Lloyd's Certificate

This Insurance is effected with certain Underwriters at Lloyd's, London.

This Certificate is issued in accordance with the limited authorization granted to the Correspondent by certain Underwriters at Lloyd's, London whose syndicate numbers and the proportions underwritten by them can be ascertained from the office of the said Correspondent (such Underwriters being hereinafter called "Underwriters") and in consideration of the premium specified herein, Underwriters hereby bind themselves severally and not jointly, each for his own part and not one for another, their Executors and Administrators.

The Assured is requested to read this Certificate, and if it is not correct, return it immediately to the Correspondent for appropriate alteration.

All inquiries regarding this Certificate should be addressed to the following Correspondent:

SEVENCORNERS

303 Congressional Boulevard
Carmel, IN 46032
1-800-335-0611
317-575-2652
317-575-2659 FAX
www.sevencorners.com

SLC-3 (USA) NMA 2868 (24/08/2000
From approved by Lloyd's Underwriters' Non-Marine Association Limited
EASON PRINTING CO., CHICAGO

CERTIFICATE PROVISIONS

1. Signature Required. This Certificate shall not be valid unless signed by the Correspondent on the attached Declaration Page.

2. Correspondent Not Insurer. The Correspondent is not an Insurer hereunder and neither is nor shall be liable for any loss or claim whatsoever. The Insurers hereunder are those Underwriters at Lloyd's, London whose syndicate numbers can be ascertained as hereinbefore set forth. As used in this Certificate "Underwriters" shall be deemed to include incorporated as well as unincorporated persons or entities that are Underwriters at Lloyd's, London.

3. Cancellation. If this Certificate provides for cancellation and this Certificate is cancelled after the inception date, earned premium must be paid for the time the insurance has been in force.

4. Service of Suit. It is agreed that in the event of the failure of Underwriters to pay any amount claimed to be due hereunder, Underwriters, at the request of the Assured, will submit to the jurisdiction of a Court of competent jurisdiction within the United States. Nothing in this Clause constitutes or should be understood to constitute a waiver of Underwriters' rights to commence an action in any Court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another Court as permitted by the laws of the United States or of any State in the United States. It is further agreed that service of process in such suit may be made upon Mendes and Mount; 750 Seventh Avenue; New York, NY 10019-6829 USA, and that in any suit instituted against any one of them upon this contract, Underwriters will abide by the final decision of such Court or of any Appellate Court in the event of an appeal.

The above-named are authorized and directed to accept service of process on behalf of Underwriters in any such suit and/or upon request of the Assured to give a written undertaking to the Assured that they will enter a general appearance upon Underwriters' behalf in the event such a suit shall be instituted.

Further, pursuant to any statute of any state, territory or district of the United States which makes provision therefor, Underwriters hereby designate the Superintendent, Commissioner or Director of Insurance or other officer specified for that purpose in the statute, or his successors in office, as their true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the Assured or any beneficiary hereunder arising out of this contract of insurance, and hereby designate the above-mentioned as the person to whom the said officer is authorized to mail such process or a true copy thereof.

5. Assignment. This Certificate shall not be assigned either in whole or in part without the written consent of the Correspondent endorsed hereon.

6. Attached Conditions Incorporated. This Certificate is made and accepted subject to all the provisions, conditions and warranties set forth herein, attached or endorsed, all of which are to be considered as incorporated herein.

7. Short Rate Cancellation. If the attached provisions provide for cancellation, the table below will be used to calculate the short rate proportion of the premium when applicable under the terms of cancellation.

Short Rate Cancellation Table for Term of 364 Days.

Days Insurance In Force	Per Cent of 364 Days Premium	Days Insurance In Force	Per Cent of 364 Days Premium	Days Insurance In Force	Per Cent of 364 Days Premium	Days Insurance In Force	Per Cent of 364 Days Premium
1	5 %	66 - 69	29 %	154 -	156 53 %	256 -	260 77 %
2	6	70 - 73	30	157 -	160 54	261 -	264 78
3 - 4	7	74 - 76	31	161 -	164 55	265 -	269 79
5 - 6	8	77 - 80	32	165 -	167 56	270 -	273 (9 mos.) 80
7 - 8	9	81 - 83	33	168 -	171 57	274 -	278 81
9 - 10	10	84 - 87	34	172 -	175 58	279 -	282 82
11-12	11	88 -91 (3 mos.)	35	176 -	178 59	283 -	287 83
13-14	12	92 - 94	36	179 -	182 (6 mos.) 60	288 -	291 84
15-16	13	95 - 98	37	183 -	187 61	292 -	296 85
17-18	14	99 -102	38	188 -	191 62	297 -	301 86
19-20	15	103 -	105 39	192 -	196 63	302 -	305 (10 mos.) 87
21-22	16	106 -	109 40	197 -	200 64	306 -	310 88
23-25	17	110 -	113 41	201 -	205 65	311 -	314 89
26-29	18	114 -	116 42	206 -	209 66	315 -	319 90
30-32 (1 mos.)	19	117 -	120 43	210 -	214 (7 mos.) 67	320 -	323 91
33-36	20	121 -	124 (4 mos.) 44	215 -	218 68	324 -	328 92
37-40	21	125 -	127 45	219 -	223 69	329 -	332 93
41-43	22	128 -	131 46	224 -	228 70	333 -	337 (11 mos.) 94
44-47	23	132 -	135 47	229 -	232 71	338 -	342 95
48-51	24	136 -	138 48	233 -	237 72	343 -	346 96
52-54	25	139 -	142 49	238 -	241 73	347 -	351 97
55-58	26	143 -	146 50	242 -	246 (8 mos.) 74	352 -	355 98
59-62 (2 mos.)	27	147 -	149 51	247 -	250 75	356 -	360 99
63-65	28	150 -	153 (5 mos.) 52	251 -	255 76	361 -	364 100

Rules applicable to insurance with terms less than or more than 364 Days:

A. If insurance has been in force for 364 days or less, apply the short rate table for 364 Days insurance to the full 364 days premium determined as for insurance written for a term of 364 days.

B. If insurance has been in force for more than 364 days:
   1. Determine full 364 days premium as for insurance written for a term on 364 days.
   2. Deduct such premium from the full insurance premium, and on the remainder calculate the pro rata earned premium on the basis of the ratio of the length of time beyond 364 days the insurance has been in force to the length of time beyond 364 days for which the policy was originally written.
   3. Add premium produced in accordance with items (1) and (2) to obtain earned premium during full period insurance has been in force.

CERTIFICATE OF INSURANCE
DECLARATIONS

This Declaration is attached to and forms part of certificate provisions

ITEM 1. NAMED INSURED AND MAILING ADDRESS

Lifeboat
1434 Blume Drive
Elgin, IL 60124-8719

PRODUCING AGENT NAME AND MAILING ADDRESS

Kuffel, Eggert, Collimore & Company
1434 Blume Drive
Elgin, IL 60124-8719

ITEM 2. POLICY PERIOD FROM: 01/01/2012 TO: 12/31/2012 TERM: 364 days

[X] 12:01 A.M., North American Eastern Time

Insurance is effective with **CERTAIN UNDERWRITERS AT LLOYD'S, LONDON.** The Binding Authority Reference Number is **NA12SC01**

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS CERTIFICATE, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS CERTIFICATE.
THIS POLICY CONSISTS OF THE FOLLOWING COVERAGE PARTS FOR WHICH A PREMIUM IS INDICATED. THIS PREMIUM MAY BE SUBJECT TO ADJUSTMENT.

International Major Medical Coverage: A Coverage Period is 364 days in length.

