

UnitedHealthcare Inpat Health U.S.A. Standard Certificate of Insurance



IMPORTANT NOTICE REGARDING AFFORDABLE CARE ACT (ACA):

This insurance is intended only for Insured Persons who are Expatriates (see definition below) residing outside their Home Country (see definition below). By applying for and enrolling in this insurance, the Insured Person acknowledges and agrees that they meet the definition of an Expatriate who is residing outside their Home Country. This insurance is not subject to and does not provide minimum essential coverage as defined under the Affordable Care Act ("ACA") or under any similar state law. Individuals who are subject to such laws may be required to obtain separate health insurance coverage that complies with applicable requirements, and taxes, penalties, or other assessments may apply for failure to do so.

Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including ACA. Please note that it is solely the Insured Person's responsibility to determine if any insurance coverage requirements apply to them, and the Company and its Administrator shall have no liability whatsoever, including for any penalties that the Insured Person may incur, for their failure to obtain coverage required by any applicable law, including without limitation ACA.

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SAMPLE
For Inquiry Purposes Only

BENEFIT SUMMARY

Coverage Limit / Maximum Amount for Eligible Medical Expenses		
Period of Coverage	Maximum: 12 months	
Area of Coverage	Worldwide Coverage is limited to 180 aggregate days per Period of Coverage in the Insured Person's Home Country.	
Lifetime Maximum	\$500,000	
Benefit Plan Features		
United States: 50 states and the District of Columbia International: United States territories and countries other than the United States	United States	International
	In-Network	International
Within the United States, this plan provides benefits for Eligible Medical Expenses from In-Network providers only except for Emergency Treatment. Emergency Treatment from a United States Out-of-Network provider will be treated as In-Network.		
Deductible / Out of Pocket Maximum for Eligible Medical Expenses		
Deductible options - Per Insured Person - Per Period of Coverage - Refer to Declaration for Deductible amount	\$5,000, \$7,500, \$10,000, or \$12,000	\$5,000, \$7,500, \$10,000, or \$12,000
Coinsurance for Eligible Medical Expenses		
Coinsurance - In addition to Deductible - Per Period of Coverage - Per Insured Person	Plan pays 80% Insured pays 20%	Plan pays 100% Insured pays 0%
Insured Person's Out-of-Pocket Maximum	\$10,000	\$0
Pre-certification		
- Transplants: No coverage if Pre-certification requirements are not met. - All other Treatments & supplies: 50% reduction of Eligible Medical Expenses if Pre-certification requirements are not met. - Deductible is taken after reduction where a Deductible is applicable. - Coinsurance is applied to remainder of the reduced amount where Coinsurance is applicable. - Refer to PRE-CERTIFICATION REQUIREMENTS provision for a complete list of services that require Pre-certification.		
Inpatient or Outpatient Services		
Subject to either a Deductible or Copayment Coverage only available for In-Network providers within the United States except for Emergency Treatment		
Benefit	United States In-Network	International
Outpatient Primary Care Physician	Copayment: \$25	Subject to Deductible and Coinsurance
Outpatient Specialty Physician Visit	Copayment: \$50	Subject to Deductible and Coinsurance
Teladoc Consultation	- Not subject to Deductible and Coinsurance - Applicable in the United States - Coverage for a Teladoc Consultation is not a determination that any specific condition discussed, raised or identified during such consultation is covered under this insurance. The Company reserves the right to decline future claims relating to or arising from any condition discussed, raised or identified during a Teladoc Consultation where the Illness or Injury is otherwise excluded under this Certificate of Insurance	

Inpatient or Outpatient Services Subject to either a Deductible or Copayment Coverage only available for In-Network providers within the United States except for Emergency Treatment		
Benefit	United States In-Network	International
Urgent Care Clinic Visit	Copayment: \$75	Subject to Deductible and Coinsurance
Convenience Clinic Visit	Copayment: \$50	Subject to Deductible and Coinsurance
Hospital Emergency Room: Injury	Subject to Deductible and Coinsurance	
Hospital Emergency Room: Illness	Subject to Deductible and Coinsurance United States: \$500 additional Deductible for each visit that does not result in a direct Hospital admission	
Eligible Medical Expenses	Subject to Deductible and Coinsurance	
Inpatient Physician Visits / Services	Subject to Deductible and Coinsurance	
Hospitalization / Room & Board - Average private room rate - Includes nursing, miscellaneous and Ancillary Services	Subject to Deductible and Coinsurance	
Intensive Care Includes nursing, miscellaneous and Ancillary Services	Subject to Deductible and Coinsurance	
Outpatient Surgical / Hospital Facility	Subject to Deductible and Coinsurance	
Laboratory	Subject to Deductible and Coinsurance	
Radiology / X-ray	Subject to Deductible and Coinsurance	
PET, CT scans, MRI, Echocardiography, and Endoscopic procedures (including Gastroscopy, Colonoscopy, Cystoscopy) - Maximum per visit: \$600 - Maximum per visit includes facility and professional services	Subject to Deductible and Coinsurance	
Chemotherapy / Radiation Therapy	Subject to Deductible and Coinsurance	
Pre-admission Testing	Subject to Deductible and Coinsurance	
Surgery	Subject to Deductible and Coinsurance	
Reconstructive Surgery Surgery is incidental to and follows Surgery that was covered under the plan	Subject to Deductible and Coinsurance	
Assistant Surgeon 20% of the primary surgeon's eligible fee	Subject to Deductible and Coinsurance	
Anesthesia	Subject to Deductible and Coinsurance	
Inpatient Prescription Drugs and Medication Orders - Orphan and Biologic Drugs: \$250,000 Lifetime Maximum - All other medications: Up to the plan Lifetime Maximum	Subject to Deductible and Coinsurance	
Outpatient Prescription Drugs - Maximum per Period of Coverage: \$5,000 - Dispensing maximum for retail pharmacy: 90 days per prescription	Subject to Deductible and Coinsurance	

Inpatient or Outpatient Services Subject to either a Deductible or Copayment Coverage only available for In-Network providers within the United States except for Emergency Treatment		
Benefit	United States In-Network	International
Durable Medical Equipment	Subject to Deductible and Coinsurance	
Physical Therapy Available for 90 days following Hospitalization or Outpatient Surgery	Maximum per visit: up to \$40 Maximum visits per Diagnosis: 10	
Extended Care Facility Upon direct transfer from an acute care Facility where Hospitalization was for a covered Injury or Illness	Subject to Deductible and Coinsurance	
Hospice - Maximum: 180 days - Terminally ill – 6 months to live - Inpatient Hospice Facility - Insured Person's home	Subject to Deductible and Coinsurance	
Transplant - Transplant Limit: 1 per life of the policy - Lifetime Maximum: \$250,000 - For coverage in the United States -must be obtained within UnitedHealth Care's Centers of Excellence (COE) - For coverage Internationally – must be Pre-certified and approved in advance by the Company - Lifetime Maximum: \$100,000 - For Transplants NOT obtained within UnitedHealth Care's Centers of Excellence (COE) but in the United Choice Plus network - Organ procurement & harvesting costs: \$10,000 (included in the Transplant Lifetime Maximum) - Travel & lodging: \$5,000 (included in the Transplant Lifetime Maximum) - Covered Transplants: heart, heart/lung, lung, kidney, kidney/pancreas, liver, allogeneic or autologous bone marrow	Subject to Deductible and Coinsurance	
Emergency Local Ambulance - Maximum per Injury or Illness: \$1,500 - Injury or Illness resulting in Hospital confinement as an Inpatient	Subject to Deductible and Coinsurance	
Interfacility Ambulance Transfer - Maximum per Injury or Illness: \$1,500 - United States only	Subject to Deductible and Coinsurance	Not Applicable
Traumatic Dental Injury - Maximum per Period of Coverage: \$1,000 - Treatment at a Hospital Facility due to an Accident	Subject to Deductible and Coinsurance	

- A. BENEFIT SUMMARY:** Subject to the Terms of this insurance and the insurance plan shown in the Declaration, the insurance plan is available to the Insured Person and offers benefits and coverage arising out of Injury or Illness incurred while the insurance plan shown in the Declaration is in effect and subject to the AGREEMENT provision.
- B. AGREEMENT:** SiriusPoint Specialty Insurance Corporation (the Company) promises and agrees to provide the Insured Person with the benefits described in the Master Policy, as outlined herein and coverage for which is certified hereunder by the Company. The Company makes this promise and agreement in consideration of the Assured's Application, the accuracy and truthfulness of the Insured Person's Application and payment of Premium, and subject to all of the Terms of the Master Policy, Declaration and any Riders. The Master Policy is effective as of October 1, 2026 and shall remain in effect until terminated in accordance with the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF MASTER POLICY provision. This Certificate shall be effective as of the Effective Date of Coverage and shall remain in effect until terminated in accordance with the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF COVERAGE FOR INSURED PERSONS provision. This Certificate is not part of the insurance contract. The contract is the Master Policy, the Application, the Declaration (such insurance being sometimes referred to herein as "this insurance" or "the plan") and any applicable Riders. This Certificate is merely a description of and evidence of the Insured Person's rights and benefits under the contract. The Declaration likewise is evidence of the coverage under the contract and a statement of the Effective Date of Coverage, subject always to the Terms of coverage contained within the contract. The Company hereby recognizes International Medical Group®, Inc., as the Company's authorized representative and as the Plan Administrator of the Master Policy and this Certificate. Subject to the Terms of the CONDITIONS AND GENERAL PROVISIONS, SERVICE OF SUIT; VENUE; CHOICE OF LAW provision, all communications, notices and payments to the Company that are required or permitted under the Master Policy and/or as described in this Certificate shall be transmitted through the Plan Administrator, and receipt of same by the Plan Administrator shall be considered receipt by the Company. **SURPLUS LINES NOTICE:** This insurance is issued pursuant to applicable surplus lines law. Persons insured by surplus lines carriers do not have the protection of state Insurance Guaranty laws to the extent of any right of recovery for the obligation of an insolvent unlicensed insurer.
- C. CONDITIONS AND GENERAL PROVISIONS:** The following Terms are conditions precedent to the Company's liability under the insurance provided to the Insured Person pursuant to and in accordance with the Terms of this insurance:
- (1) **ENTIRE AGREEMENT:** The Master Policy, the Application, the Declaration and any Riders shall constitute the entire agreement among the Company, the Assured, and the Insured Person. This Certificate, the Application, the Declaration, and any Riders are an outline and evidence of the insurance provided by the Master Policy. This Certificate does not extend or change the coverage provided by the Master Policy. The insurance evidenced by this Certificate is subject to all Terms of the Master Policy, the Application, the Declaration, and any Riders.
- (2) **PREMIUM:** Payment of required Premium shall be remitted to the Company:
- (a) on or before the Due Date(s) specified on the Declaration
 - (b) on or before any renewal date subject to the CONDITIONS AND GENERAL PROVISIONS, RENEWAL; AMENDMENTS provision
 - (c) prior to any reinstatement under the CONDITIONS AND GENERAL PROVISIONS, REINSTATEMENT OF COVERAGE FOR INSURED PERSONS provision.

