a patient; provided always that such care is provided in lieu of Medically Necessary Inpatient care in a Hospital.

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

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

Hospital does not mean:

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

The term "**Ill or Illness**" shall mean Sickness or Disease of any kind listed in the most recent edition of the International Classification of Diseases ICD-9-CM, which is the required reporting tool for all diagnoses and diseases to all U.S. Public Health Service and Health Care Financing Administration programs.

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

The term "**Injury**" shall mean bodily Injury listed in the most recent edition of the International Classification of Diseases ICD-9-CM, which is the required reporting tool for all diagnoses and diseases to all U.S. Public Health Service and Health Care Financing Administration programs and caused solely and directly by Accidental, external, and visible means occurring while this Certificate is in force and resulting directly and independently of all other causes resulting in a Covered Event under this Certificate.

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

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

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

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

The term "**Loss**" shall mean, in reference to quadriplegia, paraplegia, hemiplegia and uniplegia, shall mean the complete and irreversible paralysis of such limbs and with regard to hands and feet, actual severance through or above the wrist or ankle joints, and with regard to eyes, entire irrecoverable loss of sight.

The term "**Manifestation**" shall mean the demonstration of the presence of a sign, symptom, or alteration, especially one that is associated with a disease process.

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

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

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

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

The term "**Mental Illness**" shall mean Mental, emotional, and psychiatric disorders, Illnesses or conditions (whether organic or non-organic, whether biological, non-biological, genetic, chemical or non-chemical in origin). Mental and nervous disorders include, but are not limited to psychoses; neurotic disorders; bipolar disorders; affective disorders; personality disorders; psychological or behavioral abnormalities, associated with transient or permanent dysfunction of the brain or related neurohormonal systems; and disorders, conditions, and Illnesses listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders IV-R or the most recent edition of the International Classification of Diseases ICD-9-CM, which is the required reporting tool for all diagnoses and diseases to all U.S. Public Health Service and Health Care Financing Administration programs on the date the medical care or Treatment is rendered to an Insured Person.

The term "**Newborn**" shall mean a Child from the moment of birth through the first 31 days of life.

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

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

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

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

The term "**Physiotherapy**" shall mean physical therapy, recommended by a Physician for the treatment of a specific Covered Event and administered by a licensed physical therapist.

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

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

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

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

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

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

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

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

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

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

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

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

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

The term “**Rescind**” or “**Rescinding of a Certificate**” or “**Void**” shall mean termination of the Certificate retroactive to the original Individual Effective Date of Coverage as the result of inaccurate information provided on the Application or accompanying health statements, which will constitute the return of Premium to the payor.

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

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

The term “**Sickness**” shall mean Illness or Disease of any kind listed in the most recent edition of the International Classification of Diseases ICD-9-CM, which is the required reporting tool for all diagnoses and diseases to all U.S. Public Health Service and Health Care Financing Administration programs.

The term “**Surgery or Surgical Procedure**” shall mean an invasive diagnostic procedure; or the Treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

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

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

The term “**United States**” or “**U.S.**” shall mean the 50 United States of America and the District of Columbia.

SECTION 2: SCHEDULE OF BENEFITS

A. Deductible and Coinsurance

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

Medical Benefits Deductible for each

Period of Coverage:	Per Insured Person:	Amount stated on the ID Card
	Per Insured Family Unit:	3x per person (or max. 3 per family)

Eligible Benefit Percentage Payable after Deductible has been satisfied:

Eligible Benefits Incurred Outside the United States: The Company pays 100% of Eligible Benefits up to the Medical Maximum. All Hospital admissions must be Pre-Notified through the Pre-Notification Program.

Eligible Benefits Incurred Inside the United States: The Company pays 80% of the next \$5,000 of Eligible Benefits and then 100% up to the Medical Maximum. All Hospital admissions and expenses above \$1,000 must be Pre-Notified and Approved PPO facilities must be utilized through the Pre-Notification Program. Each Insured Person is responsible for the Coinsurance amount.

If the Insured Person follows Pre-Notification Program the maximum out of pocket expenses that an Insured Person in the United States will be required to pay after satisfying their Individual Deductible is \$1,000. The maximum out of pocket expenses that a family unit in the United States will be required to pay after satisfying their Family Deductible is \$3,000.

B. Eligible Benefits and Maximum Limits

Subject to the Deductible and Coinsurance as described in SECTION 2, A, the Eligible Benefits and Maximum Limits for Benefits I through III shall be as follows:

I.	Lifetime Maximum Benefit	\$5,000,000 Lifetime each Insured Person
II.	Pregnancy Benefit	\$7,500 per Pregnancy 12 month waiting period
III.	Well-Child Care Benefit	\$200 maximum per Coverage Period after a 12 month waiting period.

Subject to the Deductible and Coinsurance as described within Benefits IV through VII, the Eligible Benefits and Maximum Limits for Benefits IV through VII shall be as follows:

IV.	Mental and Nervous Benefit	\$10,000 Coverage Period maximum after a 12 month waiting period. Inpatient limited to a maximum of 45 days per coverage period. Outpatient Benefit limited to a maximum of 40 visits per Coverage Period at 70% (separate from overall coinsurance) of Eligible Benefits. Lifetime Maximum of \$30,000.
V.	Chiropractic / Physiotherapy Benefit	\$10,000 Lifetime benefit combined, limited to 12 visits per Coverage Period and \$75 per visit.

There is a 12 month waiting period for these benefits.

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| VI. | Dental Benefit (due to Accident only) | \$500.00 per Coverage Period subject to a \$50.00 per occurrence Deductible. |
| VII. | Transplant Benefit | \$1,000,000 Lifetime Maximum. To cover Bone Marrow, Liver, Heart, Pancreas, Heart/Lung, Kidney/Pancreas, Lung |

Benefits VIII through XII are **not** subject to a Deductible or Coinsurance, the Eligible Benefits and Maximum Limits for Benefits VIII through XII shall be as follows:

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| VIII. | Preventive Benefits | \$175 per Coverage Period Maximum after a 12 month waiting period |
| IX. | Emergency Medical Evacuation Benefit | \$50,000 per Coverage Period |
| X. | Return of Mortal Remains Benefit | \$20,000 |
| XI. | Emergency Medical Reunion Benefit | \$10,000 per occurrence |
| XII. | Accidental Death and Dismemberment | |
| | 24 Hour Accidental Death and Dismemberment | |
| | Insured and Spouse | \$10,000 Principal Sum |
| | Dependent Children | \$2,000 Principal Sum |
| | Common Carrier Accidental Death and Dismemberment | |
| | Insured and Spouse | \$40,000 Principal Sum |
| | Dependent Children | \$8,000 Principal Sum |

SECTION 3: INSURANCE PROVISIONS

A. Eligibility Requirements

For all Applicants / Insured Persons: Primary and named Dependent Insured Persons must be at least 14 days old and have not yet reached their 75th birthday. Dependents are the Primary Insured's Spouse and natural or legally adopted unmarried children over fourteen (14) days old and under nineteen (19) years old, but not older than twenty-three (23) years old if enrolled as a Full-Time Student at an accredited school or college and is not employed on a full-time basis.