$500 364 Days Coverage Period
Deductible

Single Age	364 Days Premium	Surplus Lines Tax	Stamping Fee	364 Days Charge Male	364 Days Premium	Surplus Lines Tax	Stamping Fee	364 Days Charge Female
14 days through 18	$915.69	2%	0%	$934	$915.69	2%	0%	$934
19 through 29	$1,800.00	2%	0%	$1,836	$2,045.10	2%	0%	$2,086
30 through 39	$2,094.12	2%	0%	$2,136	$2,380.39	2%	0%	$2,428
40 through 44	$2,398.04	2%	0%	$2,446	$2,715.69	2%	0%	$2,770
45 through 49	$2,643.14	2%	0%	$2,696	$2,990.20	2%	0%	$3,050
50 through 54	$3,237.25	2%	0%	$3,302	$3,419.61	2%	0%	$3,488
55 through 59	$3,972.55	2%	0%	$4,052	$3,972.55	2%	0%	$4,052
60 through 64	$5,660.78	2%	0%	$5,774	$5,343.14	2%	0%	$5,450
65 through 79	$10,239.22	2%	0%	$10,444	$8,892.16	2%	0%	$9,070
70	$12,066.67	2%	0%	$12,308	$10,464.71	2%	0%	$10,674
71	$12,656.86	2%	0%	$12,910	$10,923.53	2%	0%	$11,142
72	$13,229.41	2%	0%	$13,494	$11,433.33	2%	0%	$11,662
73	$13,819.61	2%	0%	$14,096	$11,943.14	2%	0%	$12,182
74	$14,472.55	2%	0%	$14,762	$12,494.12	2%	0%	$12,744
Dependent Child	$735.29	2%	0%	$750	$735.29	2%	0%	$750

$1,000 364 Days Deductible Single								
Age	364 Days Premium	Surplus Lines Tax	Stamping Fee	364 Days Charge Male	364 Days Premium	Surplus Lines Tax	Stamping Fee	364 Days Charge Female
14 days through 18	$470.59	2%	0%	$480	$470.59	2%	0%	$480
19 through 29	$873.53	2%	0%	$891	$993.14	2%	0%	$1,013
30 through 39	$1,014.71	2%	0%	$1,035	$1,152.94	2%	0%	$1,176
40 through 44	$1,161.76	2%	0%	$1,185	$1,314.71	2%	0%	$1,341
45 through 49	$1,279.41	2%	0%	$1,305	$1,446.08	2%	0%	$1,475
50 through 54	$1,566.67	2%	0%	$1,598	$1,651.96	2%	0%	$1,685
55 through 59	$1,920.59	2%	0%	$1,959	$1,920.59	2%	0%	$1,959
60 through 64	$2,731.37	2%	0%	$2,786	$2,578.43	2%	0%	$2,630
65 through 79	$4,935.29	2%	0%	$5,034	$4,288.24	2%	0%	$4,374
70	$5,813.73	2%	0%	$5,930	$5,044.12	2%	0%	$5,145
71	$6,099.02	2%	0%	$6,221	$5,264.71	2%	0%	$5,370
72	$6,373.53	2%	0%	$6,501	$5,509.80	2%	0%	$5,620
73	$6,657.84	2%	0%	$6,791	$5,753.92	2%	0%	$5,869
74	$6,971.57	2%	0%	$7,111	$6,020.59	2%	0%	$6,141
Dependent Child	$358.82	2%	0%	$366	$358.82	2%	0%	$366

$2,500 364 Days Deductible Single								
Age	364 Days Premium	Surplus Lines Tax	Stamping Fee	364 Days Charge Male	364 Days Premium	Surplus Lines Tax	Stamping Fee	364 Days Charge Female
14 days through 18	$439.22	2%	0%	$448	$439.22	2%	0%	$448
19 through 29	$764.71	2%	0%	$780	$867.65	2%	0%	$885
30 through 39	$887.25	2%	0%	$905	$1,008.82	2%	0%	$1,029
40 through 44	$1,014.71	2%	0%	$1,035	$1,147.06	2%	0%	$1,170
45 through 49	$1,116.67	2%	0%	$1,139	$1,239.22	2%	0%	$1,264
50 through 54	$1,363.73	2%	0%	$1,391	$1,441.18	2%	0%	$1,470
55 through 59	$1,674.51	2%	0%	$1,708	$1,674.51	2%	0%	$1,708
60 through 64	$2,381.37	2%	0%	$2,429	$2,250.00	2%	0%	$2,295
65 through 79	$4,299.02	2%	0%	$4,385	$3,819.61	2%	0%	$3,896
70	$5,062.75	2%	0%	$5,164	$4,392.16	2%	0%	$4,480
71	$5,311.76	2%	0%	$5,418	$4,584.31	2%	0%	$4,676
72	$5,550.00	2%	0%	$5,661	$4,799.02	2%	0%	$4,895
73	$5,798.04	2%	0%	$5,914	$5,010.78	2%	0%	$5,111
74	$6,071.57	2%	0%	$6,193	$5,241.18	2%	0%	$5,346
Dependent Child	$315.69	2%	0%	$322	$315.69	2%	0%	$322

$5,000 364 Days Deductible Single								
Age	364 Days Premium	Surplus Lines Tax	Stamping Fee	364 Days Charge Male	364 Days Premium	Surplus Lines Tax	Stamping Fee	364 Days Charge Female
14 days through 18	$435.29	2%	0%	$444.00	$435.29	2%	0%	$444
19 through 29	$632.35	2%	0%	$645.00	$716.67	2%	0%	$731
30 through 39	$733.33	2%	0%	$748.00	$833.33	2%	0%	$850
40 through 44	$836.27	2%	0%	$853.00	$946.08	2%	0%	$965
45 through 49	$919.61	2%	0%	$938.00	$1,042.16	2%	0%	$1,063
50 through 54	$1,123.53	2%	0%	$1,146.00	$1,186.27	2%	0%	$1,210
55 through 59	$1,376.47	2%	0%	$1,404.00	$1,376.47	2%	0%	$1,404
60 through 64	$1,916.67	2%	0%	$1,955.00	$1,808.82	2%	0%	$1,845
65 through 79	$3,454.90	2%	0%	$3,524.00	$3,000.98	2%	0%	$3,061
70	$4,067.65	2%	0%	$4,149.00	$3,529.41	2%	0%	$3,600
71	$4,265.69	2%	0%	$4,351.00	$3,684.31	2%	0%	$3,758
72	$4,458.82	2%	0%	$4,548.00	$3,853.92	2%	0%	$3,931
73	$4,655.88	2%	0%	$4,749.00	$4,027.45	2%	0%	$4,108
74	$4,875.49	2%	0%	$4,973.00	$4,210.78	2%	0%	$4,295
Dependent Child	$304.90	2%	0%	$311.00	$304.90	2%	0%	$311

Premium shown above, payable: **Mode**
One Payment per Coverage Period 1.00 / Two Installments per Coverage Period 0.55 /
Four Installments per Coverage Period 0.28 / Twelve Installments per Coverage Period 0.10

Surplus Lines Agent: James J. Krampen, Jr.
Surplus Lines Agent License #: 2845819 (DC)
Surplus Lines Agent Address: 303 Congressional Blvd.
Carmel, IN 46032

This certificate of Insurance is made and accepted subject to the foregoing stipulations and conditions together with such other provisions, agreement or conditions as may be endorsed or added here to.

Dated: 07/02/2012

By: _____
(Correspondent – James J. Krampen, Jr.)

Lifeboat 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 Seven Corners, 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(es) or self inflicted means, which is the direct cause of bodily Injury(ies) to an Insured Person(s).