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

- (3) **CLAIMS NOTIFICATION:** All claims and related claim information should be filed with the Company through the Plan Administrator via the MyIMG customer portal at www.imglobal.com/member within the timely filing requirements outlined below. Alternatively, claims can be filed at the contact information below:

International Medical Group, Inc.

Attn: Claims Department

PO Box 240429

Apple Valley, MN 55124

USA

Proof of Claim: When the Insured Person receives Treatment or the Company receives notice of a claim for benefits under this insurance, the Insured Person shall submit an IMG Claim Form as a necessary component of the Proof of Claim. An IMG Claim Form may be completed online via the MyIMG customer portal at www.imglobal.com/member or obtained by contacting the Company.

- (a) A Proof of Claim shall not be effective and will not satisfy the Terms of this insurance unless it includes all the following:

- (i) a duly completed, timely submitted and signed IMG Claim Form for each new Illness, diagnosis or Injury unless the Company waives such requirement in writing
- (ii) an Authorization for Release of Medical Information when specifically requested by IMG
- (iii) all original Universal Billing Forms, Superbill and statements of service rendered from Physicians, Hospitals, and other healthcare or medical service providers involved with respect to the claim
- (iv) all original receipts for any costs, prescription medications, fees or expenses that have been incurred or paid by, or on behalf of, the Insured Person with respect to the claims, including without limitation all original receipts for any cash and/or credit card payments. The provider of service's full name, address, telephone number (including area/country code), date of service, description of service (applicable procedure codes), and diagnosis codes must be included on the receipts.

If the claims are submitted online, digital copies of the above items are acceptable; however, the Company reserves the right to request the original documents.

- (b) **TIMELY FILING REQUIREMENTS:** The Insured Person and/or Physician, Hospital and other healthcare and medical service providers and suppliers shall have one hundred eighty (180) days from the date a claim is incurred to submit a complete Proof of Claim. The Company at its option may pend resolution and adjudication of submitted claims and/or may deny coverage due to either of the following:
 - (i) IMG's Receipt of an incomplete Proof of Claim
 - (ii) failure to submit any Proof of Claim
 - (iii) Insured Person's, Physician's or Hospital's failure to submit a timely Proof of Claim
- (c) The Company may require the Insured Person to sign an Authorization for Release of Medical Information to request medical records on their behalf or supply us with additional documentation if we are unable to make a benefit determination based on the submitted Proof of Claim. The Insured Person and/or Physician, Hospital and other healthcare and medical service providers and suppliers shall have sixty (60) days from the date of the request to submit the requested information. If the information is not received within the designated time period, previously submitted and subsequent claims will be denied.
- (d) **SECONDARY INSURANCE:** When IMG is the secondary payer to all other insurance, the Insured Person must notify the Company within one hundred eighty (180) days of submitting a claim with the primary payer. To claim for costs left uncovered by the primary coverage, the Insured Person must submit to the Company within three hundred sixty (360) days of the initial date of service previously submitted to the primary payer and provide the following information to IMG:
 - (i) all original receipts for any costs, prescription medications, fees or expenses that were submitted to the primary payer
 - (ii) a copy of the Explanation of Benefits (EOB) from primary payer
 - (iii) a completed Proof of Claim
 - (iv) any additional information to substantiate the claim

- (4) **APPEALING A CLAIM:** In the event the Company denies all or part of a claim, the Insured Person shall have ninety (90) days from the date that the notice of denial was mailed to the Insured Person's last known residence or mailing address within which to appeal the determination. The Insured Person must file an appeal prior to bringing any legal action under the contract of insurance. The Insured Person should submit a written request for an appeal along with comments, all relevant, pertinent or related documents, medical records, and other information relating to the claim.

The appeal must be sent to:

International Medical Group

Attn: Benefit Review

PO Box 240429

Apple Valley, MN 55124

USA

The Company's review will take into account all comments, documents, records, and other information submitted by the Insured Person relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. Upon receipt of a written appeal, the Company shall have an opportunity for further reasonable investigation and/or review as set forth in the CONDITIONS AND GENERAL PROVISIONS, EXPLANATION OR VERIFICATION OF BENEFITS provision, and will respond in writing as soon as reasonably practicable, and in any event within ninety (90) days from receipt thereof.

- (5) **ASSIGNMENT, CHANGE OR WAIVER:** Notwithstanding any law, statute, judicial decision, or rule to the contrary which may be or may purport to be otherwise applicable within the jurisdiction, locale or forum state of any healthcare or medical

service provider, no transfer or assignment of any of the Insured Person's rights, benefits or interests under this insurance shall be valid, binding on or enforceable against the Company or Plan Administrator unless first expressly agreed and consented to in writing by the Company. Any such purported transfer or assignment not in compliance with the foregoing Terms shall be void *ab initio* and without effect as against the Company or Plan Administrator, and the Company shall have no liability of any kind under this insurance to any such purported transferee or assignee with respect thereto. The Terms of the Master Policy as evidenced by this Certificate shall not be waived or modified except by the express written agreement of the Company.

- (6) **SERVICE OF SUIT; VENUE; CHOICE OF LAW:** No action or proceeding of any kind can be brought by an Insured Person to recover on the contract of insurance prior to the later of (a) expiration of sixty (60) days after written Proof of Claim has been furnished in accordance with the contract of insurance or (b) exhaustion of one (1) appeal under the CONDITIONS AND GENERAL PROVISIONS, APPEALING A CLAIM provision above. No action or proceeding can be brought after the expiration of three (3) years after the time written Proof of Claim is required to be furnished under the contract of insurance. The contract of insurance between the Insured Person and the Company, as evidenced by the Master Policy and this Certificate, shall be deemed issued, finalized and made in Indianapolis, Indiana. Sole and exclusive jurisdiction and venue for any action or proceeding of any kind relating to or arising from this insurance and/or the Terms and conditions of this Certificate (including any amendment thereto) shall be in Marion County, Indiana, for which the Company and the Insured Person expressly consent. The subjects, risks and benefits of insurance covered by the Master Policy and evidenced by this Certificate are not intended or considered by the Insured Person or the Company (or the Plan Administrator) to be resident, located, or performed in any particular State of the United States. Indiana surplus lines law shall govern all rights and claims relating to or arising from this insurance and/or this Certificate (including any amendment thereto).

In the event of the failure of the Company to provide benefits or pay or reimburse any amount claimed to be due under this insurance, the Company, at the request of the Insured Person and upon receipt of lawful process or summons, will submit to the jurisdiction of a court of competent subject matter jurisdiction located in Marion County, Indiana, provided there exists an independent statutory and constitutional basis for in *personam* jurisdiction over the Company in said court and by said forum State. The Company and the Insured Person consent to personal jurisdiction and venue in the Circuit and/or Superior Courts of Marion County, Indiana, and in the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful). The Company reserves the right, acting by and through the Plan Administrator or otherwise, to initiate and pursue actions for declaratory judgment and/or other appropriate relief with respect to the validity, binding effect, administration of and/or any dispute, claim, or controversy relating to or arising from this insurance. In any suit instituted by or against the Company or the Insured Person pursuant to the Terms of this provision, the Company and the Insured Person will abide by the final decision of such Indiana court or of any appellate court in the event of an appeal. Nothing in this provision constitutes or should be deemed, considered or understood to constitute a waiver of the Company's or the Insured Person's rights to: (i) oppose venue or jurisdiction in any forum other than the Circuit or Superior Courts of Marion County, Indiana, or the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful), or (ii) remove an action to the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise lawful and appropriate); all of which rights are expressly reserved and retained.

Subject to and without limiting, expanding, superseding, modifying or waiving any of the foregoing Terms contained in this provision pursuant to any statute of any State, territory or district of the United States which makes provision thereof, the Company hereby designates the Superintendent, Commissioner, or Director of Insurance (or such other officer specified for that purpose in the statute), or their successor or successors in office, as its true and lawful attorney, under a special power of attorney, upon whom may be served any lawful process issued in connection with the initiation of any action, suit or proceeding instituted by or on behalf of the Insured Person arising out of this insurance, including specifically the Commissioner of Insurance for the Indiana Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, IN 46204, and hereby designates and appoints John N. Emmanuel, Locke Lord, LLP, Brookfield Place, 200 Vesey Street, 20th Floor, New York, New York 10281-2101, as its attorney-in-fact and agent for service of process to whom said officer or Commissioner is authorized to mail or serve any such process or a true copy thereof.

In the event that the Company is the prevailing party in any litigation, arbitration, or other proceeding of any kind relating to or arising from this insurance and/or the Terms and conditions of this Certificate (including any amendment thereto), regardless of the nature of the claim, the Company shall be awarded its reasonable attorney fees, and costs and expenses incurred in addition to any compensatory damages or other remedies in law or equity.

For Florida residents only: Any dispute, claim, or controversy of any kind, whether sounding in contract, tort, or otherwise, relating to or arising from this insurance and/or the Terms and conditions of this Certificate may be resolved by binding arbitration upon the request of the Company, the Assured, or the Insured Person. Any such arbitration shall be conducted in accordance with the procedures of the American Arbitration Association. Any such arbitration shall be held within fifty (50) miles of the Insured Person's residence, with the Company to pay costs and fees (not including any attorney fees) of the proceeding in excess of five hundred dollars (\$500.00).

- (7) **WAIVER OF ANY RIGHT TO JURY TRIAL:** THE COMPANY AND THE INSURED PERSON EACH KNOWINGLY, VOLUNTARILY, AND IRREVOCABLY WAIVE ANY RIGHT TO A TRIAL BY JURY FOR ANY CLAIM, DEMAND, ACTION, OR PROCEEDING OF ANY KIND, WHETHER SOUNDING IN CONTRACT, TORT, OR OTHERWISE, RELATING TO OR ARISING FROM: (I) THIS INSURANCE; AND/OR (II) THIS CERTIFICATE, INCLUDING ANY AMENDMENT THERETO. THE COMPANY AND THE INSURED PERSON EACH KNOWINGLY, VOLUNTARILY AND IRREVOCABLY AGREE THAT ANY SUCH CLAIM, DEMAND, ACTION, OR PROCEEDING SHALL BE EXCLUSIVELY PRESENTED TO AND DETERMINED SOLELY BY THE COURT AS THE TRIER OF FACT, AND NOT BEFORE A JURY. NO ATTEMPT SHALL

BE MADE TO CONSOLIDATE, BY COUNTERCLAIM OR OTHERWISE, ANY ACTION OR PROCEEDING WITH ANY OTHER ACTION OR PROCEEDING IN WHICH THERE IS A TRIAL BY JURY OR IN WHICH A JURY TRIAL CANNOT OR HAS NOT BEEN WAIVED. THE COMPANY AND THE INSURED PERSON EACH AGREE THAT A COPY OF THIS PROVISION MAY BE FILED WITH ANY COURT AS WRITTEN EVIDENCE OF THE AGREEMENT OF THE WAIVER OF ANY RIGHT TO TRIAL BY JURY.