For US Citizens: Applicants / Insured Persons must either be outside the United States at the time of application / renewal, or must depart the United States within 30 days of the Certificate's Effective Date / Renewal Date. In addition, the Insured Person must reside outside the United States at least 6 months during any given 12-month Certificate Period to meet the Eligibility Requirements of an Insured Person. Should any Insured Person reside in the United States longer than 6 months during any given 12-month Certificate Period, their Coverage shall immediately terminate.

For Non-US Citizens: Applicants / Insured Persons must be outside the United States at the time of application / renewal, or must depart the United States within 30 days of the Certificate's Effective Date / Renewal Date. In addition, the Insured Person must reside outside the United States at least 6 months during any given 12-month Certificate Period to meet the Eligibility Requirements of an Insured Person. Should any Insured Person reside in the United States longer than 6 months during any given 12-month Certificate period, their Coverage shall immediately terminate.

It is the Insured Person's responsibility to maintain all records regarding travel history, age and student status and provide any documents to the Administrator, which would verify the Eligibility Requirements.

For Insured Persons who apply and are Approved for coverage prior to their 65th birthday and remain continuously insured for ten consecutive years under this program, the Insured Person will automatically be converted to the Reside Prime Senior Provider upon the renewal date after their 75th birthday. This conversion is contingent upon the Insured Person continuing to meet the Eligibility Requirements.

Newborn Children

Newborn Children of the Insureds are covered from the moment of birth and accepted as any other new Insured Person subject to the Insurance Provisions, Scope of Coverage and Exclusions sections of this Policy or other sections relating to a Newborn Child up to the maximum amount of this program as long as the following conditions are met: (1) An application is submitted to SRI along with any applicable premium amounts within 31 days of the birth of the new child. (2) The pregnancy that led to the birth was an eligible pregnancy covered under this Certificate; (3) That the mother of the new child remain covered under this Certificate; (4) The child meets and will continue to meet the eligibility requirement of this certificate

Newborn Children who are Approved by the Company as any other new Insured Person will not be required to depart the United States within thirty (30) days of the Effective Date, provided that the Newborn Child's parent(s), who are current Insured Person(s), have met and will continue to meet all Eligibility Requirements listed in SECTION 3. INSURANCE PROVISIONS.

B. Individual Effective Date of Coverage

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

C. Individual Termination Date of Coverage

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

SECTION 4: SCOPE OF COVERAGE

A. Description of Coverage

Benefits are payable under the Reside Prime Worldwide Plan for Covered Events resulting in Eligible Benefits incurred by an Insured Person during the Coverage Period. Eligible Benefits shall be payable to either the Insured Person or the Service Provider for Eligible Benefits incurred by the Insured Person worldwide. **For all Hospital admissions worldwide, or for any expenses incurred in the United States, the Insured Person must utilize the Pre-Notification Program. Failure to utilize the Pre-Notification Program will result in a 25% reduction of the Eligible Benefits stated in the Schedule of Benefits.**

A charge incurred by an Insured Person shall be deemed a Reasonable and Customary charge for the services and supplies for which the charge is made if it is not in excess of the average charge for such services and supplies in the locality where received, considering the nature and severity of the bodily Injury or Illness in connection with which such services and supplies are received. If the charge incurred is in excess of such Reasonable and Customary charge the excess amount shall not be recognized as a Covered Expense. All charges shall be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, were rendered or obtained.

B. Medical Benefits

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

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

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

- 1.) Charges made by a Hospital for room and board, Inpatient floor nursing while confined in a ward or semi-private room and other services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation. Emergency treatment of an Injury (Hospital admission is not required); Emergency treatment of an Illness; in order for emergency room charges to be considered Covered Expenses, the Insured must be directly admitted to the Hospital as an inpatient for treatment of that Illness;
- 2.) Charges made for Intensive Care or Coronary Care charges and Inpatient nursing services.
- 3.) Charges made for diagnosis, treatment and Surgery by a Physician; charges made by an assistant Surgeon are covered up to 20% for Reasonable and Customary charge of the primary Surgeon.
- 4.) Charges made for an operating room.
- 5.) Charges made for Outpatient treatment, same as any other treatment covered on an Inpatient basis. This includes ambulatory Surgical centers, Physicians' Outpatient visits/examinations, clinic care, and Surgical opinion consultations.
- 6.) Charges made for Inpatient Convalescent Care Facility services and supplies furnished by the facility during the first thirty (30) days of Convalescent confinement. Admittance to a Convalescent Care Facility must be recommended by a Physician. Admittance to the Convalescent Care Facility must occur within three (3) days from discharge from a Hospital confinement. Only charges incurred in connection with Convalescence from the Illness or Injury for which the Insured Person is confined will be eligible for benefits. These expenses include:
 - a. room and board, paid at the Convalescent Care facility's semi-private room rate, including any charges such as general nursing, made by the facility as a condition of occupancy, or on a regular daily or weekly basis;
 - b. nursing care by a Registered Nurse; or a licensed practical nurse, a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse;
 - c. physical therapy when rendered by a licensed therapist;
 - d. medical supplies, including drugs and the use of medical appliances;
 - e. Physicians' services; and
 - f. services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician;