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

The term **"Aggregate Limit of Indemnity"** shall mean the total limit of the Company's liability for all indemnities payable under the Accidental Death & Dismemberment Benefit with respect to all Class(es) of Insured Person(s) arising out of Injury(ies) sustained by two or more Insured Person(s) as the result of any one Accident.

If the total of such indemnity exceeds said Aggregate Limit, the Company shall not be liable to any one such Insured Person(s) for a greater proportion of such Insured Person(s)'s indemnity afforded by the Accidental Death & Dismemberment Benefit than their equal share as divided by the total of all indemnities afforded by this benefit to all such Insured Person(s).

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 Child(ren)) 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 Rider(s) and/or an increase to the Premium to an Insured Person(s), 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)'s Application and any endorsements, Exclusionary Rider(s) or amendments that will attach during the Insured Person(s)'s Period of Coverage.

The term **"Child(ren)"** shall mean the Primary Insured Person's natural child, step-child or a Child under the Insured Person(s)'s legal guardianship, but only if such Child(ren) 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(ren) does not include a foster Child(ren) 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(s) of the spinal column, neck, extremities or other joints other than for Treatment(s) of a fracture or Surgery(ies).

The term **"Class(es)"** shall mean a group of Insured Person(s) 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 is the responsibility of each Insured Person(s) and must be paid by each Insured Person(s), 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(s)"** shall mean either a visit or a session with a Physician(s) or Service Provider.

The term **"Convalescent"** shall mean Treatment(s), 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(ies) or Disease(s), 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, full-time supervision of a Physician(s) or Registered Nurse, c.) it maintains a complete medical record on each patient and has 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(s) is eligible for reimbursement from the Company or payment for the Treatment(s) 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)'s ID Card.

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

The term **"Covered Expense(s)"** shall mean expenses which are for Medically Necessary services, supplies, care, or Treatment(s); due to Illness(es) or Injury(ies), as described in the Certificate; prescribed, performed or ordered by a licensed Physician(s) and/or Service Provider; Reasonable and Customary charges; incurred by the Insured Person(s) 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(s) for an Illness(es) or Injury(ies). 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(s) and must be paid by each Insured Person(s), 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(s)"** shall mean any condition or Disease(s) listed in the most recent edition of the International Classification of Disease(s) or a condition accepted and recognized as a known Illness(es) or Injury(ies) 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(ren) from fourteen (14) days old until his/her nineteenth (19th) birthday; or the Primary Insured Person's unmarried Child(ren) who is at least nineteen (19) years old but under twenty-four (24) years old, is 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(ren) 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(es) or Injury(ies). 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(s); due to Illness(es) or Injury(ies); prescribed, performed or ordered by a licensed Physician(s) and/or Service Provider; Reasonable and Customary charges; incurred by the Insured Person(s) 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)'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)'s medical condition warrants immediate transportation from the place where the Insured Person(s) is Ill or Injured to the nearest adequate medical facility where medical Treatment(s) 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)'s medical condition warrants transportation with a qualified medical attendant to his/her current Home Country to obtain further medical Treatment(s) or to recover; or c) both a) and b) above.

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

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

1. the Treatment(s), drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. the Treatment(s), 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(s), in both the short and long term.
4. the Treatment(s), drug, device, procedure, supply or service is not generally accepted medical practice in the state or Country where the Insured Person(s) 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(s) with Physician(s), authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.
5. the Treatment(s), 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(s) or someone acting on their behalf may be required to sign.

The fact that a procedure, service, supply, Treatment(s), 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(s) 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; 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(s) by a Physician(s), 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 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(s). 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(s) to Sick or Injured persons for which a charge is made that the Insured Person(s) is legally obligated to pay in the absence of insurance 2.) provides such care and Treatment(s) 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 Physician(s). 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 Heath 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(s) of drug addicts or alcoholics.

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

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

The term **"Injury(ies)"** shall mean bodily Injury(ies) listed in the most recent edition of the International Classification of Disease(s) ICD-9-CM, which is the required reporting tool for all diagnoses and Disease(s) 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(s) 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(es)"** shall mean, in reference to quadriplegia, paraplegia, hemiplegia and uniplegia, 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 **"Manifest(ed)"** or **"Manifesting"** shall mean the demonstration of the presence of a sign, symptom, or alteration, especially one that is associated with a Disease(s) process.

The term **"Medically Necessary"** or **"Medical Necessity"** shall mean services, Treatment(s) or supplies received by the Insured Person(s) that are determined by the Company to be: 1.) appropriate and necessary for the symptoms, diagnosis, or direct care and Treatment(s) of the Insured Person(s)'s medical conditions; 2.) within the standards the organized medical community deems good medical practice for the Insured Person(s)'s condition; 3.) not provided solely for educational purposes or primarily for the convenience of the Insured Person(s), the Insured Person(s)'s Physician(s) 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(s).

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kinds of services the Insured Person(s) is receiving or the severity of the Insured Person(s)'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(s) may prescribe, order, recommend, or approve a service, Treatment(s), supply or level of care, does not of itself, make such Treatment(s) Medically Necessary or make the charge a Covered Expense(s) under this Certificate.

The term **"Medicine"** or **"Medications"** shall mean the drugs and/or anesthetics prescribed by a Physician(s) and dispensed to the Insured Person(s), by a licensed pharmacist, as a result of a Covered Expense(s). 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, Illness(es) 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 neurohomonal systems; and disorders, conditions, and Illness(es) 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 Disease(s) ICD-9-CM, which is the required reporting tool for all diagnoses and Disease(s) to all U.S. Public Health Service and Health Care Financing Administration programs on the date the medical care or Treatment(s) is rendered to an Insured Person(s).

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

The term **"Occupational Disease"** shall mean a Disease(s) arising out of employment that is caused by a hazard recognized as peculiar to a particular trade, process, occupation or employment as a direct result of continuous exposure to the normal working conditions of such employment. Occupational Disease is not a contagious Disease(s) resulting from exposure to fellow employees or from a hazard to which the workman would have been equally exposed outside of his employment. An Occupational Disease is also not ordinary Disease(s) of life to which the general public is equally exposed, unless such Disease(s) follows as a complication and a natural incident of an Occupational Disease or unless there is a constant exposure peculiar to the occupation itself that makes such Disease(s) a hazard inherent in such occupation.

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)'s office, for an Illness(es) or Injury(ies), but who is not confined and is not charged for room and board.

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

The term **"Permanent Residence"** shall mean the country where an Insured Person(s) 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(s)"** or **"Surgeon"** shall mean a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform Surgery(ies) 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(s) for the Treatment(s) of a specific Covered Event(s) 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(s) prior to the Individual Effective Date of Coverage under this Certificate; 2) A condition for which medical advice, diagnosis, care or Treatment(s), 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 Manifest(ed) 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 Rider(s) 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(s) 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(s) has been continuously insured for two (2) consecutive and continuous Coverage Periods (seven hundred and twenty-eight (728) days).

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 afforded in this Certificate, which applies to the Insured Person(s)'s age, gender, Deductible, maximum limit and any medical conditions of the Insured Person(s) 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 who may have Dependents, who are Insured Person(s).

The term **"Pre-Notification"** and **"Pre-Notify"** shall mean that the Insured Person(s) notifies the Administrator in advance of any Hospital admission worldwide or of any Outpatient Surgery(ies) or Eligible Benefits. The Pre-Notification process will be complete after the Insured Person receives Treatment(s) 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(ren), 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(s).

The term **"Repatriation"** shall mean transport to the Insured Person(s)'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 payer.

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(s), 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(es) or Disease(s) of any kind listed in the most recent edition of the International Classification of Disease(s) ICD-9-CM, which is the required reporting tool for all diagnoses and Disease(s) to all U.S. Public Health Service and Health Care Financing Administration programs.