- (8) **ECONOMIC SANCTIONS:** The Company will not cover any person as an Insured Person if such cover would result in the Company being exposed to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws, or regulations of the European Union, United Kingdom or the United States of America.
- (9) **MISREPRESENTATION:** Any false representation, incomplete information, misleading statement, misstatement, omission, concealment or fraud, whether or not innocently made, either in the Insured Person's Application or in relation to any claim form, statement, certification or warranty made by the Insured Person or their representatives, agents or proxies, whether in writing or otherwise, to the Company or the Plan Administrator or their respective agents, employees or representatives, or in connection with the making of any claim under this insurance, shall render the Declaration and this Certificate null and void and all claims and benefits under this insurance shall be forfeited and waived.
- (10) **INSOLVENCY:** The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors or dissolution of the Assured or any Insured Person shall not impose upon the Company any liability or obligation other than that specifically included in this insurance.
- (11) **SUBROGATION CLAUSE:** The Insured Person shall undertake to pursue in their own name and stead, and to fully cooperate with the Company in the pursuit and prosecution of, any and all valid claims that the Insured Person may have against any third party who may be liable or responsible for any loss or damage arising out of any act, omission or occurrence which results or may result in a loss payment, provision of benefits, or coverage of claim by the Company under this insurance, and to fully account to the Company for any amounts recovered or recoverable in connection therewith, on the basis that the Company shall be reimbursed and entitled to recover first in full for any sums paid or to be paid by it before the Insured Person shares in any amount so recovered, regardless of whether or not the Insured Person has been made whole or has been fully compensated for their injuries.

The Insured Person further agrees and understands that the Company requires the Insured Person to complete a subrogation questionnaire, sign an acknowledgment of the Company's subrogation rights and sign an agreement before the Company considers paying, or continues to pay, any claims. Should the Insured Person fail to so cooperate, account, or to prosecute any valid claims against any such third party or parties, and the Company thereupon or otherwise becomes liable or otherwise obligated to make payment under the Terms of this insurance, then the Company shall be fully subrogated to all rights and interests of the Insured Person with respect thereto and may prosecute such claims in its own name as subrogee.

The Insured Person's submission of Proof of Claim or acceptance of coverage or benefits under this insurance shall be deemed to constitute an authorization, consent and assignment of such subrogation rights by the Insured Person to the Company. The Insured Person agrees the Company has a secured proprietary interest in any settlement proceeds the Insured Person receives or may be entitled to receive.

The Insured Person understands and agrees the Company is entitled to a constructive trust interest in the proceeds of any settlement or recovery. The Insured Person agrees to include the Company as a co-payee on any settlement check or check from any third party or insurer. The Insured Person agrees he/she will not release any party or their insured without prior written approval from the Company and will take no action which prejudices the Company's rights.

The Insured Person is obligated to inform their legal representative of the Company's rights and lien and to make no distributions from any settlement or judgment which will in any way result in the Company receiving less than the full amount of its lien without the written approval of the Company. Any amount recovered by the Company in accordance with the foregoing shall first be used to pay in full the costs and expenses of collection incurred by the Company, including reasonable attorneys' fees, and for reimbursement to the Company for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts recovered shall be paid to the Insured Person or other persons lawfully entitled thereto, as applicable. In the event that the Insured Person receives any form or type of settlement and either fails or refuses to abide by the Terms of this insurance contract, in addition to any other remedies the Company may have, the Company retains a right of equitable offset against future claims.

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

The Company reserves the right to cancel any and all coverage if it is determined an Insured Person has Stacked Insurance.

- (13) **CANCELLATION BY INSURED PERSON:** The Insured Person shall have fifteen (15) days from the Initial Effective Date, as defined herein, (the "Review Period") to review the benefits, conditions, limitations, exclusions and all other Terms of the

Master Policy as evidenced and outlined by this Certificate. If not completely satisfied, the Insured Person may request cancellation of this insurance retroactive to the Initial Effective Date via the MyIMG customer portal (www.imglobal.com/member) or by sending a written request to the Company by email, mail or fax so that it is received by the Company within the Review Period, thereby qualifying to receive a full refund of Premium paid. Upon effectuation of such cancellation and refund, neither the Company nor the Insured Person shall have any further rights, liabilities or obligations under this insurance.

After the Review Period, the Insured Person may request cancellation of the Declaration and this Certificate by giving the Company not less than five (5) days advance written request. Cancellation is at the sole option of the Company, except as provided in the CONDITIONS AND GENERAL PROVISIONS, RENEWAL; AMENDMENTS provision, and the Company may request and/or require the Insured Person to execute a release of claims as a condition to and/or in consideration of granting such cancellation. If the Company grants cancellation, coverage for the Insured Person under this insurance shall terminate with effect from the cancellation date specified by the Company. The Company shall calculate the amount of Premium earned upon the Declaration and Certificate through the requested date of cancellation (Short Rate Earned Premium) in accordance with the Short Rate Cancellation Table in effect as of the date of the request for cancellation. If the Insured Person has paid more than the Short Rate Earned Premium, the Company shall refund the difference between the amount actually paid and the Short Rate Earned Premium. If the Insured Person has paid less than the Short Rate Earned Premium, the Insured Person shall remit to the Company the difference between the Short Rate Earned Premium and the amount actually paid as a condition to cancellation as of such requested date, or the cancellation date will be established retroactive to the date through which and for which Premiums have actually been paid.

- (14) **APPLICABLE CURRENCY:** All benefit amounts, coverage, monetary limits and sub-limits, and other amounts stated in the Master Policy, the Application, the Declaration, this Certificate, and in any Riders, including Premium, are in USD (United States Dollars).
- (15) **COOPERATION:** The Insured Person and their Physicians, Hospitals and other healthcare and medical service providers and suppliers shall undertake to cooperate fully with the Company and the Plan Administrator in reviewing, investigating, adjudicating, considering an appeal of, and/or administering any claim for benefits under this insurance, including granting full right of access to all relevant, pertinent or related records, medical documentation, medical histories, reports, laboratory or test results, x-rays, and all other available evidence relating to or affecting the review, investigation, adjudication or administration of the claim. The Company at its own expense shall have the right and opportunity to examine all evidence related to a claim when and as often as it may reasonably require during the pendency of a claim hereunder. The Company at its option may suspend or pend adjudication of a claim and/or may deny benefits and/or coverage for a claim when any of the following has occurred:
- (a) a refusal to so cooperate
 - (b) an unreasonable delay in such cooperation
 - (c) any other act or omission on the part of the Insured Person and/or their healthcare providers which hinders, delays, impairs or otherwise prejudices the performance of the Company's obligations under this insurance.
- (16) **CLAIM SETTLEMENT:** Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have previously been paid by or on behalf of the Insured Person at the time of the Company's favorable adjudication thereof will be reimbursed by the Company directly to the Insured Person, by check, at their last known residence or mailing address. While this insurance is in effect, in order to effectuate proper administration, the Insured Person shall undertake to promptly notify the Company of any change in such addresses. Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have not been paid by or on behalf of the Insured Person at the time of adjudication will be paid by the Company by check or electronic funds transfer to the Insured Person at their last known residence or mailing address, or, at the sole option and discretion of the Company (but without obligation to do so), and as an accommodation to the Insured Person, directly to the provider(s), as applicable. All claim settlements, payments and reimbursements are subject to the insurance plan shown in the Declaration and all other Terms of this insurance. No healthcare or medical service provider or supplier, or any other third-party, shall have any direct or indirect interest, claim or right of action against the Company under this Certificate, the Declaration or the Master Policy, whether by purported assignment of benefits, subrogation of interests or otherwise, unless first expressly agreed and consented to in writing by the Company, and notwithstanding the Company's exercise or failure to exercise any option or discretion under this provision regarding the method of claim payment. No such provider, supplier or other third-party is intended to have or shall have any rights as a third-party beneficiary under this Certificate, the Declaration, or the Master Policy.
- (17) **FRAUDULENT CLAIMS:** A person who knowingly and with intent to defraud the Company files a statement of claim containing any false, incomplete, or misleading information commits a felony. If any claim or request for benefits under this insurance shall knowingly be in any respect false, incomplete, misleading, concealing, fraudulent or deceitful, or if the Insured Person or anyone acting for or on their behalf under this insurance knowingly uses any false, incomplete, misleading, concealing, fraudulent or deceitful statements regarding the Insured Person, the insurance contract and all coverage thereunder may be cancelled, voided, rescinded and terminated by the Company in its sole and absolute discretion, and the Company shall have no obligation or liability for any such benefits, coverage or claims.
- (18) **ARBITRATION:** With the exception of Florida residents' option to refer to arbitration, no claim for benefits for which liability, eligibility, or coverage under this insurance has been denied in whole or in part by the Company nor any other dispute or controversy arising under or related to this insurance shall be arbitrable or subject to arbitration under any circumstances or for any reason.

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

(20) TERMINATION OF COVERAGE FOR INSURED PERSONS: Coverage and benefits for the Insured Person under this insurance will terminate effective at 12:01 AM local time, at the Insured Person's location, on the earliest of the following dates:

- (a) the date any Premium or other charge (including any relevant tax) is not paid in full within thirty (30) days of the date on which it is due and will give the Insured Person written notice if we are going to terminate coverage for this reason
- (b) the date it becomes unlawful for the Company to provide the Insured Person coverage under this insurance, or the Company is required to terminate the coverage in any jurisdiction or territory at the direction of a Regulatory Body or Authority with competent jurisdiction
- (c) the termination date as shown on the Declaration for this Certificate
- (d) the date the Master Policy is terminated pursuant to the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF MASTER POLICY provision
- (e) the date the Insured Person is no longer an Expatriate or first fails to meet or no longer meets the eligibility requirements for this insurance as set forth in the Master Policy and outlined in this Certificate
- (f) the date an Insured Person is identified on any list imposing financial sanctions or targeted individuals or entities maintained by the United Nations Security Council, the European Union, the United States Office of Foreign Assets Control, or any other applicable jurisdiction. Furthermore, the Company will not pay claims for services received in sanctioned countries if doing so would violate the requirements of the United Nations Security Council, the European Union, or the United States Department of Treasury's Office of Foreign Assets Control
- (g) the date the Insured Person has failed to provide the Company with the requested information including at the time of Application
- (h) the cancellation date specified by the Company pursuant to the CONDITIONS AND GENERAL PROVISIONS, CANCELLATION BY INSURED PERSON provision
- (i) the cancellation date specified by the Insured Person pursuant to the CONDITIONS AND GENERAL PROVISIONS, RENEWAL; AMENDMENTS provision
- (j) the date specified by the Company in any notice of cancellation, forfeiture or rescission issued pursuant to or as a result of the circumstances described in the MISREPRESENTATION, FRAUDULENT CLAIMS and RIGHT OF RECOVERY subparagraphs of the CONDITIONS AND GENERAL PROVISIONS, or as otherwise permitted by the Terms of this insurance.

Coverage for the Insured Person shall remain in full force and effect unless terminated pursuant to this provision, except as otherwise provided in the Master Policy, the Declaration, or this Certificate.