- 7.) Charges made for Inpatient Hospice Care Facility services and supplies furnished by the facility during the first thirty (30) days of Hospice confinement. Admittance to a Hospice Care Facility must be recommended by a Physician. Admittance to the Hospice Care Facility must occur within three (3) days from discharge from a Hospital confinement. Only charges incurred in connection with Hospice services from the Illness or Injury for which the Insured Person is confined will be eligible for benefits. These expenses include:
 - a. room and board, paid at the Hospice Care Facility's private room rate, including any charges such as general nursing, made by the facility as a condition of occupancy, or on a regular daily or weekly basis;
 - b. nursing care by a Registered Nurse; or a licensed practical nurse, a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse;
 - c. physical therapy when rendered by a licensed therapist;
 - d. medical supplies, including drugs and the use of medical appliances;
 - e. Physicians' services; and
 - f. services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician;
- 8.) Charges made for Home Health Care services and supplies furnished by a Home Health Care Agency limited to thirty (30) days per Covered Event. Home Health Care must be recommended by a Physician and must occur within three (3) days from discharge from a Hospital confinement. Only charges incurred in connection with Home Health Care services from the Illness or Injury for which the Insured Person is being treated will be eligible for benefits. These expenses include:
 - a. nursing care by a Registered Nurse; or a licensed practical nurse, a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse;
 - b. physical therapy when rendered by a licensed therapist;
 - c. medical supplies, including drugs and the use of medical appliances;
 - d. services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician;
- 9.) Charges made for the cost and administration of anesthetics.
- 10.) Charges for x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, chemotherapy, oxygen, blood, transfusions, iron lungs, casts, splints, braces and crutches.
- 11.) Hotel room charge, when the Insured Person would otherwise be confined in a Hospital, shall be under the care of a duly qualified Physician in a hotel room owing to unavailability of a Hospital room by reason of capacity or distance or to any other circumstances beyond control of the Insured Person.
- 12.) Dressings, Medications, and Medicines that can only be obtained upon a written prescription of a Physician or Surgeon and dispensed by a licensed pharmacist.
- 13.) Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.
- 14.) Local transportation to the nearest Hospital or to the nearest Hospital with facilities for required treatment. Such transportation shall be by licensed ground ambulance only, within the metropolitan area in which the Insured Person is located at that time the service is used. If the Insured Person is in a rural area, then licensed ground ambulance transportation to the nearest metropolitan area shall be considered a Covered Expense.

Only those expenses specifically described above, which are incurred from the onset of the Illness or Injury and which are not excluded in the Exclusions, are considered Eligible Benefits. Initial treatment of an Illness or Injury must occur within 365 days of the onset of the Illness or Injury. Illness or Injury must first manifest itself during the Insured Person's Period of Coverage.

C. Pregnancy Benefits

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

The Insured Person or their representative must Pre-Notify the Administrator of a Pregnancy within the first ninety (90) days of the Pregnancy. The Insured Person may Pre-Notify a Pregnancy with the Administrator by utilizing the following:

- 1.) Call 1-800-690-6295 within the United States or from outside the United States call (collect) 0-317-818-2808, or;
- 2.) Fax 317-575-2659, or;
- 3.) E-mail: sriassist@specialtyrisk.com

FAILURE TO PRE-NOTIFY THE ADMINISTRATOR OF A PREGNANCY WITHIN THE FIRST 90 DAYS OF THE PREGNANCY WILL RESULT IN A 25% REDUCTION OF THE ELIGIBLE BENEFITS STATED IN THE SCHEDULE OF

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

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

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

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

D. Well-Child Care Benefits

This benefit applies to Dependent Children, who have been underwritten and Approved, by the Administrator as Insured Persons. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Benefits during any one Period of Coverage. This benefit includes: Coverage for preventive and primary care services, including physical examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include three (3) visits per year for Dependent Children under nineteen (19) years of age. Preventive and primary care services shall also include, as recommended by the Physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

E. Preventive Benefits

The Company will pay expenses, as per the limits stated in the Schedule of Benefits, for the following Eligible Benefits. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Benefits during any one Period of Coverage. Coverage is limited to the following expenses incurred subject to any Exclusions listed in the Exclusions. These Preventative Benefits are not subject to Deductible or Coinsurance.

Covered Preventive Benefit expenses include:

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

F. Mental and Nervous Benefits

When covered Mental and Nervous expenses are incurred by the Insured Person the Company will pay Reasonable and Customary expenses in excess of the Deductible and Coinsurance as stated in the Schedule of Benefits. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits as to Eligible Benefits during the stated period of time.

1. Mental or Nervous

For the purpose of this section, only such expenses, incurred as the result of Mental or Nervous treatment or Medication, which are specifically enumerated in the following list of charges, and which are not excluded in the Exclusions, shall be considered as Eligible Benefits:

- a.) Inpatient Care:
 - i.) Charges made by a Hospital or mental institution for room and board, floor nursing and other services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's or mental institution's average charge for semiprivate room and board accommodation.
 - ii.) Charges made for diagnosis and treatment by a Physician.
 - iii.) Charges made for the cost and administration of anesthetics.
 - iv.) Charges for Medication, x-ray services, laboratory tests and services, oxygen, and medical treatment.
 - v.) Medicines that can only be obtained upon a written prescription of a Physician and dispensed by a licensed pharmacist.
- b.) Outpatient Care:
 - i.) Charges made for diagnosis and treatment by a Physician.
 - ii.) Charges made for the cost and administration of anesthetics.
 - iii.) Charges for Medication, x-ray services, laboratory tests and services, oxygen, and medical treatment.
 - iv.) Medicines that can only be obtained upon a written prescription of a Physician and dispensed by a licensed pharmacist.

Only those expenses specifically described above which are incurred within the Limits stated in the Schedule of Benefits from the onset of the Mental Illness and which are not excluded in the Exclusions, are considered Eligible Benefits. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible benefits during any one Period of Coverage. Mental and Nervous disorder must first manifest itself during the Insured Person's Period of Coverage.

G. Dental Benefit

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

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

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

H. Chiropractic / Physiotherapy

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

For Chiropractic: For the purpose of this section, only such expenses, incurred by the Insured Person, which are prescribed, performed, or ordered by a licensed Physician for the relief of pain, and which are not excluded in the Exclusions, shall be considered as Eligible Benefits. The Chiropractic condition must first manifest itself during the Insured Person's Period of Coverage.

Physiotherapy must be recommended by a Physician for the treatment of a specific Covered Event and administered by a licensed physical therapist.