The term **"Surgery(ies)"** or **"Surgical Procedure"** shall mean an invasive diagnostic procedure; or the Treatment(s) of Illness(es) or Injury(ies) by manual or instrumental operations performed by a Physician(s) 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(s) fails to meet the Eligibility Requirements described in SECTION 3, A; (3.) The date the Company cancels Coverage for a specific Class(es) of Insured Person(s), which the individual Insured Person(s) may be included.

The term **"Treatment(s)"** shall mean medical or surgical management of a patient designed to resolve the Illness(es) or Injury(ies) 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(s) 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(es) or Injury(ies) is incurred by the Insured Person(s), 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(s):	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 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 utilize the Pre-Notification Program, see Section 4, M. Pre-Notification Program. Each Insured Person(s) is responsible for the Coinsurance amount.
Eligible Benefits Incurred Inside the United States:	The Company pays 60% 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 utilize the Pre-Notification Program; see Section 4, J. Pre-Notification Program. Each Insured Person(s) is responsible for the Coinsurance amount

If the Insured Person(s) follows the Pre-Notification Program the maximum out of pocket expenses that an Insured Person(s) in the United States will be required to pay after satisfying their Individual Deductible is $2,000. 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 $6,000.

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 the following Benefits shall be as follows:

I.	Medical Benefit	$5,000,000 Lifetime each Insured Person(s)

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

II.	Mental and Nervous Benefit	$10,000 Coverage Period maximum after a 364-day 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.
III.	Chiropractic/Physiotherapy Benefit	$10,000 Lifetime benefit combined, limited to 12 visits per Coverage Period and $75 per visit. There is a 364-day waiting period for these benefits.
IV.	Dental Benefit (due to Accident only)	$500.00 per Coverage Period subject to a $50.00 per occurrence Deductible.

V.	Transplant Benefit	$1,000,000 Lifetime Maximum. To cover Bone Marrow, Liver, Heart, Pancreas, Heart/Lung, Kidney/Pancreas, Lung

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

VI.	Emergency Medical Evacuation Benefit	$50,000 per Coverage Period
VII.	Return of Mortal Remains Benefit	$20,000
VIII.	Emergency Medical Reunion Benefit	$10,000 per occurrence
IX.	Accidental Death and Dismemberment	
	24 Hour Accidental Death and Dismemberment	
	Insured and Spouse	$10,000 Principal Sum
	Dependent Child(ren)	$2,000 Principal Sum
	Common Carrier Accidental Death and Dismemberment	
	Insured and Spouse	$40,000 Principal Sum
	Dependent Child(ren)	$8,000 Principal Sum
X.	Amateur and Interscholastic Athletic Benefit	$25,000 Lifetime, subject to a $5,000 Coverage Period Deductible.

SECTION 3: INSURANCE PROVISIONS

A. Eligibility Requirements

For all Applicants / Insured Person(s): Primary and named Dependent Insured Person(s) must be at least 14 days old and have not yet reached their 75th birthday.

For US Citizens: Applicants/Insured Person(s) must reside outside the United States at least one hundred and eighty (180) days during any given three hundred and sixty-four (364) day Certificate Period to meet the Eligibility Requirements of an Insured Person(s). Should any Insured Person(s) reside in the United States longer than one hundred and eighty (180) days during any given three hundred and sixty-four (364) day Certificate Period, their Coverage shall immediately terminate.

For Non-US Citizens: Applicants/Insured Person(s) must reside outside the United States at least one hundred and eighty (180) days during any given three hundred and sixty-four (364) day Certificate Period to meet the Eligibility Requirements of an Insured Person(s). Should any Insured Person(s) reside in the United States longer than one hundred and eighty (180) days during any given three hundred and sixty-four (364) day Certificate period, their Coverage shall immediately terminate.

It is the Insured Person(s)'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 Person(s) 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(s) will automatically be converted to the Lifeboat Senior Provider upon the renewal date after their 75th birthday. This conversion is contingent upon the Insured Person(s) continuing to meet the Eligibility Requirements.

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 Coverag

rlier of the following: (1.) The end of the period for which Premium has been paid, (2.) to meet the Eligibility Requirements described in SECTION 3, A; (3.) The date the ecific Class(es) of Insured Person(s), which the individual Insured Person(s) may be

Coverage will terminate upon the ea
The date the Insured Person(s) fails
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SECTION 4: SCOPE OF COVERAGE

A. Description of Coverage

Benefits are payable under the Lifeboat Worldwide Plan for Covered Event(s) resulting in Eligible Benefits incurred by an Insured Person(s) during the Coverage Period. Eligible Benefits shall be payable to either the Insured Person(s) or the Service Provider for Eligible Benefits incurred by the Insured Person(s) worldwide. **For all Hospital admissions worldwide, or for any expenses incurred in the United States, the Insured Person(s) must utilize the Pre-Notification Program. Failure to utilize the Pre-Notification Program will result in a 50% reduction of the Eligible Benefits stated in the Schedule of Benefits.**

A charge incurred by an Insured Person(s) 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(ies) or Illness(es) 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(s). 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 Injury(ies) or Illness(es) existing simultaneously, which are due to the same or related causes shall be considered one Covered Event(s). If a Covered Event(s) is due to causes which are the same or related to the cause of a prior Covered Event(s) (including complications arising there from), the Covered Event(s) shall be considered a continuation of the prior Covered Event(s) and not a separate Covered Event(s).

When a covered Illness(es) or Injury(ies) is incurred by the Insured Person(s), 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(s), 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(s) of an Injury(ies) (Hospital admission is not required); Emergency Treatment(s) of an Illness(es); in order for emergency room charges to be considered Covered Expense(s), the Insured must be directly admitted to the Hospital as an Inpatient for Treatment(s) of that Illness(es);

2.) Charges made for Intensive Care or Coronary Care charges and Inpatient nursing services.

3.) Charges made for diagnosis, Treatment(s) and Surgery(ies) by a Physician(s); 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(s), same as any other Treatment(s) covered on an Inpatient basis. This includes ambulatory Surgical centers, Physician(s)' Outpatient visits/examinations, clinic care, and Surgical opinion Consultation(s).

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(s). 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(es) or Injury(ies) for which the Insured Person(s) 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. Physician(s)' services; and

f. services, supplies, and Treatment(s) deemed Medically Necessary and ordered by a licensed Physician(s);

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(s). 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(es) or Injury(ies) for which the Insured Person(s) 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. Physician(s)' services; and
f. services, supplies, and Treatment(s) deemed Medically Necessary and ordered by a licensed Physician(s);

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(s). Home Health Care must be recommended by a Physician(s) 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(es) or Injury(ies) for which the Insured Person(s) 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 Treatment(s) deemed Medically Necessary and ordered by a licensed Physician(s);

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(s) would otherwise be confined in a Hospital, shall be under the care of a duly qualified Physician(s) 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(s).

12.) Dressings, Medications, and Medicines that can only be obtained upon a written prescription of a Physician(s) 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(s). Such transportation shall be by licensed ground ambulance only, within the metropolitan area in which the Insured Person(s) is located at the time the service is used. If the Insured Person(s) is in a rural area, then licensed ground ambulance transportation to the nearest metropolitan area shall be considered a Covered Expense(s).

Only those expenses specifically described above, which are incurred from the onset of the Illness(es) or Injury(ies) and which are not excluded in the Exclusions, are considered Eligible Benefits. Initial Treatment(s) of an Illness(es) or Injury(ies) must occur within three hundred and sixty four (364) days of the onset of the Illness(es) or Injury(ies). Illness(es) or Injury(ies) must first Manifest(ed) itself during the Insured Person(s)'s Period of Coverage.