(21) RENEWAL; AMENDMENTS: Subject to the Terms of the TERMINATION OF MASTER POLICY, TERMINATION OF COVERAGE FOR INSURED PERSONS, and REINSTATEMENT OF COVERAGE FOR INSURED PERSONS subparagraphs of the CONDITIONS AND GENERAL PROVISIONS, coverage under the insurance plan will be automatically renewed on each anniversary of the Insured Person's first day of coverage for an additional duration identical to the original Period of Coverage or twelve (12) months, whichever is shorter. Renewal is subject to the Terms of the plan then in effect (including the Terms of the then applicable Master Policy) and so long as renewal Premium is paid when due or within the allowable grace period and the Insured Person otherwise continues to meet the applicable eligibility requirements of the plan. Coverage under the insurance plan will not automatically renew if and only if:

- (a) the Company provides a written notice to the Insured Person at least thirty (30) days prior to the expiration date of the then existing Period of Coverage; or
- (b) the Insured Person has cancelled the policy in accordance with the CONDITIONS AND GENERAL PROVISIONS, CANCELLATION BY INSURED PERSON provision.

The Company reserves the right in its sole discretion to make changes, additions and/or deletions to the Terms of the Master Policy, this Certificate, renewals or replacements of either, and/or to the insurance plan (including the issuance of Riders to effectuate same) at any time or from time to time after the Effective Date of Coverage of this Certificate, upon no less than thirty (30) days prior written notice to the Assured and the Insured Person ("Notice of Amendment"). The Notice of Amendment shall include a complete description of the changes, additions and/or deletions to be made, the effective date thereof (the "Change Date"), and notice of the Insured Person's cancellation rights as set forth below, and shall be sent electronically or first class mail, postage prepaid, to the last known residence or mailing address of the Insured Person. Upon issuance of the Notice of Amendment, the Assured and/or the Insured Person shall have the right to request cancellation of this Certificate above, at any time prior to the Change Date; provided, however that cancellation under this provision shall be at the option of the Insured Person, and coverage under this insurance shall terminate with effect from the cancellation date specified by the Insured Person (subject to the provisions of the CONDITIONS AND GENERAL

PROVISIONS, TERMINATION OF COVERAGE FOR INSURED PERSONS). If the Insured Person does not elect to cancel this Certificate in accordance with the foregoing, the changes, additions and/or deletions as made by the Company and specified in said Notice of Amendment shall take effect as of the Change Date specified in the Company's Notice, and this insurance shall thereafter continue in effect in accordance with its Terms, as so amended and modified.

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

- (a) a written request for Reinstatement
- (b) a newly completed Reinstatement Application, which shall become a part of the Master Policy and any reinstated Certificate
- (c) a written statement giving full details, as requested by the Company, of any claims incurred, diagnoses made, manifestations of symptoms or health conditions experienced, and/or Treatment or supplies received by the Insured Person since the Initial Effective Date under this insurance plan
- (d) a written statement giving full details of the reason for the previous failure to pay Premium when due
- (e) payment of all Premium due.

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

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

- (a) to make payment for Treatment and/or supplies which, although not expressly covered under this insurance, may be beneficial to the Insured Person and cost effective to the Company; and/or
- (b) to deny coverage and/or benefits for any Charges, including Eligible Medical Expenses otherwise eligible for coverage but for the Terms of this provision, which exceed the amount the Company would have covered had the Insured Person accepted and followed the recommendations of the Patient Advocacy program.

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

- (a) all or part of the claim was not incurred by or paid by or on behalf of the Insured Person
- (b) the Insured Person or any of the Insured Person's Relatives, whether or not the Relative is or was an Insured Person under this insurance plan, is repaid or is entitled to be repaid for all or part of the claim in accordance with the CONDITIONS AND GENERAL PROVISIONS, OTHER INSURANCE provision, for defective equipment or medical devices covered under a warranty, or by or from a source other than the Company
- (c) all or part of the claim was not eligible for payment or coverage under the Terms of this insurance

- (d) all or part of the claim was paid or reimbursed based on an incorrect or mistaken application of benefits under this insurance
- (e) all or part of the claim has been excused, waived, abandoned, forfeited, discounted or released by the provider
- (f) the Insured Person is not liable or responsible as a matter of law for all or part of a claim.

The Company shall have the right to receive a refund and to recover the amount of overpayment from the Insured Person and/or the Hospital, Physician and/or other provider of services or supplies (as the case may be). The amount of the refund and recovery for overpayment of claims shall be the difference between: the amount actually paid by the Company; and the amount, if any, that should have been paid by the Company under the Terms of this insurance.

For all other overpayments, the amount of the refund and recovery shall be the amount overpaid.

If the Insured Person, Hospital, Physician, or other provider of services or supplies does not promptly make any such refund to the Company, the Company may, in addition to any other rights or remedies available to it (all of which are reserved):

- (i) reduce or deduct from the amount of any future claim that is otherwise eligible for coverage or payment under this insurance, to the full extent of the refund due to the Company; and/or
- (ii) cancel this Certificate and all further coverage of the Insured Person under the Master Policy by giving thirty (30) days advance written notice by mail to the Insured Person at their last known residence or mailing address, and offset against the amount of any refund of Premium due the Insured Person to the full extent of the refund due to the Company.

(25) EXPLANATION OR VERIFICATION OF BENEFITS: In the event of any verbal or telephone inquiry, every attempt will be made to help the Insured Person and their healthcare providers and suppliers understand the status, scope and extent of available benefits and coverage under this insurance; provided, however, that no statement made by any agent, employee or representative of the Company or the Plan Administrator will be deemed or construed as an actionable representation, promise, or an estoppel, or will create any liability against the Company or the Plan Administrator or be deemed or construed to bind the Company or to modify, replace, waive, extend or amend any of the Terms of the Master Policy or this Certificate, unless expressly set forth in writing and signed by an authorized agent or representative of the Company. Actual eligibility determinations, benefit verifications, final coverage decisions, claim adjudications, final payments, reimbursements of benefits, or claims shall be determined and adjudicated only after or at the time a proper and complete Application and/or Proof of Claim is submitted (as the case may be), an opportunity for reasonable investigation and/or review is provided, cooperation required hereunder received, and all facts and supporting information, including relevant data, information and medical records when deemed necessary or appropriate by the Company, are presented in writing. Appealed claims may be further investigated and/or reviewed. The Terms of the Master Policy govern all available coverage and payments made or to be made. If a definite answer to a specific benefits or coverage question is required for any reason, the Insured Person or their healthcare providers may submit a written request to the Company, including all pertinent medical information and a statement from the attending Physician (if applicable), and a written reply will be sent by the Company and kept on file. If the Company elects to verify generally and/or preliminarily to a provider or the Insured Person that an Injury, Illness, diagnosis or proposed Treatment is or may be covered under this insurance, or that benefits for same are or may be available as outlined in this Certificate, any such verification of benefits does not guaranty either payment of benefits or the amount or eligibility of benefits. Final eligibility determinations, coverage decisions, claim appeals, and actual reimbursement or payment of claims or benefits are subject to all Terms of this insurance, including without limitation filing a proper and complete Proof of Claim and complying with the CONDITIONS AND GENERAL PROVISIONS, COOPERATION provision.

D. ELIGIBILITY:

(1) This insurance is only offered to Insured Persons who are Expatriates. Therefore, this Certificate will only cover the costs of Treatment in an Insured Person's Home Country in circumstances where the Insured Person is a temporary resident in their Home Country. Such circumstances may not exceed one hundred and eighty (180) days in aggregate per Period of Coverage, and the Home Country must be within this Certificate's area of coverage. If an Insured Person is not eligible, this Certificate is void *ab initio* and all Premium paid will be refunded. To be eligible and qualified for coverage under this insurance, a person must meet all the following requirements:

- (a) the Insured Person must provide the Company with all the requested customer identification documentation as outlined on the Application (for example a copy of the Insured Person's passport and proof of address dated within the last three (3) months) in relation to any Insured Person
 - (i) until the Company receives the requested documentation, the Company will not approve coverage or any Treatment under this insurance, the Company will not issue any Guarantee of Payment, or settle any claims for Treatment in relation to any Insured Person
 - (ii) failure to provide the Company with the documentation within thirty (30) days of the requested Effective Date will give rise to a right, exercisable by the Company, to decline coverage under this insurance.
 - (iii) if there are any changes that occur between the Insured Person's Application and the Initial Effective Date or any information that the Insured Person provides the Company in their Application changes during the Application Period, the Insured Person must let the Company know. The Company reserves the right to cancel this insurance or apply any additional Premiums or exclusions because of any change to the Insured Person's

state of health which they have notified the Company of before the Initial Effective Date. If the Insured Person fails to inform the Company of any change to their state of health during this Application Period, the Company may treat this as misrepresentation, and shall render the Declaration and this Certificate null and void and all claims and benefits under this insurance shall be forfeited and waived

- (iv) this insurance will not cover any costs relating to Treatment received before the Effective Date, or after the coverage ends (even if Treatment was approved by the Company before the coverage ends).
- (b) complete and sign an Application as the Insured Person (or be listed thereon by proxy as an applicant and proposed Insured Person), and/or as the Insured Person's Spouse and/or Child
- (c) pay the required Premium on or before the Effective Date of Coverage
- (d) receive written acceptance of their Application or renewal from the Company
- (e) be at least fourteen (14) days old but not yet sixty-five (65) years old on the Initial Effective Date or have not reached the age of seventy-five (75) upon their renewal date
- (f) not be Pregnant, Hospitalized or Disabled on the Initial Effective Date
- (g) not be HIV+ on the Initial Effective Date

E. CHANGES TO HOST COUNTRY, ADDRESS, AND/OR ADDRESS AND/OR NATIONALITY:

- (1) If any Insured Person changes their Host Country, the Insured Person must inform the Company as soon as practicable and in any event within thirty (30) days. The Company reserves the right to ask the Insured Person for further information about a change in their Host Country from time to time. Note that any change to the Insured Person's Host Country may result in an increase in Premium or additional tax becoming payable, meaning the Insured Person may have to make an additional payment of Premium, or the Insured Person's monthly, quarterly or semi-annual Premium payments may be adjusted. If the Premium increases, the Company will give the Insured Person the right to cancel the Certificate, please refer to the TERMINATION OF COVERAGE BY INSURED PERSON for those Terms and conditions.
- (2) If an Insured Person returns to their Home Country, then the Treatment which they can obtain will be limited to one hundred and eighty (180) days in aggregate during the Period of Coverage.
- (3) The Company reserves the right to review all claims submitted by an Insured Person in their Home Country and in circumstances where the Company knows or reasonable believes the Insured Person is or intends to be resident in their Home Country in excess of one hundred and eighty (180) days in aggregate per Period of Coverage. In such circumstances the Company may no longer consider the Insured Person an Expatriate as they have returned to their Home Country for a sustained period and the Company may refuse payment of any claim or issuance of a Guarantee of Payment.
- (4) The Company reserves the right to terminate this insurance if any Insured Person ceases to be an Expatriate whether because of a change to an Insured Person's Home Country or Host Country.
- (5) If any Insured Person ceases to be an Expatriate whether because of a change to an Insured Person's Home Country or Host Country, then the Insured Person can either
 - (a) leave the Certificate in force for the remainder of the Period of Coverage. The Insured Person must inform the Company upon renewal if they cease to be an Expatriate and the Company will determine if we can offer the Insured Person an alternative health plan; or
 - (b) terminate the insurance by giving written notice with the Effective Date that coverage will end for the Insured Person
- (6) any Premium which has been paid in relation to the period after termination will be refunded to the extent that it does not relate to a period of time in which we have provided coverage, so long as we have not paid claims or issued any Guarantees of Payment during the Period of Coverage.