I. Emergency Medical Evacuation/Repatriation Benefit

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

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

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

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

J. Return of Mortal Remains Benefit

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

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

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

K. Emergency Medical Reunion Benefit

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

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

1. The cost of a round trip economy air fare for one individual selected by the Insured Person, from the Insured Person's current Home Country to the location where the Insured Person is hospitalized and return to the current Home Country;
2. Reasonable travel and accommodation expenses incurred in relation to the Emergency Medical Reunion up to the maximum stated in the Schedule of Benefits, not to exceed \$250 per day.
3. The period of Emergency Medical Reunion is not to exceed 10 days, including travel.
4. All transportation in connection with an Emergency Medical Reunion must be pre-approved and arranged by an Administrator Company representative appointed by the Company.

L. Accidental Death & Dismemberment Benefit (AD&D)

<u>Table of Losses</u>		<u>Principal Sum</u>
<u>Description of Loss (For Loss of:)</u>		
Life		100%
Both Hands or Both Feet or Sight of Both Eyes		100%
One Hand and One Foot	100%	
Either Hand or Foot and Sight of One Eye		100%
Either Hand or Foot		50%
Sight of One Eye		50%
Quadriplegia		100%
Paraplegia (total paralysis of both lower limbs)		75%
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)		50%
Uniplegia (total paralysis of one limb)		25%

The combined Aggregate Limit of Indemnity for all Insured Persons per any one covered Accident shall be five times the Principal Sum to a Maximum Aggregate Limit not to exceed \$200,000 per Accident.

The Company shall pay the Principal Sum from the Schedule of Benefits and the Table of Losses above, if an Insured Person sustains a Loss stated therein resulting from Accidental Injury, provided that: (a) such Loss occurs within ninety (90) days after the date of Accident causing such Loss; and (b) the indemnity payable for any such Loss shall be the Principal Sum stated in the Schedule of Benefits and Table of Losses as applicable to such Insured Person and this Insurance; and (c) if more than one Loss stated in the Table of Losses is sustained as the result of one Accident, only one of the amounts so stated in the Table of Losses, the largest, shall be payable. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits and Table of Losses.

Exposure

If by reason of an Accident covered by the Certificate an Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a Loss for which the Principal Sum is otherwise payable hereunder such Loss will be covered under the terms of the Certificate.

Disappearance

If the body of an Insured Person has not been found within 12 months of the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which such Insured Person was an occupant, than it shall be deemed, subject to all other terms and Provisions of the Certificate, that such Insured Person shall have suffered Loss of life within the meaning of the Certificate.

Beneficiary Designation and Change

The beneficiary or beneficiaries of an Insured Person shall be that person or those persons designated by the Insured Person and filed with the Company. Any Insured Person who has not made an irrevocable designation of beneficiary may designate a new beneficiary at any time, without the consent of the beneficiary, by filing with the Company a written request for such change but such change shall become effective only upon receipt of such request at the office of the Company. When such request is received by the Company, whether the Insured Person be then living or not, the change of beneficiary shall relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment theretofore made by it.

Common Carrier Accidental Death and Dismemberment - Additional Description

The Accidental Death and Dismemberment Benefit is afforded to an Insured Person which shall apply only to Loss, as defined in SECTION 1: Definitions, sustained by such Insured Person during the Period of Coverage. Eligible Benefits includes Loss sustained during a trip while the Insured Person is riding as a passenger (but not as a pilot, operator or member of the crew) in or on, boarding or alighting from: (a.) any civilian aircraft having a current and valid Airworthiness Certificate, and piloted by a person who then holds a valid and current certificate of competency of a rating authorizing him to pilot such aircraft; or (b.) any transport type aircraft operated by the Military Airlift Command (MAC) of the United States, or by the similar air transport service of any duly constituted governmental authority of any other recognized country; provided that this Insurance shall not apply while such Insured Person is riding in any civilian or military aircraft other than a expressly described above, unless previously consented to in writing by the Company.

M. Pre-Notification Program

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

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

1. Contact the Administrator

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

The Administrator can be contacted at:

- ~~ES~~ Toll Free within the United States and Canada 1-800-690-6295
- ~~ES~~ Call Collect from outside the United States and Canada 01- 317-818-2808
- ~~ES~~ Fax 1- 317-575-2659
- ~~ES~~ E-mail: sriassist@specialtyrisk.com

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

Services and Treatment in the United States must be received at an approved PPO Service Provider facility, if one exists within a 50 mile radius of where the Insured Person is located. To obtain a list of approved PPO Service Providers contact the Administrator or visit the approved PPO Service Provider website at: www.specialtyrisk.com/ppo

Failure to follow the protocol outlined in number 1 and 2 above of the Pre-Notification Program will result in a 25% reduction of the Eligible Benefits stated in the Schedule of Benefits.

Benefits payable under the Certificate are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Certificate. Pre-Notification does not guarantee or confirm benefits under the Certificate. Treatment, confinement, care, services or supplies that are excluded from Coverage under any provision, exclusion or limitation of this Certificate are not covered whether Pre-notification was received or not.

3. Pre-Notification Appeal

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

N. Hospital Daily Indemnity Benefit

For every Medically Necessary night spent in a Hospital (Hospital admission) outside of the United States and Canada, the Company will pay an indemnity benefit of \$50 (maximum amount payable per policy period is \$1,000).

O. Transplant Benefit

The Eligible Benefits of Human Organ Tissue Transplants Expenses are limited to amounts and procedures listed in the Schedule of Benefits for the following Medically Necessary Human Organ and Tissue Transplants: Bone Marrow, Liver, Heart, Pancreas, Heart/Lung, Kidney/Pancreas, Lung.

Covered Transplant Services:

1. Inpatient and Outpatient Hospital services
2. Services of a Physician for diagnosis, treatment, and Surgery for a Covered Transplant Procedure.
3. Diagnostic services.
4. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue; Eligible Benefits are limited to the actual procurement expenses, and the Eligible Benefits are subject to the amounts shown in the Maximums section.
5. Medically Necessary transportation costs for travel related to a Covered Transplant Procedure for the transplant recipient and one companion during a Benefit Period. Eligible Benefits for transportation are subject to the amounts shown in the Maximums section.
6. If the recipient is a minor, transportation costs for two companions may be covered. Eligible Benefits for transportation are subject to the amounts shown in the Maximums section.
7. Reasonable and necessary lodging and meal expenses incurred by the recipient and the recipient's companion(s), related to a Covered Transplant Procedure, during the Benefit Period. Eligible Benefits for lodging and meals are subject to the amounts shown in the Maximums section.
8. Rental of durable medical equipment for use outside the Hospital. Eligible Benefits are limited to the purchase price of the same equipment.
9. Prescription Medication, including immunosuppressive drugs.
10. Oxygen.
11. Speech Therapy, Occupational Therapy, Physical Therapy and Chemotherapy.
12. Surgical dressings and supplies.
13. Services and supplies for and related to High Dose Chemotherapy and Bone Marrow Tissue transplantation when provided as part of a treatment plan which includes Bone Marrow transplantation and High Dose Chemotherapy.
14. Home Health Care.