C. Mental and Nervous Benefits

When covered Mental and Nervous expenses are incurred by the Insured Person(s) 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(s) 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(s) by a Physician(s).

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(s).

v.) Medicines that can only be obtained upon a written prescription of a Physician(s) and dispensed by a licensed pharmacist.

b.) Outpatient Care:

i.) Charges made for diagnosis and Treatment(s) by a Physician(s).

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(s).

iv.) Medicines that can only be obtained upon a written prescription of a Physician(s) 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(ed) itself during the Insured Person(s)'s Period of Coverage.

D. Dental Benefit

When covered Dental expenses are incurred by the Insured Person(s) 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(s) must be completed within three hundred and sixty-four (364) days of the Accident.

E. Chiropractic / Physiotherapy

When covered Chiropractic / Physiotherapy expenses are incurred by the Insured Person(s) 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(s), which are prescribed, performed, or ordered by a licensed Physician(s) for the relief of pain, and which is not excluded in the Exclusions, shall be considered as Eligible Benefits. The Chiropractic condition must first Manifest(ed) itself during the Insured Person(s)'s Period of Coverage.

Physiotherapy must be recommended by a Physician(s) for the Treatment(s) of a specific Covered Event(s) and administered by a licensed physical therapist.

F. 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(es) or Injury(ies) commencing during the Insured Person(s)'s Period of Coverage results in the Medically Necessary Emergency Medical Evacuation or Repatriation of the Insured Person(s). 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)'s local attending Physician(s).

Emergency Medical Evacuation or Repatriation means: a) the Insured Person(s)'s medical condition warrants immediate transportation from the place where the Insured Person(s) is Ill or Injured to the nearest adequate medical facility where medical Treatment(s) 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)'s medical condition warrants transportation with a qualified medical attendant to his/her current Home Country to obtain further medical Treatment(s) 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(s), which are specifically enumerated in the following list, and which are not excluded in the Exclusions, shall be considered 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(s). 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(s). Transportation means any land, water or air conveyance required to transport the Insured Person(s). 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.

G. Return of Mortal Remains Benefit

The Return of Mortal Remains Benefit shall only apply when the Insured Person(s) is traveling outside of their current Home Country. The Company shall pay Eligible Benefits incurred up to the maximum stated in the Schedule of Benefits, if any covered Illness(es) or Injury(ies) commencing during the Insured Person(s)'s Period of Coverage results in Return of Mortal Remains of the Insured Person(s). The Company will pay the reasonable Eligible Benefits incurred to return the Insured Person(s)'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(s), which are specifically enumerated in the following list, and which are not excluded in the Exclusions, shall be considered 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.

H. Emergency Medical Reunion Benefit

The Emergency Medical Reunion Benefit shall only apply when the Insured Person(s) 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(s) is eligible for a covered Emergency Medical Evacuation or Repatriation under this Certificate and the Administrator representative, and the attending Physician(s) determine that Emergency Medical Evacuation or Repatriation is necessary and prudent for the Insured Person(s).

For the purpose of this section, only such expenses, incurred as the result of a Covered Event(s), 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(s), from the Insured Person(s)'s current Home Country to the location where the Insured Person(s) 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.

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

Table of Loss(es)

Description of Loss(es) (For Loss(es) of:)	Principal Sum
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 Person(s) per any one covered Accident shall be five times the Principal Sum not to exceed $200,000 per Accident.

The Company shall pay the Principal Sum from the Schedule of Benefits and the Table of Loss(es) above, if an Insured Person(s) sustains a Loss(es) stated therein resulting from Accidental Injury(ies), provided that: (a) such Loss(es) occurs within ninety (90) days after the date of Accident causing such Loss(es); and (b) the indemnity payable for any such Loss(es) shall be the Principal Sum stated in the Schedule of Benefits and Table of Loss(es) as applicable to such Insured Person(s) and this Insurance; and (c) if more than one Loss(es) stated in the Table of Loss(es) is sustained as the result of one Accident, only one of the amounts so stated in the Table of Loss(es), 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 Loss(es).

Exposure

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

Disappearance

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

Beneficiary Designation and Change

The beneficiary or beneficiaries of an Insured Person(s) shall be that person or those persons designated by the Insured Person(s) and filed with the Company. Any Insured Person(s) 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(s) 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(s) which shall apply only to Loss(es), as defined in SECTION 1: Definitions, sustained by such Insured Person(s) during the Period of Coverage. Eligible Benefits includes Loss(es) sustained during a trip while the Insured Person(s) 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(s) is riding in any civilian or military aircraft other than a expressly described above, unless previously consented to in writing by the Company.

J. Pre-Notification Program

The Pre-Notification Program requires that the Insured Person(s) (or someone on his behalf) obtain Pre-Notification by contacting the Administrator as soon as possible, but not less than forty-eight (48) hours prior to the date of a scheduled Hospital admission or within forty-eight (48) hours after an Emergency Hospital admission anywhere in the world.

Additionally, Outpatient services worldwide 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(s) utilize an approved Preferred Provider Organization (PPO) Service Provider for services and Treatment(s) received in the United States.

Pre-Notification requires the Insured Person(s) 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(s): 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(s) and the diagnosis and approximate number of days to be confined.

   The Administrator can be contacted at:
   - Toll Free within the United States and Canada 1-800-690-6295
   - Call Collect from outside the United States and Canada 01-317-818-2808
   - Fax 1-317-575-2256
   - E-mail: assist@sevencorners.com

2. **Utilize an approved PPO Service Provider within the United States**
   Services and Treatment(s) 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(s) is located. To obtain a list of approved PPO Service Providers contact the Administrator or visit the approved PPO Service Provider website at: www.sevencorners.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(s), 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(s) 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(s) or Service Provider at the time of admission or when the Treatment(s) and services were rendered, the Administrator may, upon review, Pre-Notify the expenses retroactively if justified.

K. 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(s) for diagnosis, Treatment(s), and Surgery(ies) 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 Schedule of Benefits section.
5. Medically Necessary transportation costs for travel related to a Covered Transplant Procedure for the transplant recipient and one companion during a Coverage Period. Eligible Benefits for transportation are subject to the amounts shown in the Schedule of Benefits 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 Schedule of Benefits section.

7. Reasonable and necessary lodging and meal expenses incurred by the recipient and the recipients companion(s), related to a Covered Transplant Procedure, during the Coverage Period. Eligible Benefits for lodging and meals are subject to the amounts shown in the Schedule of Benefits 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(s) 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 BENEFTS. 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(s), Medication, charges or the consequences thereof, related to the following Exclusions, unless specifically included or modified on the Schedule of Benefits numbers I through VIII and number X 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(ies) or Illness(es) which meets the following criteria: 1) A condition that would have caused a person to seek medical advice, diagnosis, care or Treatment(s) prior to the Individual Effective Date of Coverage under this Certificate; 2) A condition for which medical advice, diagnosis, care or Treatment(s), 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 Manifest(ed) prior to the Individual Effective Date of Coverage under this Certificate;
2. Exclusionary Rider(s) 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(s) 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(s) has been continuously insured for two (2) consecutive and continuous Coverage Periods (seven hundred and twenty-eight (728) days);
2. Charges for Treatment(s) of the following Illness(es) or Surgery(ies), which Manifest(ed) themselves or are recommended, or symptoms occur during the first one hundred and eighty (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(ies) that is not Emergency in nature, as Emergency is defined hereunder. Note: Coverage for such Illness(es) or Surgery(ies) may be further limited under the Pre-existing Condition exclusion and definition contained herein, or other exclusions contained herein;
3. Injury(ies) or Illness(es) 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(s), which is not Medically Necessary;
5. Services provided at no cost to the Insured Person(s);
6. Treatment(s), which exceed Reasonable and Customary charges;
7. Surgery(ies) or Treatment(s) which are Investigational, Experimental, or for Research purposes;
8. Services, supplies or Treatment(s), including any period of Hospital confinement, which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician(s);
9. Suicide or any attempt there at whether the Insured Person(s) 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(s) 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(s) 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 organization(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) Utilization of Chemical weapons of mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals.