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

certification requirements of the Master Policy and this Certificate, and the Treatment or supplies are Pre-certified as Medically Necessary, the Company will reimburse the Insured Person for Eligible Medical Expenses up to the amount shown in the BENEFIT SUMMARY incurred in relation thereto, subject to all Terms of this insurance. Eligibility for and payment of benefits are subject to all of the Terms of this insurance.

- (1) **SPECIFIC REQUIREMENTS:** The following must always be Pre-certified for Medical Necessity by the Company through the Plan Administrator before admission or receiving the Treatments and/or supplies:
- (a) Chemotherapy
 - (b) Extended Care Facility
 - (c) Hospice Care
 - (d) Inpatient Hospitalization
 - (e) Interfacility Ambulance Transfer
 - (f) Procedures rendered at an Outpatient Surgical Center or Outpatient Hospital
 - (g) Radiation Therapy
 - (h) Surgery or Surgical procedure
 - (i) Transplant
- (2) **GENERAL REQUIREMENTS:** To comply with the Pre-certification requirements of this insurance for the Treatments and/or supplies or services listed in the SPECIFIC REQUIREMENTS provision, above, the Insured Person or their Physician or healthcare provider must perform all of the following:
- (a) contact the Company through the Plan Administrator at the contact information below and on the Insured Person's ID card as soon as possible and before the Treatment or supply is to be obtained.

Inside the United States: +1.800.628.4664
Outside the United States: +1.317.655.4500 (Collect if necessary)
E-mail: precertification@imglobal.com
Website: www.imglobal.com/member/precertification
 - (b) comply with the instructions of the Company and submit any information or documents required by the Company
 - (c) notify all Physicians, Hospitals and other healthcare providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company.
- (3) **TRANSPLANT PRE-CERTIFICATION REQUIREMENTS:** To comply with the Transplant Pre-certification Requirements, the Insured Person must contact the Company through the Plan Administrator as soon as possible but always within seventy-two (72) hours of becoming a candidate for a Covered Transplant; comply with the instructions of the Company and submit any information or documents required by the Company; and notify all Physicians, Hospitals and other healthcare providers that this insurance contains Pre-certification requirements and ask them to cooperate fully with the Company.
- (4) **LOSS OF COVERAGE / BENEFITS FOR NON-COMPLIANCE OF PRE-CERTIFICATION REQUIREMENTS:** If the Insured Person or their healthcare providers do not comply with the Pre-certification requirements for the Treatment or supplies identified in the SPECIFIC REQUIREMENTS subparagraphs above, other than Covered Transplant Treatment, or if such Treatment or supplies are not Pre-certified:
- (a) Eligible Medical Expenses incurred with respect to said Treatment and/or supplies will be reduced by the amount shown in the BENEFIT SUMMARY
 - (b) the Deductible will be subtracted from the remaining amount where a Deductible is applicable
 - (c) Coinsurance will be applied where Coinsurance is applicable.
- If the Insured Person or their healthcare providers do not comply with the Pre-certification requirements for Treatment or supplies related to Covered Transplant Treatment, or if such Treatment and/or supplies are not Pre-certified, all Transplant Expense benefits shall be forfeited and waived.
- (5) **EMERGENCY PRE-CERTIFICATION:** In the event of an Emergency Hospital admission, Pre-certification must be completed within forty-eight (48) hours after the admission, or as soon as is reasonably possible.
- (6) **CONCURRENT REVIEW:** For Inpatient Treatment of any kind, the Company will Pre-certify a limited number of days of confinement based upon the disclosed medical condition. Thereafter, Pre-certification must again be requested and approved if additional days of Inpatient Treatment are necessary.
- (7) **APPEAL PROCESS:** If the Insured Person disagrees with a Pre-certification decision of the Company, the Insured Person may in writing ask the Company to reconsider the decision and may supply additional documentation to support the appeal. The Company may reconsider its decision based on review of the additional documentation and facts, if any. The Company

will advise the Insured Person of its decision within a reasonable time frame following receipt of additional documentation and facts.

The appeal must be sent to:

Phone: +1.317.655.4500, Option #2

Fax: +1.317.833.1990: ATTN: Pre-certification— Appeals

Email: precertification@imglobal.com

G. UNITED STATES DESIGNATED PROVIDER NETWORK:

- (1) Treatment or supplies eligible for coverage under this insurance must be received directly from the Company's designated provider network while the Insured Person is in the United States. All claims for Treatment or supplies received in the United States from an Out-of-Network provider are not eligible for benefits except for Emergency Treatment.
- (2) The Company, through the Plan Administrator, endeavors to maintain a contractual arrangement with a designated network of United States-based Physicians, Hospitals and other healthcare and health service providers who may provide re-pricings, discounts or reduced Charges for Treatment or supplies provided to the Insured Person. Neither the Company nor the Plan Administrator has any authority or control over the operations or business of the designated network providers. Providers within the designated network, nor any of their respective agents, employees or representatives have or shall have any power or authority whatsoever to act for or on behalf of the Company or the Plan Administrator in any respect, including without limitation no power or authority to perform any of the following:
 - (a) approve Applications or enrollments for initial, renewal or reinstated coverage under this insurance plan or to accept Premium payments
 - (b) accept risks for or on behalf of the Company
 - (c) act for, speak for or bind the Company or the Plan Administrator in any way
 - (d) waive, alter or amend any of the Terms of the Master Policy or this Certificate, or waive, release, compromise or settle any of the Company's rights, remedies or interests thereunder, or hereunder
 - (e) determine Pre-certification, coverage eligibility or verification of benefits, or make any coverage, benefit or claim adjudications or decisions of any kind.

H. ELIGIBLE MEDICAL EXPENSES: Subject to the Terms of this insurance, and the insurance plan shown in the Declaration, the Company will reimburse the Insured Person up to the amount shown in the BENEFIT SUMMARY for the following costs, Charges and expenses incurred by the Insured Person during the Period of Coverage with respect to an Illness or Injury suffered or sustained by the Insured Person during the Period of Coverage and while this Certificate is in effect, so long as the Illness or Injury is covered under this Certificate, Charges are Usual, Reasonable and Customary, and Charges are incurred for Treatment or supplies that are Medically Necessary ("Eligible Medical Expenses"):

- (1) Charges incurred at a Hospital for:
 - (a) daily room and board, nursing services, prescription medications, and Ancillary Services not to exceed the private room rate
 - (b) daily room and board, nursing services, prescription medications, and Ancillary Services in an Intensive Care Unit
 - (c) use of operating, Treatment or recovery room
 - (d) services and supplies which are routinely provided by the Hospital to Insured Persons for use while an Inpatient
 - (e) Emergency Treatment of an Injury, even if Hospital confinement is not required
 - (f) Emergency Treatment of an Illness; however, an additional Deductible (as shown in the BENEFIT SUMMARY) will be required unless the Insured Person is directly admitted to the Hospital as Inpatient for further Treatment of that Illness
- (2) Charges incurred for Surgery at an Outpatient Surgical Facility, including services and supplies
- (3) Charges by a Physician for professional services rendered, including Surgery; provided, however, that Charges by or for an assistant surgeon will be limited and covered at the rate of up to twenty percent (20%) of the Usual, Reasonable and Customary charge of the primary surgeon; and provided, further, that the standby availability of a Physician or surgeon will not be deemed to be a professional service and is not eligible for coverage
- (4) Charges incurred for:
 - (a) dressings, sutures, casts or other supplies which are Medically Necessary
 - (b) diagnostic testing using Radiology, ultrasonography or laboratory services. Laboratory services billed for professional component fees are covered if the pathologist has direct involvement in providing a written report or verbal consultation for specimen-specific pathology services

- (c) Positron Emission Tomography (PET) scans, Computerized Tomography (CT) scans, Magnetic Resonance Imaging (MRI), echocardiography, and endoscopic procedures (including gastroscopy, colonoscopy, and cystoscopy), including both facility services and professional services, up to the amount shown in the BENEFIT SUMMARY
- (d) Implant devices that are Medically Necessary; however, any Implants provided outside the designated provider network are limited to a payment of no more than one hundred fifty percent (150%) of the established invoice price and/or list price for that item
- (e) basic functional artificial limbs, eye, larynx, or breast prostheses covered under this insurance, but not the replacement or repair thereof
- (f) reconstructive Surgery when the Surgery is incidental to and follows Surgery which was covered hereunder
- (g) radiation therapy or Treatment, and chemotherapy except for cancer Treatment during the first one hundred eighty (180) days after the Initial Effective Date
- (h) hemodialysis and the Charges by a Hospital for processing and administration of blood or blood components
- (i) oxygen and other gases and their administration
- (j) anesthetics and their administration by a Physician
- (k) Outpatient retail drugs that require a prescription by a Physician for Treatment of Illness or Injury, Outpatient drugs prescribed by a Physician for an Outpatient surgery or related services, or retail drugs from a pharmacy located outside of the United States that require a prescription by a Physician for Treatment of Illness or Injury, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, and for a maximum supply of ninety (90) days of any one (1) prescription
- (l) Inpatient drugs prescribed by a Physician during a covered Hospital or Facility confinement
- (m) care in a licensed Extended Care Facility upon direct transfer from an acute care Facility where Hospitalization was for a covered Injury or Illness
- (n) Charges made by Hospice for Room and board charged by the Hospice and part-time nursing by a Registered Nurse when the following conditions apply:
 - (i) the Physician must certify that the Insured Person is terminally ill with six (6) months or less to live
 - (ii) services for the Insured Person must be received in an Inpatient Hospice Facility or in the Insured Person's home
 - (iii) Hospice Care is limited to the number of days listed in the BENEFIT SUMMARY
- (o) Emergency Local Ambulance Transport necessarily incurred in connection with an Injury or an Illness resulting in Hospital confinement as an Inpatient, up to the amount shown in the BENEFIT SUMMARY
- (p) Interfacility Ambulance Transfer must be a result of an Inpatient Hospital Admission, Medically Necessary and from one licensed health care Facility to another licensed health care Facility via air or land ambulance, up to the amount shown in the BENEFIT SUMMARY
- (q) Medically Necessary rental of Durable Medical Equipment, up to the purchase price
- (r) physical therapy prescribed by a Physician, performed by a professional therapist, and necessarily incurred to continue recovery from a covered Injury or covered Illness
- (s) the initial purchase, fitting, repair and replacement of orthotic appliances such as braces, splints or other appliances required for support of an injured or deformed part of the body as a result of an Injury or Illness
- (5) Charges incurred for a Teleconsultation or Virtual Physician Visit**
- (6) Charges incurred for a Teladoc Consultation subject to the limitations set forth in the BENEFIT SUMMARY**
- (7) Charges for Treatment of an Injury to the foot due to an Accident covered hereunder**
- (8) Charges for Treatment of an Illness for which foot Surgery is Medically Necessary and determined to be the only appropriate method of Treatment**
- (9) Charges for a lens transplant due to cataracts or other eye conditions**
- (10) Charges for Treatment following Traumatic Dental Injury from a covered Accident that resulted in physical Injury to the Insured Person, up to the amount shown in the BENEFIT SUMMARY**
- (11) Charges incurred for Treatment at an Urgent Care Clinic**
- (12) Charges incurred for Treatment at a Convenience Clinic**
- (13) Charges incurred for Treatment of an Injury sustained while participating in Amateur Athletics (except activities specifically listed as excluded in the EXCLUSIONS provision) and engaged in by the Insured Person solely for recreational, entertainment or fitness purposes**

(14) Charges for Treatment resulting from COVID-19/SARS-CoV-2.