Eligible Benefit paid will be reduced by 20% should Transplant expenses occur in a non-approved PPO Transplant Facility.

The Company's payments for Organ Procurement expenses for a donor organ or tissue will not exceed \$25,000 per Covered Transplant Procedure.

FAILURE TO PRE-NOTIFY THE ADMINISTRATOR OF A TRANSPLANT WILL RESULT IN A 100% REDUCTION OF THE ELIGIBLE BENEFITS STATED IN THE SCHEDULE OF BENEFITS. IN ADDITION, THE PRE-NOTIFICATION PROGRAM MUST BE FOLLOWED, AS STATED IN SECTION 4, M. PRE-NOTIFICATION PROGRAM.

SECTION 5: EXCLUSIONS

A. Medical Benefit Exclusions

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

1. Pre-Existing Conditions, which are any Injury or Illness which meets the following criteria: 1) A condition that would have caused a person to seek medical advice, diagnosis, care or Treatment prior to the Individual Effective Date of Coverage under this Certificate; 2) A condition for which medical advice, diagnosis, care or Treatment, including Medication, was sought, recommended or received prior to the Individual Effective Date of Coverage

under this Certificate; 3) the symptoms which occurred prior to the Individual Effective Date of the Coverage under this Certificate would have allowed a person trained in medicine to make a diagnosis of the condition producing the symptoms; 4) a condition which manifested prior to the Individual Effective Date of Coverage under this Certificate; 5) Expenses for Pregnancy within twelve (12) months after the Individual Effective Date of Coverage under this Certificate. Exclusionary Riders may be issued by the Administrator, for certain Pre-Existing Conditions. Pre-Existing Conditions that are fully and accurately disclosed on the Application and Approved and accepted by the Administrator, without an Exclusionary Rider or other restriction will be covered up to a lifetime maximum of \$50,000 (\$5,000 limit per Period of Coverage) after the Insured Person has been continuously insured for 24 months.

2. Charges for treatment of the following illnesses or surgeries, which manifest themselves or are recommended, or symptoms occur during the first 180 days of coverage hereunder beginning on the initial effective date: any condition of the breast, any condition of the prostate, disorders of the reproductive system, gall stones or kidney stones, any acne diagnosis or acne related condition, or any surgery that is not emergency in nature, as emergency is defined hereunder. Note: coverage for such illnesses or surgeries may be further limited under the pre existing condition exclusion and definition contained herein, or other exclusions contained herein;
3. Injury or Illness which is not presented to the Company for payment within ninety (90) days immediately following the Incident, which gave rise to the expenses.
4. Treatment which is not Medically Necessary.
5. Services provided at no cost to the Insured Person.
6. Treatment which exceed Reasonable and Customary charges.
7. Surgeries or Treatments which are Investigational, Experimental, or for Research purposes.
8. Services, supplies or Treatment, including any period of Hospital confinement, which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician.
9. Suicide or any attempt there at whether the Insured Person committing them is sane or insane;
10. War, hostilities or warlike operations (whether war be declared or not), Invasion, Act of an enemy foreign to the nationality of the insured person or the country in, or over, which the act occurs, Civil war, Riot, Rebellion, Insurrection, Revolution, Overthrow of the legally constituted government, Civil commotion assuming the proportions of, or amounting to, an uprising, Military or usurped power, Explosions of war weapons, Utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined, Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the insured person whether war be declared with that state or not, Terrorist activity.

For the purpose of this Exclusion ;

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

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

11. Injury sustained while participating in organized, professional, amateur, or interscholastic athletics sponsored by a school or organization;
12. Vaccinations, inoculations, routine physicals or other examinations where there are no objective indications of impairment in normal health, and laboratory diagnostic or x-ray examinations, except in the course of a Covered Event established by a prior call or attendance of a Physician; unless otherwise covered under this Certificate;

13. Treatment of the Temporomandibular Joint (TMJ) or for maxillary and/or mandibular hypoplasia and/or hyperplasia.
14. Vocational, occupational, speech, recreational, or music therapy.
15. Services performed or supplies or treatment recommended or rendered by a Relative of the Insured Person or any person who ordinarily resides with the Insured Person. This exclusion includes any treatment as the result of a referral to or by a Relative of the Insured Person or any person who ordinarily resides with the insured, to another physician.
16. Cosmetic or plastic Surgery and any related Hospital admission, except as the result of a covered Injury. For the purposes of this Insurance, Treatment of a deviated nasal septum shall be considered a cosmetic condition.
17. Treatment, purchase and fitting of false teeth or dentures and hearing aids;
18. Eye refractions or eye examinations for the purpose of prescribing corrective lenses or eye glasses or for the fitting thereof and radial keratotomy, unless caused by Accidental bodily Injury incurred while insured hereunder;
19. Injury sustained while under the influence of or disablement due to 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 for a condition which is covered hereunder, but not for the treatment of drug addiction.
20. Telephone consultations or failure to keep a scheduled appointment.
21. Treatment while confined primarily to receive Custodial Care, educational or rehabilitative care and nursing services in a long term care facility, spa, hydroclinic, weight loss clinic, sanatorium, nursing home or similar facilities.
22. Congenital abnormalities and conditions arising out of or resulting there from; unless otherwise covered under this Certificate;
23. Services and supplies which are non-medical in nature.
24. The Insured Person's unused airline ticket for the transportation back to the Insured Person's Home Country, where an Emergency Medical Evacuation or Repatriation and/or Return of Mortal Remains benefit is provided.
25. Intentionally self-inflicted Injury or Illness whether the Insured Person committing them is sane or insane;
26. Commission or attempt to commit a felony offense or from the Insured Person being engaged in an illegal occupation or activity;
27. Injury sustained while taking part in mountaineering where ropes or guides are normally used, hang gliding, parachuting, bungee jumping, racing by horse, motor or motorcycle, scuba diving, involving underwater breathing apparatus - unless PADI, NAUI, YMCA, SSI or PDIC certified;
28. Treatment paid for or furnished under any other individual or group policy or other service or medical prepayment plan arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for Treatment without cost to any individual;
29. Injuries for which benefits are payable under any no-fault automobile insurance policy;
30. Treatment of venereal disease, sexually transmitted disease, or expenses for a sex change;
31. Routine Dental Treatment and services for Dental care of the teeth or periodontium or the surrounding tissue or structure, except as the result of Injury to sound, natural teeth caused by Accident;
32. Pregnancy expenses incurred by a Dependent Child;
33. Treatments, Medications or procedures that either promotes or prevents conception, or prevents childbirth, including but not limited to: artificial insemination, in vitro fertilization, gamete intra fallopian transfer (GIFT), Treatment for infertility or impotency, sterilization or reversal thereof, or abortion.
34. Treatment in connection with alcoholism and drug addiction, or use of any drug or narcotic agent;
35. Any Mental and Nervous disorders or rest cures, unless otherwise covered in this Certificate.
36. Treatment which is incurred by Insured Persons who were HIV Positive at the time of Application for this Insurance, or testing for the following: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, or AIDS.
37. Treatment for the AIDS virus, AIDS related Illness, ARC Syndrome, AIDS, and/or any Illness arising as complications from these conditions.
38. Treatment for Chronic Fatigue Syndrome, including but not limited to diagnostic workups.
39. Service or Treatment for any form of food supplement or augmentation or for any program for weight control, whether for obesity or any diagnosis, by diet, injection of any fluid, or use of any Medications or Surgery of any kind.
40. Chiropractic care, unless otherwise covered under this Certificate.
41. Purchase or rental of durable medical equipment outside of a Hospital, including but not limited to wheelchairs, crutches, oxygen tanks and walkers.
42. Land and/or sea rescues.