    iv) Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (Disease(s) 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(es) 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(ies) sustained while participating in professional athletics
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(s) established by a prior call or attendance of a Physician(s); unless otherwise covered under this Certificate;
13. Treatment(s) 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(s) recommended or rendered by a Relative of the Insured Person(s) or any person who ordinarily resides with the Insured Person(s). This exclusion includes any Treatment(s) as the result of a referral to or by a Relative of the Insured Person(s) or any person who ordinarily resides with the insured, to another Physician(s);
16. Cosmetic or plastic Surgery(ies) and any related Hospital admission, except as the result of a covered Injury(ies). For the purposes of this Insurance, Treatment(s) of a deviated nasal septum shall be considered a cosmetic condition;
17. Treatment(s), 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(ies) incurred while insured hereunder;
19. Injury(ies) 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(s) prescribed and directed by a Physician(s) for a condition which is covered hereunder, but not for the Treatment(s) of drug addiction;
20. Telephone Consultation(s) or failure to keep a scheduled appointment;
21. Treatment(s) 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 therefrom; unless otherwise covered under this Certificate;
23. Services and supplies, which are non-medical in nature;

24. The Insured Person(s)'s unused airline ticket for the transportation back to the Insured Person(s)'s Home Country, where an Emergency Medical Evacuation or Repatriation and/or Return of Mortal Remains benefit is provided;
25. Intentionally self-inflicted Injury(ies) or Illness(es) whether the Insured Person(s) committing them is sane or insane;
26. Commission or attempt to commit a felony offense or from the Insured Person(s) being engaged in an illegal occupation or activity;
27. Injury(ies) 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(s) paid for or furnished under any other individual or group policy or other service or medical pre-payment plan arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for Treatment(s) without cost to any individual;
29. Injury(ies) for which benefits are payable under any no-fault automobile insurance policy;
30. Treatment(s) of venereal disease, sexually transmitted disease, or expenses for a sex change;
31. Routine Dental Treatment(s) and services for Dental care of the teeth or periodontium or the surrounding tissue or structure, except as the result of Injury(ies) to sound, natural teeth caused by Accident;
32. Pregnancy expenses, including Complications of Pregnancy;
33. Treatment(s), 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(s) for infertility or impotency, sterilization or reversal thereof, or abortion;
34. Treatment(s) 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(s) which is incurred by Insured Person(s) 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 Illness(es), ARC Syndrome, or AIDS;
37. Treatment(s) for the AIDS virus, AIDS related Illness(es), ARC Syndrome, AIDS, and/or any Illness(es) arising as complications from these conditions;
38. Treatment(s) for Chronic Fatigue Syndrome, including but not limited to diagnostic workups.
39. Service or Treatment(s) 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(ies) of any kind including but not limited to gastric bypass, gastric stapling or gastroplasty procedures whether or not in connection with morbid obesity. Additionally, procedures for removal of excess skin are considered cosmetic and are excluded from Coverage;
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(s) for Illness(es) or Injury(ies) resulting from or in the course of any employment for wage or profit by the Insured Person(s);
44. Treatment(s), services and supplies for flat feet, fallen arches, corns, bunions, callouses and care of toenails;
45. Treatment(s), services and supplies for Convalescent, Hospice and Home Health Care which exceed 30 days in duration for any one Incident;
46. Newborn Child(ren) who are not Approved by the Administrator;
47. Occupational Diseases, including but not limited to Disease(s) related to asbestos exposure, and the complications thereof, including asbestosis and mesothelioma related to asbestos exposure.

B. Accidental Death and Dismemberment Benefit Exclusions

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

1. Suicide, attempted suicide or intentionally self-inflicted Injury(ies) whether the Insured Person(s) committing them is sane or insane;
2. Disease(s) 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(ies) sustained while the Insured Person(s) 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(ies) sustained while the Insured Person(s) 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(s) 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(s) 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 organization(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) Utilization of Chemical weapons of mass destruction means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing incapacitating disablement or death amongst people or animals.

   iv) Utilization of Biological weapons of mass destruction means the emission, discharge, dispersal, release or escape of any pathogenic (Disease(s) 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(es) 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(s) or Surgeon;
11. Injury(ies) occasioned or occurring while the Insured Person(s) is committing or attempting to commit a felony or from the Insured Person(s) 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(ies) arising out of a Pre-Existing Condition. However, an Injury(ies) for which the Treatment(s) has not been rendered or Treatment(s) medically recommended for the past thirty consecutive months shall not be considered a Pre-Existing Condition unless otherwise specifically excluded.

SECTION 6: CERTIFICATE PROVISIONS

1. **Entire Contract; Changes:** The Certificate, including the, Application, Schedule of Benefits, Exclusionary Rider(s), 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(s) 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(s) and the Certificate Number on the ID Cards to identify the Insured Person(s) 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(s) 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(s). 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. The Company at its option may pend resolution and adjudication of submitted claims and/or deny coverage for Proof of Loss submitted thereafter, or for incomplete Proof of Loss and/or failure to submit Proof of Loss.

5. **Payment of Claims:** Subject to any written direction of the Insured Person(s) 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(ies) or Illness(es) 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 may, if not resolved by the parties, be referred to arbitration by either party pursuant to the commercial arbitration rules of the American Arbitration Association ("AAA"). Either party may make a demand for arbitration and such arbitration shall be conducted in Carmel, Indiana, and judgment on any award rendered in such arbitration may be entered in any state or federal court in Indiana. 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 303 Congressional Boulevard, Carmel, Indiana 46032 and on the Insured Person(s) at the most current address appearing in the records of the Company, with the same effect as if personally served in Carmel, Indiana.

   Arbitration shall be before a single arbitrator jointly selected by the parties hereto. If the parties are unable to agree on an arbitrator within thirty (30) days after the arbitration demand is filed, the AAA shall select the arbitrator. The arbitration filing fee, if any, and fees of the arbitrator shall initially be shared equally between the parties, provided however, that the prevailing party shall be reimbursed for these costs by the non-prevailing party at the conclusion of the arbitration proceeding. Each side shall bear their own legal fees and costs and any other fees associated with participating in the arbitration process. All fees and expenses of the arbitration shall be borne by the parties equally.

   The arbitrators are precluded from awarding punitive, treble or exemplary damages, however so denominated. If more than one insured is involved in the same dispute arising out of the same Policy and relating to the same Loss or claim, all such Insured(s) will constitute and act as one party for the purposes of the arbitration. Nothing in this clause will be construed to impair the rights of the Insured(s) to assert several, rather than joint, claims or defenses.

   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 the requirements of this Certificate. No such action shall be brought after expiration of three (3) years after the time that written Proof of Loss is required to be furnished.

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(s) 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 Event(s) resulting from Injury(ies) that are sustained after the date of reinstatement and those Covered Event(s) due to Illness(es) 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(s) fails to meet the Eligibility Requirements described in SECTION 3, A; (3.) The date the Company cancels Coverage for a specific Class(es) of Insured Person(s), which the individual Insured Person(s) 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(s) 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(s) 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(ren) 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(ren) to an Insured Person(s) shall not constitute valid Insurance under this contract for the Newborn Child(ren).