I. PUBLIC HEALTH EMERGENCY: Subject to all other Terms of this insurance, in the event of a Public Health Emergency of International Concern, Epidemic, Pandemic, other disease outbreak, or Natural Disaster, that may affect an Insured Person's health, the Company will cover an Illness or Injury incurred during the Period of Coverage and caused by the Public Health Emergency of International Concern, Epidemic, Pandemic, other disease outbreak, or Natural Disaster when, prior to the issuance of a Travel Warning for the Host Country or a Global Travel Warning:

- (1) the Effective Date of Coverage has occurred; and
- (2) the Insured Person has arrived in the Host Country or Affected Area.

In the event that the applicable Travel Warning is removed for the Host Country or Affected Area, coverage for an Illness or Injury incurred during the Period of Coverage after the Travel Warning is removed, which was caused by the Public Health Emergency of International Concern, Epidemic, Pandemic, other disease outbreak, or Natural Disaster will be considered by the Company the same as any other Illness or Injury, subject to all other Terms and conditions of this insurance.

Notwithstanding the above provisions of this section PUBLIC HEALTH EMERGENCY, COVID-19/SARS-CoV-2 shall be considered by the Company the same as any other Illness or Injury, subject to all other Terms and conditions of this insurance.

J. TRANSPLANT: Subject to the Terms of this insurance, the insurance plan shown in the Declaration, and the conditions and restrictions set forth below, the Company will reimburse the Insured Person up to the amount shown in the BENEFIT SUMMARY for the following costs, Charges and expenses incurred by the Insured Person with respect to a Covered Transplant obtained or received by the Insured Person while this Certificate is in effect, so long as such costs, Charges or expenses are Usual, Reasonable and Customary:

- (1) Eligible Medical Expenses incurred by a live donor will be Treated as if they were the expenses of the Insured Person receiving a Covered Transplant if the Insured Person received an organ or tissue of the live donor
- (2) organ procurement and harvesting costs, including donor preparation, excluding acquisition or purchase of the actual organ or tissue, up to the amount shown in the BENEFIT SUMMARY
- (3) Charges incurred for pre-transplant evaluation, the Covered Transplant procedure, re-transplantation (if incurred during the initial Hospital confinement as an Inpatient for the Covered Transplant), and post-transplant care
- (4) reasonable travel and lodging expenses of the Insured Person if travel of more than fifty (50) miles is necessary to receive the Covered Transplant Treatment and supplies from the approved Center of Excellence (COE) or an approved Transplant network, up to the amount shown in the BENEFIT SUMMARY.

Transplant Pre-certification: To become eligible for Transplant benefits under this insurance, the Transplant must be a Covered Transplant. The Insured Person must receive all Covered Transplant Treatment and supplies from the approved COE or the approved Transplant network and the Covered Transplant must be Pre-certified by the Company in accordance with the Terms of this insurance. If the Insured Person receives Covered Transplant Treatment and supplies from a provider that is not from the approved COE or the approved Transplant network, or if the transplant is not a Covered Transplant or is not properly Pre-certified, no Transplant benefits shall be available under this insurance. Neither the Company nor the Plan Administrator shall have any right, obligation, or authority of any kind to ultimately select Physicians, Hospitals, or other healthcare providers for the Insured Person or to make any medical Treatment decisions for or on behalf of the Insured Person regarding transplants, and all such decisions shall be made solely and exclusively by the Insured Person and/or their family members, Treating Physicians, and other healthcare providers. All claims for Transplant benefits are subject to the Terms of this insurance and the insurance plan shown in the BENEFIT SUMMARY.

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

- (1) **ECONOMIC SANCTIONS:** Charges incurred under this Certificate of Insurance that would result in the Company being exposed to any sanction, prohibition, or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.
- (2) **WAR; MILITARY ACTION:** The Company shall not be liable for and will not provide coverage or benefits for any claim or Charges incurred with respect to any Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising or incurred in connection with or as a result of any of the following acts or occurrences:
 - (a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war
 - (b) mutiny, riot, strike, military or popular uprising, insurrection, insurgency, rebellion, revolution, military or usurped power
 - (c) any act of any person acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the Government de jure or de facto or to the influencing of it by violence of any type

- (d) martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege
- (e) any use of radiological, chemical, nuclear or biological weapons or any other radiological, chemical, nuclear or biological events of any type (including in connection with an act of Terrorism).

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

- (3) **TERRORISM**: The Company shall not be liable for and will not provide coverage or benefits for any claim or charges, Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with any act of Terrorism. Further, the Company shall not be liable for and will not provide any coverage or benefits for any claim, charges, Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with the following:
 - (a) the Insured Person's active and voluntary planning or coordination of or participation in any act of Terrorism
 - (b) any act of Terrorism that takes place in a location, post, area, territory or country for which a Travel Warning or Emergency Travel Advisory was issued or in effect on or within six (6) months prior to the Insured Person's date of arrival in said location, post, area, territory or country
 - (c) any act of Terrorism that takes place in a location, post, area, territory or country for which a Travel Warning or Emergency Travel Advisory becomes effective or is in effect on or after the Insured Person's date of arrival in said location, post, area, territory or country, and the Insured Person unreasonably fails or refuses to heed such warning and thereafter remains in said location, post, area, territory or country.
- (4) **PRE-EXISTING CONDITIONS**: Charges resulting directly or indirectly from or relating to any Pre-existing Condition are excluded from coverage under this insurance including:
 - (a) Non-disclosed Conditions on the Insured Person's Application
 - (b) conditions subject of a special exclusion provided in a Rider to the Certificate of Insurance
 - (c) any condition that existed prior to the Insured Person's Application whether known or unknown
- (5) **ILLNESS OR SURGERY WITHIN 180 DAYS**: Charges for Treatment of the following Illnesses or Surgeries which manifest themselves and/or involve procedures which take place and/or are recommended during the first one-hundred eighty (180) days of coverage under this insurance plan, beginning on the Initial Effective Date: acne, asthma, allergies, cancer, any condition of the breast, any condition of the prostate, tonsillectomy, adenoidectomy, hemorrhoids or hemorrhoidectomy, disorders of the reproductive system, diverticulitis, hysterectomy, hernia, intervertebral disc disease, gall bladder disease or gall stones and kidney stones. Note: Coverage and/or benefits for these Illnesses or Surgeries (or for similar or different Illnesses or Surgeries) may be separately or further limited.
- (6) **MATERNITY AND NEWBORN CARE**: Charges for pre-natal care, delivery, post-natal care, and care of newborns immediately following delivery and while remaining in the Hospital, including complications of pregnancy, miscarriage, and complications of delivery are excluded from this insurance
- (7) **MENTAL OR NERVOUS DISORDERS**: Charges for Treatment of Mental or Nervous Disorders are excluded from coverage under this insurance
- (8) **PREVENTATIVE CARE**: Charges for Routine Physical Examinations and immunizations are excluded from coverage under this insurance
- (9) Charges for any Treatment or supplies that are:
 - (a) not incurred, obtained or received by an Insured Person during the Period of Coverage
 - (b) not presented to the Company for payment by way of a completed Proof of Claim within one hundred eighty (180) days from the date such Charges are incurred
 - (c) not administered or ordered by a Physician
 - (d) not Medically Necessary for the diagnosis, care or Treatment of the physical or mental condition involved. This also applies when and if they are prescribed, recommended or approved by the attending Physician
 - (e) provided at no cost to the Insured Person or for which the Insured Person is not otherwise liable
 - (f) in excess of Usual, Reasonable, and Customary
 - (g) incurred by an Insured Person who was HIV + on or before the Initial Effective Date of this insurance, whether or not the Insured Person had knowledge of their HIV status prior to the Effective Date, and whether or not the Charges are incurred in relation to or as a result of said status. This exclusion includes Charges for any Treatment or supplies

relating to or arising or resulting directly or indirectly from HIV, AIDS virus, AIDS related illness, ARC Syndrome, AIDS and/or any other illness arising or resulting from any complications or consequences of any of the foregoing conditions