43. Treatment for Illness or Injury resulting from or in the course of any employment for wage or profit by the Insured Person.
44. Treatment, services and supplies for flat feet, fallen arches, corns, bunions, callouses and care of toenails.
45. Treatment, services and supplies for Convalescent, Hospice and Home Health Care which exceed 30 days in duration for any one Incident.
46. Newborn children who are not Approved by the Administrator and covered under the Pregnancy Benefit.

B. Accidental Death and Dismemberment Benefit Exclusions

This Insurance does not cover any Loss or the consequences thereof, related to the following Exclusions, unless specifically included or modified on the Schedule of Benefits number XII in this Certificate. With regards to Accidental Death and Dismemberment, this Insurance does not cover:

1. Suicide, attempted suicide or intentionally self-inflicted Injuries whether the Insured Person committing them is sane or insane;
2. Disease or sickness of any kind;
3. Bacterial infections except pyogenic infection which shall occur through an accidental cut or wound;
4. Hernia of any kind;
5. Injury sustained while the Insured Person is riding as a pilot, student pilot, operator or crew member (including in or on, boarding or alighting, from any type of aircraft);
6. Injury sustained while the Insured Person is riding as a passenger in any aircraft (a) not having a current and valid Airworthy Certificate and (b) not piloted by a person who holds a valid and current certificate of competency for piloting such aircraft; or in any aircraft that is not on a commercially scheduled flight.
7. War, hostilities or warlike operations (whether war be declared or not), Invasion, Act of an enemy foreign to the nationality of the insured person or the country in, or over, which the act occurs, Civil war, Riot, Rebellion, Insurrection, Revolution, Overthrow of the legally constituted government, Civil commotion assuming the proportions of, or amounting to, an uprising, Military or usurped power, Explosions of war weapons, Utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined, Murder or Assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the insured person whether war be declared with that state or not, Terrorist activity.

For the purpose of this Exclusion #7;

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

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

8. Service in the military, naval or air service of any country.
9. Flying in any aircraft being used for or in connection with acrobatic or stunt flying, racing, endurance tests, rocket-propelled aircraft, crop dusting or seeding or spraying, fire fighting, exploration, pipe or power line inspection, any form of hunting or herding, aerial photography, banner towing or any experimental purpose.
10. Being under the influence of alcohol or having taken drugs or narcotics unless prescribed by a legally qualified physician or surgeon.
11. Injury occasioned or occurring while the Insured Person is committing or attempting to commit a felony or from the Insured Person being engaged in an illegal occupation or activity.
12. While riding or driving in any kind of competition.

13. Pregnancy, childbirth, miscarriage or abortion.
14. Injury arising out of a Preexisting Condition. However, an injury for which the treatment has not been rendered or treatment medically recommended for the past thirty consecutive months shall not be considered a Preexisting Condition unless otherwise specifically excluded.

SECTION 6: CERTIFICATE PROVISIONS

1. **Entire Contract; Changes:** The Certificate, including the, Application, Schedule of Benefits, Exclusionary Riders, endorsements and the attached papers, if any, constitutes the entire contract of Insurance. No change in the Certificate shall be valid until Approved by an executive officer of the Administrator and unless such approval is endorsed hereon. No agent has authority to change this Certificate or to waive any of its provisions.
2. **Notice of Claim:** Written notice of claim must be given to the Company within thirty (30) days after the occurrence or commencement of any Covered Event covered by the Certificate. If Notice cannot be given within 30 days because of incapacity or some similar reason, it must be given as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Administrator, or to any authorized agent of the Company, with the name of the Insured Person and the Certificate Number on the ID Cards to identify the Insured Person shall be deemed notice to the Company.
3. **Claim Forms:** The Company, upon receipt of a Notice of Claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Certificate as to Proof of Loss upon submitting, within the time fixed in the Certificate for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the Covered Event for which claim is made.
4. **Proof of Loss:** Written Proof of Loss must be furnished to the Administrator, at its said office, within ninety (90) days after the date of such Covered Event. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. In any case, the proof required must be given no later than one year from the time specified except in the absence of legal capacity.
5. **Payment of Claims:** Subject to any written direction of the Insured Person which is submitted within the time for filing the Proof of Loss, all or a portion of any indemnities provided by this Certificate for Hospital, nursing, medical or Surgical service may, at the Company's option be paid directly to the Hospital or Service Provider rendering such services.
6. **Physical Examination and Autopsy:** The Company at its own expenses shall have the right and opportunity to examine the person of any individual whose Injury or Illness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.
7. **Legal Actions:** Any disputes arising from this Certificate, or its alleged breach, if not resolved by the parties, shall be referred to arbitration by either party. Arbitration shall be conducted in the City of Indianapolis, Indiana, USA in accordance with Commercial Arbitration Rules of the American Arbitration Association. Arbitration shall be the sole remedy for alleged breach of this Certificate. Notices in connection with such arbitration and process in any judicial proceeding in connection wherewith may be served by personal delivery or registered mail on the Company at Specialty Risk International, Inc. 9200 Keystone Crossing, Suite 300, Indianapolis, Indiana 46240 USA and on the Insured Person at the most current address appearing on the records of the Company, with the same effect as if personally served in Indianapolis. The Company's liability in any such arbitration shall be limited to such amounts as the arbitrators may determine are due under this Certificate, with such interest thereon and such cost of the arbitration proceeding, if any, as the arbitrator may direct.