    The refusal or failure of the Insured Person(s)'s Relative, Employer, Insurance Company, Physician(s), 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(s) 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(s) as valid for underwriting or claim administration.

15. **Cancellation:** The Certificate is renewable at the end of each three hundred and sixty-four (364) day Coverage Period for the life of the Insured Person(s) or until the Termination Date of Individual Insurance. The Company may cancel an entire Class(es) of Insured Persons based upon claims experience in a certain region or within a gender/age category.

    NOTWITHSTANDING anything contained in this Insurance to the contrary, this Insurance may be cancelled by the Insured Person at any time by written notice or by surrendering of this Certificate of Insurance. This Insurance may also be cancelled by or on behalf of the Company by delivering to the Insured Person or by mailing to the Insured Person, by registered, certified or other first class mail, at the Insured Person's address as shown in this Insurance, written notice stating when, not less than ten (10) days thereafter, the cancellation shall be effective. The mailing of notice as aforesaid shall be sufficient proof of notice and this Insurance shall terminate at the date and hour specified in such notice.

    If this Insurance shall be cancelled by the Insured Person the Company shall retain the customary short rate proportion of the premium heron, except that if this insurance is on an adjustable basis the Company shall receive the Earned Premium hereon or the pro rata proportion of any Minimum Premium stipulated herein whichever is the greater.

    Payment or tender of any Unearned Premium by the Company shall not be a condition precedent to the effectiveness of Cancellation but such payment shall be made as soon as practicable.

If the period of limitation relating to the giving of notice is prohibited or made void by any law controlling the construction thereof, such period shall be deemed to be amended so s to be equal to the minimum period of limitation permitted by such law.

16. **Renewal of Individual Insurance:** The Certificate will be renewed every three hundred and sixty-four 9364) days subject to the provisions of the Certificate in force at the time of the renewal. The initial Period of Coverage cannot exceed 364 days. The Insured Person(s), however, may apply for renewal of Coverage. The renewal Period of Coverage may not total more 364 days. Renewal(s) will be contingent upon the Insured Person(s) submitting the applicable renewal Premiums for their Class(es), as determined by the Company. The Company can cancel an Insured Person(s), if the Insured Person(s) is included in a Class(es) that is canceled in its entirety by the Company or if the Insured Person(s)'s Coverage is Rescinded or Voided for misrepresentations. Additionally, the Company may make benefit modifications to the Certificate of an Insured Person(s), if the Insured Person(s) is included in a Class(es) 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(s), if the Insured Person(s) 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(s) 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(s), and shall be reimbursed there from. The Insured Person(s) 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(s) 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(s). The Insured Person(s) 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(s) 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(s).

The Insured Person(s) 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)'s right to pursue other forms of recovery.

If the Insured Person(s) 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(s) shall have the right to take such action in the name of the Insured Person(s) to recover that amount of benefits paid under the Certificate; provided, however, that any action taken without the consent of the Insured Person(s) shall be without prejudice to such Insured Person(s).

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)'s obligations hereunder to the Certificate are fully discharged, even though the Insured Person(s) does not receive full compensation or recovery for his/her Injury(ies), damages loss or debt. This right to subrogation pro tanto shall exist in all cases.

If an Insured Person(s) fails to comply with these requirements, the Insured Person(s) 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(s), 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)'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(ed) 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(ed) 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(s) 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(s) 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(s) to the Coverage under this Certificate.

25. **Patient Support:** To ensure that Medically Necessary services, supplies and Treatment(s) 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(s) 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(s) that a Patient Support Specialist will be assigned to the Insured Person(s) for that particular condition. From that point forward, the Company's Patient Support Specialist may make recommendations of alternative Treatment(s) 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(s) and the Company (and will result in the same or better care). The Insured Person(s) and the Insured Person(s)'s Physician(s) will have input in this evaluation. Should the recommendations be accepted by the Insured Person(s), the Insured Person(s) agrees to hold the Company harmless and the Company shall not be held liable or otherwise responsible for any Treatment(s), service, supply, procedure or care provided to the Insured Person(s) except for the payment of benefits under this Insurance. After the Insured Person(s) has been notified that the condition meets the Patient Support program requirements, the Company reserves the right to:
    a. Generate payment for Treatment(s), services, and/or supplies which are excluded under this Insurance that would be beneficial to the Insured Person(s) 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(s) followed the recommended Treatment(s) 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.

27. **Complaints:** Any initial inquiry or compliant should be addressed to the Administrator, as defined herein. If the Insured Person(s) is not satisfied with the manner in which an inquiry or complaint has been managed by the Administrator, the Insured Person(s) may request in writing to the Complaints & Advisory Department at Lloyd's to review the case without prejudice to your rights in law.

Complaints and Advisory Department of Lloyd's
1 Lime Street
London EC3M 7HA
United Kingdom

28. **Patient Protection and Affordable Care Act:** This insurance is not subject to, and does not provide certain insurance benefits required by the United States Patient Protection and Affordable Care Act ("PPACA"). The insurance benefits provided by this policy are stated in your policy documents and do not include any additional benefits required by the PPACA. The PPACA requires certain U.S. residents and citizens to obtain PPACA compliant insurance coverage. In certain circumstances penalties may be imposed on U.S. residents and citizens who do not maintain PPACA compliant insurance coverage. You should consult your attorney, insurance agent, or tax professional to determine if the PPACA's requirements are applicable to you.

29. **Coordination of Benefits:** The Company coordinates benefits with other payers when an Insured Person(s) is covered by two (2) or more health plans. Coordination of Benefits is the industry standard practice used to share the cost of care between two (2) or more carriers when an Insured Person(s) is covered by more than one (1) health benefit plan. Our Coordination of Benefits and Services provision is attached hereto as APPENDIX A.

30. SECTION 7: SENIOR PROVIDER

The following SECTION 2 shall replace in its entirety Section 2 contained previously in this Certificate and apply for Insured Person(s) who apply and are accepted for Coverage prior to their 65th birthday and remain continuously insured for ten (10) consecutive years under this program, the Insured Person(s) 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(s) continuing to meet the Eligibility Requirements.

SECTION 2: SCHEDULE OF BENEFITS

A. Deductible and Coinsurance

When a covered Illness(es) or Injury(ies) is incurred by the Insured Person(s), 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(s):	$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 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 utilize the Pre-Notification Program, see Section 4, M. Pre-Notification Program. Each Insured Person(s) is responsible for the Coinsurance amount.
Eligible Benefits Incurred Inside the United States:	The Company pays 60% 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 utilize the Pre-Notification Program; see Section 4, J. Pre-Notification Program. Each Insured Person(s) is responsible for the Coinsurance amount

If the Insured Person(s) follows Pre-Notification Program the maximum out of pocket expenses that an Insured Person(s) in the United States will be required to pay after satisfying their Individual Deductible is $2,000. 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 $6,000.