- (h) provided by or at the direction or recommendation of a chiropractor
 - (i) performed or provided by a Relative of the Insured Person
 - (j) not expressly included in the ELIGIBLE MEDICAL EXPENSES provision
 - (k) provided by a person who resides or has resided with the Insured Person or in the Insured Person's home
 - (l) required or recommended as a result of complications or consequences arising from or related to any Treatment, illness, Injury, or supply received prior to coverage under this insurance or that is excluded from coverage or which is otherwise not covered under this insurance
- (10) Telehealth or Telemedicine services not considered Medically Necessary as determined by the Company under the plan
- (11) Charges incurred due to fluctuations in exchange rates or for any bank charges the Insured Person incurs when a check, bank transfer, or payment is received from the Company
- (12) Charges incurred for failure to keep a scheduled appointment
- (13) Charges incurred for Surgeries, Treatment or supplies which are Investigational, Experimental, and for research purposes
- (14) Charges incurred related to Genetic Medicine
- (15) Charges incurred related to chimeric antigen receptor T-cell (CAR-T) therapy, including Treatment-related complications
- (16) Congenital disorders and conditions arising out of or resulting from Congenital disorders
- (17) Charges incurred for testing that attempts to measure aspects of an Insured Person's mental ability, intelligence, aptitude, personality and stress management. Such testing may include but is not limited to psychometric, behavioral and educational testing
- (18) Charges incurred for Custodial Care
- (19) Charges incurred for Home Nursing Care
- (20) Charges incurred for Educational or Rehabilitative Care that specifically relates to training or retraining an Insured Person to function in a normal or near-normal manner. Such care may include but is not limited to job or vocational training, counseling, occupational therapy and speech therapy
- (21) Charges for weight modification or any Inpatient, Outpatient, Surgical or other Treatment of obesity (including without limitation morbid obesity), including without limitation wiring of the teeth and all forms or procedures of bariatric Surgery by whatever name called, or reversal thereof, including without limitation intestinal bypass, gastric bypass, gastric banding, vertical banded gastroplasty, biliopancreatic diversion, duodenal switch, or stomach reduction or stapling
- (22) Charges for modification of the physical body in order to change or improve or attempt to change or improve the physical appearance or psychological, mental or emotional well-being of the Insured Person (such as but not limited to sex-change Surgery or Surgery relating to sexual performance or enhancement thereof)
- (23) Charges or Treatment for cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is Medically Necessary and is directly related to and/or follows a Surgery which was covered under this insurance
- (24) Charges incurred for any Treatment or supply that either promotes or prevents or attempts to promote or prevent conception, insemination (natural or otherwise) or birth, including but not limited to: artificial insemination; oral contraceptives; Treatment for infertility or impotency; vasectomy; reversal of vasectomy; sterilization; reversal of sterilization; surrogacy or abortion
- (25) Charges incurred for any Treatment or supply that either promotes, enhances or corrects or attempts to promote, enhance or correct impotency or sexual dysfunction
- (26) any illness or Injury sustained while taking part in, practicing or training for athletic activities that are sponsored by the National Collegiate Athletic Association (NCAA), the National Association of Intercollegiate Athletics (NAIA), and the National Junior College Athletic Association (NJCAA), any other collegiate sanctioning or Governing Body or the International Olympic Committee
- (27) any illness or Injury sustained while taking part in Organized Sports
- (28) any illness or Injury sustained while taking part in Collision Sports
- (29) any illness or Injury sustained while taking part in, practicing or training for Professional Athletics
- (30) any illness or Injury sustained while taking part in activities designated as Adventure Sports, which are limited to the following: abseiling; BMX; bobsledding; bungee jumping; canyoning; caving; hot air ballooning; jungle zip lining; parachuting; paragliding; parascending; rappelling; skydiving; spelunking; and windsurfing
- (31) any illness or Injury sustained while taking part in activities designated as Extreme Sports, which include but are in no way limited to the following (and include any combination or derivative of the following): BASE jumping; big game hunting; cave diving; cliff diving; downhill mountain biking and racing; extreme skiing; freediving; free flying; free running; free skiing;

freestyle scootering; gliding; heli-skiing; ice canoeing; ice climbing; mixed martial arts; motocross; motorcycle racing; motor rally; mountaineering or trekking above elevation of 4500 meters; parkour; piloting a commercial or non-commercial aircraft; powerbocking; scuba diving or sub aqua pursuits below a depth of 40 meters; snowmobile racing; truck racing; whitewater kayaking or whitewater rafting Class VI and higher difficulty; and wingsuit flying

- (32) any Illness or Injury sustained while taking part in snow skiing, snowboarding or snowmobiling where the Insured Person is in violation of applicable laws, rules or regulations of a ski resort, out of bounds or in unmarked or unpatrolled areas
- (33) any Illness or Injury sustained while taking part in backcountry skiing
- (34) any Illness or Injury sustained while taking part in skiing off-piste
- (35) any Illness or Injury sustained while taking part in athletic or recreational activities where the Insured Person is not physically or medically fit or does not hold the necessary qualifications to engage in said activities
- (36) any Illness or Injury sustained while participating in any sporting, recreational or adventure activity where such activity is undertaken against the advice or direction of any local authority or any qualified instructor or contrary to the rules, recommendations and procedures of a recognized Governing Body for the sport or activity
- (37) any Illness or Injury sustained while participating in any activity where such activity is undertaken in disregard of or against the recommendations, Treatment programs, or medical advice of a Physician or other healthcare provider
- (38) any Injury or Illness sustained as a result of being under the influence of or due wholly or partly to the effects of alcohol, liquor, intoxicating substance, narcotics or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician but not for the Treatment of Substance Abuse
- (39) any Injury or Illness sustained while operating a moving vehicle after consumption of intoxicating liquor or drugs in excess of the applicable blood/alcohol legal limit, other than drugs taken in accordance with Treatment prescribed and directed by a Physician. For purposes of this exclusion, "vehicle" shall include motorized devices regardless of whether or not a driver or operator license is required (including watercraft and aircraft) and non-motorized bicycles and scooters for which no permit or license is required
- (40) any willfully Self-inflicted Injury or Illness
- (41) any sexually transmitted or venereal disease
- (42) any testing for the following when not Medically Necessary: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS
- (43) any Illness or Injury resulting from or occurring during the Insured Person's violation of the law, including but not limited to engaging in illegal occupations or acts, whether or not the Insured Person is charged with the violation, where failure to abide by the law was the proximate cause of the Insured Person's Injury
- (44) any Substance Abuse
- (45) biofeedback, recreational, sleep or music therapy
- (46) orthoptics, visual therapy or visual eye training
- (47) any non-surgical Illness or Treatment of the feet, including without limitation: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; Treatment of weak, strained, flat, unstable or unbalanced feet; metatarsalgia, bone spurs, hammer toes or bunions; and any Treatment or supplies for corns, calluses or toenails; except as otherwise expressly set forth
- (48) hair loss, including without limitation wigs, hair transplants or any drug that promises to promote hair growth, whether or not prescribed by a Physician
- (49) any sleep disorder, including without limitation sleep apnea
- (50) any exercise and/or fitness program or equipment, whether or not prescribed or recommended by a Physician
- (51) any exposure to any non-medical nuclear or atomic radiation, and/or radioactive material(s)
- (52) any organ or tissue or other transplant or related services, Treatment or supplies except as otherwise expressly set forth
- (53) any artificial or mechanical devices designed to replace human organs temporarily or permanently after termination of Inpatient status
- (54) any transplant expenses incurred outside an approved Center of Excellence (COE) or approved Transplant network
- (55) any efforts to keep a donor alive for a transplant procedure
- (56) any Covered Transplant in excess of one (1) during any twelve (12) month Period of Coverage under this insurance plan, except re-transplantation Charges if incurred during the initial Covered Transplant Hospitalization
- (57) any Illness or Injury incurred in the Host Country, Affected Area or Home Country as a result of a Public Health Emergency of International Concern, Epidemic, Pandemic, other disease outbreak, or Natural Disaster, that may affect an Insured

Person's health, unless coverage is expressly provided under the PUBLIC HEALTH EMERGENCY provision of this insurance

This exclusion DOES NOT apply to Charges resulting from COVID-19/SARS-CoV-2.

- (58) Charges incurred for eyeglasses, contact lenses, hearing aids or hearing implants and Charges for any Treatment, supply, examination or fitting related to these devices, or for eye refraction for any reason
- (59) Charges incurred for eye Surgery, such as but not limited to radial keratotomy, when the primary purpose is to correct or attempt to correct nearsightedness, farsightedness, or astigmatism
- (60) Charges incurred for Treatment or supplies for temporomandibular joint (TMJ) including but not limited to TMJ syndrome, craniomandibular syndrome, chronic TMJ pain, orthognathic Surgery, Le-Fort Surgery or splints
- (61) Charges incurred for any travel, meals, transportation and/or accommodations
- (62) Charges or expenses incurred for nonprescription drugs, medicines, vitamins, food extracts, or nutritional supplements; IV vitamin or herbal therapy; drugs or medicines not approved by the U.S. Food and Drug Administration (FDA) or which are considered "off-label" drug use; and for drugs or medicines not prescribed by a Physician
- (63) any Treatment for an Illness or Injury requiring an unapproved U.S. Food and Drug Administration (FDA) medical product, services, Surgery, Surgical Procedure, prescription medication, drug, biological product, Durable Medical Equipment (DME) or device when an Emergency Use Authorization (EUA) is in place issued by the U.S. Food and Drug Administration (FDA)
- (64) Charges incurred at a Hospital or Facility when the Insured Person checks themselves out Against Medical Advice of their Physician and leaves before reaching a Medically Necessary specified endpoint of Treatment
- (65) Charges incurred for the Worsening of an Illness or Injury after the Insured Person left a Hospital or Facility Against Medical Advice or was a Discharge Against Medical Advice
- (66) Charges incurred for Dental Treatment, except as specifically provided for Traumatic Dental Injury
- (67) Wear and tear of teeth due to cavities and chewing or biting down on hard objects, such as but not limited to pencils, ice cubes, nuts, popcorn, and hard candies
- (68) Dental Injury without associated face, skull, neck and/or jaws Injury or that can be evaluated and treated in a dental office

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

Accident: An Unexpected occurrence directly caused by external, visible means and resulting in physical Injury to the Insured Person.

Adventure Sports: Activities undertaken for the purposes of recreation, an unusual experience or excitement. These activities are typically undertaken outdoors and involve a medium degree of risk.

Affected Area(s): Any and all countries, states, provinces, territories, cities or other areas experiencing ongoing transmission of an Epidemic, Pandemic or other disease outbreak, or Natural Disaster.

Against Medical Advice; Discharge Against Medical Advice: Against Medical Advice, or AMA, sometimes known as DAMA, Discharge Against Medical Advice, is a term used with a patient who checks themselves out of a Hospital against the advice of their Treating Physician.

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

Amateur Athletics: A sporting or athletic activity undertaken by an amateur or other non-professional that is non-Organized, non-sanctioned, non-Collision and engaged in by the Insured Person solely for recreational, entertainment or fitness purposes, and is not listed as an Adventure or Extreme Sport under this insurance.

Ancillary Services: All Hospital services for a patient other than room and board and professional services. Laboratory tests and Radiology are examples of Ancillary Services.

Application: The fully answered and signed form entitled "Application" submitted by or on behalf of the Insured Person for acceptance into, renewal of coverage under, or Reinstatement in this insurance plan. The Application shall be incorporated in and become part of the Master Policy and this Certificate and the insurance contract. Any insurance agent/broker or other person or entity assigned to, soliciting, or assisting with the Application is the representative of the applicant/Insured Person and is not and shall not be deemed or considered as an agent or representative for or on behalf of the Company or the Plan Administrator.

Application Period: The period of time when the Insured Person applies for this insurance coverage and approved by the Company for their Initial Effective Date.

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

Assured: The Global Medical Services Group Insurance Trust, c/o RBB Financial LLC, 6368 Oxbow Way, Indianapolis, IN, 46220.

Authorization for Release of Medical Information: A written authorization by the Insured Person for health providers to release medical records and information regarding their past and current Treatment.

Biologic Drugs: Pharmacologic Treatments where those Treatments are designated by the U.S. Food and Drug Administration (FDA) as Biologic Drugs, all as more particularly provided in the Purple Book of FDA-licensed (approved) biological products regulated by the Center for Drug Evaluation and Research (CDER), including licensed biosimilar and interchangeable products, and their reference products, and FDA-licensed allergenic, cellular and gene therapy, hematologic, and vaccine products regulated by the Center for Biologics Evaluation and Research (CBER), the most current version being located at <https://purplebooksearch.fda.gov/downloads>, as amended from time to time (and available to the Insured Person upon request).

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

Charges: Any cost, fee or tax incurred for Eligible Medical Expenses incurred in the treatment of an Injury or Illness.