No actions at law or in equity shall be brought to recover on the Certificate prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with requirements of this Certificate. No such action shall be brought after expiration of twelve (12) months after the time that written Proof of Loss is required to be furnished.

Any disputes arising from this Certificate shall be governed by the laws of the State of Indiana, USA.

8. **Grace Period:** A Grace Period of thirty-one (31) days will be granted for the payment of each Premium falling due after the first Premium, during which Grace Period the Certificate will continue in force, but the Insured Person shall be liable to the Company for the payment of the Premium accruing for the period the Certificate continues in force.
9. **Reinstatement:** If the Company terminates Coverage for non-payment of Premium, the Company will consider reinstatement of Coverage only after receiving proof of good health and payment of Premium. The reinstated Certificate shall cover only Covered Events resulting from Injuries that are sustained after the date of reinstatement and those Covered Events due to Illness that manifests not less than ten (10) days after the date of reinstatement. No reinstatement will be considered by the Company sixty (60) days after the Certificate has been terminated for non-payment of Premium.
10. **Effective Date of Individual Insurance:** After review and Approval of each Applicant by the Administrator, Coverage will become effective on the later of the following dates: (1.) The date requested on the Application, (2.) The date the appropriate premium and Application are received by the Administrator, or (3) The date the Applicant is Approved by the Administrator. The Insured's ID Card will state the official Effective Date of coverage, as issued by the Administrator.
11. **Termination Date of Individual Insurance:** Coverage will terminate upon the earlier of the following: (1.) The end of the period for which Premium has been paid, (2.) The date the Insured Person fails to meet the Eligibility Requirements described in SECTION 3, A; (3.) The date the Company cancels coverage for a specific Class of Insured Persons, which the individual Insured Person may be included.
12. **Not in Lieu of Worker's Compensation:** This Insurance is not in lieu of and does not affect any requirements for Coverage by Worker's Compensation Insurance.
13. **Certificate of Insurance:** The Company shall issue to each Insured Person an individual Certificate of Insurance, which shall state the essential features of Insurance to which such person is entitled and to whom benefits are payable, if required to do so by the laws of the state in which the Insured Person resides when his Insurance becomes effective.
14. **Data Furnished by Insured Person(s) or Applicant(s):** Insured Person(s) or Applicant(s) shall furnish all information requested on the Application and/or Claim Form and any additional information requested by the Company.

A newborn child born to the Primary Insured Person, after the Primary Insured Person's Individual Effective Date of Coverage under this Certificate, cannot be added to this Certificate of Insurance, without a complete Application and Approval of Administrator. The birth of a newborn child to an Insured Person shall not constitute valid Insurance under this contract for the newborn child, except where provided under the Pregnancy Benefit.

The refusal or failure of the Insured Person's Relative, Employer, Insurance Company, Physician, Hospital or Service Provider to make all medical reports and records available to the Company could cause an otherwise valid claim or Application to be denied or the file to be closed due to lack of or limited reply from the above referenced individuals and entities. Failure on the part of the Insured Person to maintain adequate documentation regarding travel history could cause an otherwise valid claim (where travel history is material to the benefit and claim) to be denied or the file to be closed.

The Company has the option whether or not to consider medical information provided by friends / relatives of the Insured Person as valid for underwriting or claim administration.

15. **Cancellation:** The Certificate is an annually renewable for the life of the Insured Person or until the Termination Date of Individual Insurance. The Company may cancel an entire class of Insured Persons based upon claims experience in a certain region or within a gender / age category.

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

16. **Renewal of Individual Insurance:** The Certificate will be renewed each year on the anniversary of the Effective Date of Individual Insurance subject to the provisions of the Certificate in force at the time of the renewal. The initial Period of Coverage cannot exceed twelve (12) months. The Insured Person, however, may apply for renewal of Coverage. The renewal Period of Coverage may not total more than twelve (12) months. Renewal(s) will be contingent upon the Insured Person submitting the applicable renewal Premiums for their class, as determined by the Company. The Company can cancel an Insured Person, if the Insured Person is included in a class that is canceled in its entirety by the Company or if the Insured Person's Coverage is Rescinded or Voided for misrepresentations. Additionally, the Company may make benefit modifications to the Certificate of an Insured Person, if the Insured Person is included in a class that is modified in its entirety by the Company.
17. **Excess Benefits:** All Coverage shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted.