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 the following Benefits shall be as follows:

I.	Lifetime Maximum Benefit	$250,000 Lifetime each Insured Person(s)
	Sublimits	
	a. Hospital Room and Board, including miscellaneous	$950 per day, 30 day maximum
	b. Surgical Treatment(s) (Inpatient and Outpatient)	$2,500 per Coverage Period

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

II.	Mental and Nervous Benefit	$10,000 Coverage Period maximum after a three hundred and sixty-four (364) day 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.
III.	Chiropractic / Physiotherapy Benefit	$10,000 Lifetime benefit combined, limited to 12 visits per Coverage Period and $75 per visit. There is a three hundred and sixty-four (364) day waiting period for these benefits.
IV.	Dental Benefit (due to Accident only)	$500.00 per Coverage Period subject to a $50.00 per occurrence Deductible.
V.	Transplant Benefit	$50,000 Lifetime Maximum. To cover Bone Marrow, Liver, Heart, Pancreas, Heart/Lung, Kidney/Pancreas, Lung

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

VI.	Emergency Medical Evacuation Benefit	$50,000 per Coverage Period
VII.	Return of Mortal Remains Benefit	$20,000
VIII.	Emergency Medical Reunion Benefit	$10,000 per occurrence
IX.	Accidental Death and Dismemberment	
	24 Hour Accidental Death and Dismemberment	
	Insured and Spouse	$10,000 Principal Sum
	Dependent Child(ren)	$2,000 Principal Sum
	Common Carrier Accidental Death and Dismemberment	
	Insured and Spouse	$40,000 Principal Sum
	Dependent Child(ren)	$8,000 Principal Sum

Appendix A - COORDINATION OF BENEFITS AND SERVICES

Purpose of This Provision

An Insured Person(s) may be covered for health benefits or services by more than one plan. If he/she is, this provision allows the Company to coordinate what the Company pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Insured Person(s) is covered.

DEFINITIONS

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

Allowable Expense: The charge for any health care service, supply, or other item of expense for which the Insured Person(s) is liable when the health care service, supply, or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this Certificate is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

The Company will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

When this Certificate is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, the Company will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which an Insured Person(s) is covered by this Certificate and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other repayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the Insured Person(s) except when coverage is being continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for an Insured Person(s)'s health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exists:

a) The Plan has no order of benefit determination rules or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the Insured Person(s) use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by the Company, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If an Insured Person(s) is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple secondary plans are paid in relation to each other. The benefits of each Secondary plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

The Company considers each plan separately when coordinating payments.

The primary plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the primary plan.

A secondary plan takes into consideration the benefits provided by a primary plan when, according to the rules set forth below, the plan is the secondary plan. If there is more than one secondary plan, the order of benefit determination rules determine the order among the secondary plans. The secondary plan(s) will pay up to the remaining unpaid allowable expenses, but no secondary plan will pay more than it would have paid if it had been the primary plan. The method the secondary plan uses to determine the amount to pay is set forth below in the **Procedures to be Followed by the Secondary Plan to Calculate Benefits** section of this provision.

The secondary plan shall not reduce Allowable Expense for medically necessary and appropriate services and supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the Insured Person(s) as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the Insured Person(s) as a Dependent. The coverage as an employee, member, subscriber or retiree is the primary plan.

The benefits of the Plan that covers the Insured Person(s) as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the Insured Person(s) as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the Insured Person(s) as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the Insured Person(s) under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the parent for a shorter period of time.
c) Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parents was born.
d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

a) The benefits of the Plan of the parent with custody of the child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the primary plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

a) The basis on which the primary plan and the secondary plan pay benefits; and
b) Whether the provider who provides or arranges the services and supplies is in the network of either the primary plan or the secondary plan.

Benefits may be based on the Usual and Customary Charge (U&C), or some similar term. This means that the provider bills a charge and the Insured person(s) may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a Usual and Customary Charge is called a "U&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule or some similar term. This means that although a provider, called a network provider, bills a charge, the Insured person(s) may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Insured person(s) uses the services of a non-network provider, the plan will be treated as a U&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the health maintenance organization (HMO) pays the provider a fixed amount per Insured Person(s). The Insured Person(s) is liable only for the applicable deductible, coinsurance, or copayment. If the Insured person(s) uses the services of a non-network provider, the HMO will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies, and "HMO" refers to a health maintenance organization plan.

Primary Plan is U&C Plan and Secondary Plan is U&C Plan

The secondary plan shall pay the lesser of:

a) The difference between the amount of the billed charges and the amount paid by the primary plan; or

b) The amount the secondary plan would have paid if it had been the primary plan.

When the benefits of the secondary plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the primary plan and the secondary plan, the Allowable Expense shall be the fee schedule of the primary plan. The secondary plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the primary plan; or

b) The amount the secondary plan would have paid if it had been the primary plan.

The total amount the provider receives from the primary plan, the secondary plan and the Insured Person(s) shall not exceed the fee schedule of the primary plan. In no event shall the Insured Person(s) be responsible for any payment in excess of the copayment, coinsurance or deductible of the secondary plan.

Primary Plan is U&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the secondary plan, the secondary plan shall pay the lesser of:

a) The difference between the amount of the billed charges for the Allowable Charges and the amount paid by the primary plan; or

b) The amount the secondary plan would have paid if it had been the primary plan.

The Insured Person(s) shall only be liable for the copayment, deductible, or coinsurance under the secondary plan if the Insured Person(s) has no liability for copayment, deductible or coinsurance under the primary plan and the total payments by both the primary and secondary plans are less than the provider's billed charges. In no event shall the Insured Person(s) be responsible for any payment in excess of the copayment, coinsurance or deductible of the secondary plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is U&C Plan

If the provider is a network provider in the primary plan, the Allowable Expense considered by the secondary plan shall be the fee schedule of the primary plan. The secondary plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the primary plan; or

b) The amount the secondary plan would have paid if it had been the primary plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is U&C Plan or Fee Schedule Plan

If the primary plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured Person(s) receives from a non-network provider is not considered as urgent care or emergency care, the secondary plan shall pay benefits as if it were the primary plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or U&C Plan

If the Insured Person(s) receives services or supplies from a provider who is in the network of both the primary plan and the secondary plan, the secondary plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the primary plan; or

b) The amount the secondary plan would have paid if it had been the primary plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or U&C Plan and Secondary Plan is Capitation Plan

If the Insured Person(s) receives services or supplies from a provider who is in the network of the secondary plan, the secondary plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the primary plan. The Insured Person(s) shall not be liable to pay any deductible, coinsurance or copayments of either the primary plan or the secondary plan.

Primary Plan is an HMO and Secondary Plan is an HMO

If the primary plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured Person(s) receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the secondary plan, the secondary plan shall pay benefits as if it were the primary plan.

SEVERABILITY OF INTEREST CLAUSE

This Policy shall operate in all respects as if a separate Policy had been issued to each party insured hereunder, except that in no event shall the total liability of the Insurers in respect of all parties insured hereunder exceed the Limit of Indemnity stated in this Policy. - **LSW1001**

LLOYD'S PRIVACY POLICY STATEMENT

UNDERWRITERS AT LLOYD'S, LONDON

The Certain Underwriters at Lloyd's, London want you to know how we protect the confidentiality of your non-public personal information. We want you to know how and why we use and disclose the information that we have about you. The following describes our policies and practices for securing the privacy of our current and former customers.

INFORMATION WE COLLECT

The non-public personal information that we collect about you includes, but is not limited to:
Information contained in applications or other forms that you submit to us, such as name, address, and social security number
Information about your transactions with our affiliates or other third-parties, such as balances and payment history
c) Information we receive from a consumer-reporting agency, such as credit-worthiness or credit history

INFORMATION WE DISCLOSE

We disclose the information that we have when it is necessary to provide our products and services. We may also disclose information when the law requires or permits us to do so,

CONFIDENTIALITY AND SECURITY

Only our employees and others who need the information to service your account have access to your personal information. We have measures in place to secure our paper files and computer systems.

RIGHT TO ACCESS OR CORRECT YOUR PERSONAL INFORMATION

You have a right to request access to or correction of your personal information that is in our possession.

CONTACTING US

If you have any questions about this privacy notice or would like to learn more about how we protect your privacy, please contact the agent or broker who handled this insurance. We can provide a more detailed statement of our privacy practices upon request. - **LSW1135b**

LLOYD'S

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