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

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

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

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

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

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

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

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

19. **Change of Residence:** The Certificate will become null and void unless the Company is notified of any change in the Home Country of the Insured Person, within thirty (30) days of the change. All terms and conditions are subject to review and revision upon a change in the Insured Person's Home Country.
20. **Monetary Limits:** The monetary limits stated in this Certificate and the Premium shall be in United States dollars. For services outside of the territorial limits of the United States, the exchange rate used to determine the amount of United States dollars to be paid is the exchange rate effective for the date the claims expense was incurred.
21. **Assignment:** The Insurance provided hereunder is not assignable, but benefits may be assigned in accordance with #5, Payment of Claims.
22. **Modification of Medical Condition Prior to Issuance of Certificate:** Any conditions which manifest themselves between the date the Application is signed and the date the Coverage is issued, shall be considered Pre-existing and not covered for the entire Certificate Period. Additionally, some conditions which manifest themselves between the date the Application is signed and the date the Coverage is issued may affect your eligibility for Insurance.
23. **Incontestability:** After two (2) years from the Effective Date of Individual Insurance, only fraudulent misstatements in the Application may be used to void the Certificate or deny any claim for Loss, Eligible Benefits or disability starting after the two (2) year period.
24. **Representations in Application:** Any statement or description made by or on behalf of the Insured Person on the Application for Insurance Coverage is a representation and is not a warranty. A misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the Certificate only if any of the following apply; a.) the misrepresentation, omission, concealment, or statement is fraudulent or is material either to the Approval of the Coverage for the Insured Person or payment of otherwise Eligible Benefits by the Company, b.) if the facts had been known to the Administrator or Company prior to issuance of Coverage, the Administrator or Company would not have issued Coverage, would not have issued Coverage at the same Premium, or would have issued an Exclusionary Rider to the Coverage under this Certificate.
25. **Patient Support:** To ensure that Medically Necessary services, supplies and treatment are provided in the most cost effective and appropriate manner, the Company may determine that a particular claim or diagnosis occurring under this insurance may be placed under the patient support program. Once the Insured Person follows the Pre-Notification requirement and the Company determines that the condition (or diagnosis) qualifies for the patient support requirement, the Company will advise the Insured Person that a Patient Support Specialist will be assigned to the Insured Person for that particular condition. From that point forward, the Company's Patient Support Specialist may make recommendations of alternative treatment in the form of other locations, other procedures, or other supplies that can be used that are more appropriate and/or cost effective for both the Insured Person and the Company (and will result in the same or better care). The Insured Person and the Insured Person's Physician(s) will have input in this evaluation. Should the recommendations be accepted by the Insured Person, the Insured Person agrees to hold the Company harmless and the Company shall not be held liable or otherwise responsible for any treatment, service, supply, procedure or care provided to the Insured Person except for the payment of benefits under this insurance. After the Insured Person has been notified that the condition meets the Patient Support program requirements, the Company reserves the right to:
 - a. Generate payment for treatment, services, and/or supplies which are excluded under this insurance that would be beneficial to the Insured Person and cost effective to the Company; and
 - b. Decline payment for expenses that would otherwise be covered under this insurance that exceed the amount the Company would have paid had the Insured Person followed the recommended treatment program established by the patient support program.
26. **Ten Day Right to Return Certificate:** If for any reason you are not satisfied with this certificate or any amendment/endorsement that has been added and made a part of this certificate, you may return it to the Administrator within 10 days after you receive it. You must return it to the Administrator by mail or to the agent who

sold it. Then we will refund any premium paid and the certificate will be deemed void, just as though no certificate had been issued.

The following SECTION 2 shall replace in its entirety Section 2 contained previously in this Certificate and apply for Insured Persons who apply and are accepted for coverage prior to their 65th birthday and remain continuously insured for ten consecutive years under this program, the Insured Person will automatically be converted to the following schedule of benefits upon the renewal date after their 75th birthday. This conversion is contingent upon the Insured Person continuing to meet the Eligibility Requirements.

SECTION 2: SCHEDULE OF BENEFITS

A. Deductible and Coinsurance

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

Medical Benefits Deductible for each

Period of Coverage:	Per Insured Person:	\$5,000
	Per Insured Family Unit:	3x per person (or max. 3 per family)

Eligible Benefit Percentage Payable after Deductible has been satisfied:

Eligible Benefits Incurred Outside the United States: The Company pays 100% of Eligible Benefits up to the Medical Maximum. All Hospital admissions must be Pre-Notified through the Pre-Notification Program.

Eligible Benefits Incurred Inside the United States: The Company pays 80% of the next \$5,000 of Eligible Benefits and then 100% up to the Medical Maximum. All Hospital admissions and expenses above \$1,000 must be Pre-Notified and Approved PPO facilities must be utilized through the Pre-Notification Program. Each Insured Person is responsible for the Coinsurance amount.

If the Insured Person follows Pre-Notification Program the maximum out of pocket expenses that an Insured Person in the United States will be required to pay after satisfying their Individual Deductible is \$1,000. The maximum out of pocket expenses that a family unit in the United States will be required to pay after satisfying their Family Deductible is \$3,000.

B. Eligible Benefits and Maximum Limits

Subject to the Deductible and Coinsurance as described in SECTION 2, A, the Eligible Benefits and Maximum Limits for Benefits I through III shall be as follows:

I.	Medical Benefit	\$250,000 Lifetime each Insured Person
	Sublimits	
	a. Hospital Room and Board, including miscellaneous	\$950 per day, 30 day maximum
	b. Surgical Treatment (inpatient and outpatient)	\$2,500 per Coverage Period
II.	Pregnancy Benefit	\$7,500 per Pregnancy 12 month waiting period
III.	Well-Child Care Benefit	\$200 maximum per Coverage Period after a 12 month waiting period.

Subject to the Deductible and Coinsurance as described within Benefits IV through VII, the Eligible Benefits and Maximum Limits for Benefits IV through VII shall be as follows:

IV.	Mental and Nervous Benefit	\$10,000 Coverage Period maximum after a 12 month waiting period. Inpatient limited to a maximum of 45 days per coverage period.
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Outpatient Benefit limited to a maximum of 40 visits per Coverage Period at 70% (separate from overall coinsurance) of Eligible Benefits.

- V. Chiropractic / Physiotherapy Benefit \$10,000 Lifetime benefit combined, limited to 12 visits per Coverage Period and \$75 per visit. There is a 12 month waiting period for these benefits.
- VI. Dental Benefit (due to Accident only) \$500.00 per Coverage Period subject to a \$50.00 per occurrence Deductible.
- VII. Transplant Benefit \$1,000,000 Lifetime Maximum. To cover Bone Marrow, Liver, Heart, Pancreas, Heart/Lung, Kidney/Pancreas, Lung

Benefits VIII through XII are not subject to a Deductible or Coinsurance, the Eligible Benefits and Maximum Limits for Benefits VIII through XII shall be as follows:

- VIII. Preventive Benefits \$175 per Coverage Period Maximum after a 12 month waiting period
- IX. Emergency Medical Evacuation Benefit \$50,000 per Coverage Period
- X. Return of Mortal Remains Benefit \$20,000
- XI. Emergency Medical Reunion Benefit \$10,000 per occurrence
- XII. Accidental Death and Dismemberment
 - 24 Hour Accidental Death and Dismemberment
 - Insured and Spouse \$10,000 Principal Sum
 - Dependent Children \$2,000 Principal Sum
 - Common Carrier Accidental Death and Dismemberment
 - Insured and Spouse \$40,000 Principal Sum
 - Dependent Children \$8,000 Principal Sum