Child; Children: An Insured Person who is at least fourteen (14) days old but less than nineteen (19) years of age.

Class VI: A section of a river, stream or other waterway or watercourse where the current moves with enough speed or force to meet, but not to exceed, the qualifications of Class VI as determined by the International Scale of River Difficulty or as commonly published by a local authority or government agency.

Coinsurance: The payment by or obligations of the Insured Person for payment of Eligible Medical Expenses at the percentage specified in the BENEFIT SUMMARY contained herein and not including any applicable Deductible.

Collision Sports: A sport in which the participants purposely hit or collide with each other or inanimate objects, including the ground, with great force and limited to the following (or other similar style) sports: American football, boxing, ice hockey, lacrosse, full contact martial arts, rodeo, rugby and wrestling.

Company: The Company, as referred to in the Master Policy and this Certificate, is SiriusPoint Specialty Insurance Corporation, located at One World Trade Center, 47th Floor, New York, NY 10007. This insurance and its risks are underwritten by the Company as the insurer and carrier, and the Company is solely obligated and liable for the coverage and benefits provided by this insurance.

Congenital Disorder: Any abnormality, deformity, disease, Illness, Injury or medical condition present at birth, whether diagnosed or not.

Convalescent: Treatment, services and supplies provided to aid in the recovery of a patient to reach a degree of body functioning to permit self-care in essential daily activities.

Convenience Clinic: A medical Facility that provides medical services for a minor Injury or Illness. The clinics are often found in or near retail establishments or pharmacies. The staff providing medical services are nurse practitioners and physician assistants.

Copayment: The amount the Insured Person is responsible to pay for each service listed in the BENEFIT SUMMARY, at the time the Insured Person receives the service.

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

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

Declaration: The Declaration of Insurance issued by the Plan Administrator for and on behalf of the Company to the Insured Person contemporaneously with this Certificate (and/or upon renewal or Reinstatement hereof) evidencing the Insured Person's insurance coverage under the Master Policy as evidenced by this Certificate.

Deductible: The dollar amount, as selected on the Application and specified in the Declaration, that the Insured Person must pay of ELIGIBLE MEDICAL EXPENSES per Period of Coverage prior to receiving benefits or coverage under this insurance, and not including any applicable Coinsurance.

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

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

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

Educational or Rehabilitative Care: Care for restoration (by education or training) of a person's ability to function in a normal or near normal manner following an Illness or Injury.

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

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

Emergency Treatment: Immediate medical care provided for acute Illnesses or Injuries that pose an immediate risk of death, permanent disability, or serious harm if not promptly addressed. Once the Insured Person is stabilized, care is no longer considered Emergency Treatment for United States network purposes.

Emergency Use Authorization (EUA): A temporary authorization issued by the U.S. Food and Drug Administration (FDA) to allow the use of unapproved medical product, service, a Surgery or Surgical Procedure, prescription medication, drug, biological product, Durable Medical Equipment (DME) or device; or by allowing an otherwise unapproved use or application of an approved medical product, service, Surgery or Surgical Procedure, prescription medication, drug, biological product, Durable Medical Equipment (DME) or device.

Epidemic: The occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time.

Expatriate: An Insured Person who resides outside their Home Country.

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

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

Extreme Sports: Recreational activities involving a high degree of risk. These activities often involve speed, height, a high level of physical exertion, and/or highly specialized gear and often carry the potential risk of serious or permanent physical injury and even death.

Facility: Licensed health care entity such as a Hospital, clinic, rehabilitation, and/or Extended Care Facility.

Family: An Insured Person, their Spouse, and any Child or Children who are covered as an Insured Person under this insurance plan.

Genetic Medicine: Treatment arising or resulting from, as a consequence of, or in connection with, directly or indirectly, any of the following: genetic testing, surveillance testing and/or wellness screening procedures for genetically predisposed conditions indicated by genetic medicine or genetic testing, including, but not limited to amniocentesis, drugs, recombinant adeno-associated virus vector-based gene therapy, and other medication Treatments associated with diagnoses related to genetic testing and discovery, genetic screening, risk assessment, preventive and prophylactic surgeries recommended by genetic testing, and/or any procedures used to determine genetic pre-disposition, provide genetic counseling, or administration of gene therapy.

Global Travel Warning: A published statement, warning or advisory, including any website document, issued by the United States Centers for Disease Control & Prevention (CDC), United States Department of State, United States Bureau of Consular Affairs, or similar government or non-governmental agency of the Insured Person's Home Country or Host Country, warning that any global travel (travel anywhere) poses serious risks to health, safety and security or exposes the Insured Person to a greater likelihood of life-threatening risks, including all United States Department of State global advisories or global warnings Levels "3 - reconsider travel" and "4 -do not travel" and CDC global advisories or global warnings Level "3 – avoid nonessential travel" or any higher level. When multiple government or non-governmental agencies have issued different levels of warnings or advisories, the highest warning or advisory applicable to the Insured Person's Home Country or Host Country will be considered for coverage under this insurance. For the avoidance of doubt, a Global Travel Warning covers all Affected Areas, including the United States of America and all of its territories.

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

Guarantee of Payment: A written assurance from the Company that a specific medical Treatment will be covered.

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

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

Home Country: The Home Country is the Insured Person's country of nationality. In the event the Insured Person has more than one (1) Home Country under the above listed criteria, the Home Country is the primary country of nationality as declared by the Insured Person on their Application.

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

Home Nursing Care: Services and/or Treatment provided by a Home Health Care Agency and supervised by a Registered Nurse that are directed toward the Convalescent care of a patient, provided always that such care is Medically Necessary and in lieu of Medically Necessary Inpatient care. Home Nursing Care does not include services or Treatment primarily for Custodial Care or rehabilitative purposes.

Hospice; Hospice Care: Care provided in an Inpatient Facility or at a patient's home. Hospice Care must be certified by a Physician and life expectancy is six (6) months or less.

Hospital: An institution which operates as a Hospital pursuant to law; is licensed by the state or country in which it operates; operates primarily for the reception, care, and Treatment of sick or injured persons as Inpatient; provides twenty-four (24) hour nursing service by Registered Nurses on duty or call; has a staff of one (1) or more Physicians available at all times; provides organized Facilities and equipment for diagnosis and Treatment of acute medical, surgical or Mental or Nervous conditions on its premises; and is not primarily a long-term care Facility, Extended Care Facility, nursing, rest, Custodial Care, convalescent home, place for the aged, drug addicts or abusers, alcoholics or runaways, or similar establishment.

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

Host Country: On the Initial Effective Date and at each subsequent renewal date, the country in which the Insured Person expects to live and spend the majority of their time during that Period of Coverage.

Illness: A sickness, disorder, illness, pathology, abnormality, malady, morbidity, affliction, disability, defect, handicap, deformity, birth defect, congenital defect, symptomatology, syndrome, malaise, infection, infirmity, ailment, disease of any kind, or any other medical, physical or health condition. Provided, however, that Illness does not include learning disabilities, or attitudinal disorders or disciplinary problems. All Illnesses that exist simultaneously or which arise subsequent to a prior Illness and which directly or indirectly relate to or result or arise from the same or related causes or as a consequence thereof or from one another are considered to be a single Illness. Further, if a subsequent Illness results or arises from causes or consequences that are the same as or related to the causes or consequences of a prior Illness, the subsequent Illness will be deemed to be a continuation of the prior Illness and not a separate Illness.

IMG Claim Form: A form that allows the Insured Person to request reimbursement or direct payment for medical services obtained.

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

Initial Effective Date: The Initial Effective Date commences at 12:01 AM local time on the date the Insured Person is originally approved for coverage under this insurance plan and maintains continuous unbroken coverage thereafter.

Injury: Bodily injury resulting or arising directly from an Accident. All Injuries resulting or arising from the same Accident shall be deemed to be a single Injury.

Inpatient: A person who has been admitted to and charged by a Hospital for bed occupancy for purposes of receiving Inpatient Hospital services. Generally, a patient is considered an Inpatient if billed by the Hospital for Charges as an Inpatient, and formally admitted as an Inpatient with the expectation that person will occupy a bed and (a) remain at least overnight or (b) is expected to need Hospital care for twenty-four (24) hours or more.

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

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

Interfacility Ambulance Transfer: Movement of the patient locally within the United States from one licensed health care Facility to another licensed health care Facility via air or land ambulance (examples: Hospital to Hospital, clinic to Hospital, Hospital to Extended Care Facility). The Interfacility Ambulance Transfer must be Medically Necessary and Pre-certified in advance to be an Eligible Medical Expense.

Investigational: Any Treatment that includes drugs, procedures, or services that are still in the clinical stages of evaluation and not yet approved for use by the U.S. Food and Drug Administration (FDA) including an Emergency Use Authorization by the FDA.

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

Local Ambulance Transport; Local Ambulance Expense: Transportation and accompanying Treatment provided by designated, licensed, qualified, professional emergency personnel from the location of an Accident, Injury or acute Illness to a Hospital or other appropriate health care Facility. Local ambulance transport does not include subsequent Interfacility transfers of admitted patients.

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

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

Mental or Nervous Disorders: Any mental, nervous, or emotional Illness which generally denotes an Illness of the brain with predominant behavioral symptoms; an Illness of the mind or personality, evidenced by abnormal behavior; or an Illness or disorder of conduct evidenced by socially deviant behavior. Mental or Nervous Disorders include without limitation: psychosis; depression; schizophrenia; bipolar affective disorder; any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases as published by the U.S. Department of Health and Human Services; and those psychiatric and other mental Illnesses listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders published by the American Psychiatric Association. For purposes of this insurance, Mental or Nervous Disorders do not include Substance Abuse, learning disabilities, developmental delay, conduct disorders, behavioral problems, and attitudinal disorders or disciplinary problems.

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

Organized Sports: Athletic activities organized by an institution, league, or association that sets and enforces rules, conducts formal practices, and schedules competitions.

Orphan Drugs: Pharmacologic Treatments where those Treatments are designated by the U.S. Food and Drug Administration (FDA) as orphan drugs, all as more particularly provided in the Purple Book of FDA-licensed (approved) biological products regulated by the Center for Drug Evaluation and Research (CDER), including licensed biosimilar and interchangeable products, and their reference products, and FDA-licensed allergenic, cellular and gene therapy, hematologic, and vaccine products regulated by the Center for Biologics Evaluation and Research (CBER), the most current version being located at <https://www.accessdata.fda.gov/scripts/opdlisting/oopd/index.cfm>, as amended from time to time (and available to the Insured Person upon request).

Outpatient: A person who receives Medically Necessary Treatment by a Physician or other healthcare provider and is not an Inpatient, regardless of the hour that the person arrived at the hospital, whether a bed was used, or whether the person remained in the hospital past midnight.

Pandemic: A global outbreak of a disease.

Period of Coverage: The period beginning on the Effective Date of Coverage of this Certificate and ending on the earliest of the following dates:

- (a) the termination date specified in the Declaration; or
- (b) the termination date as determined in accordance with the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF COVERAGE FOR INSURED PERSONS provision.

The Period of Coverage can be no more than twelve (12) consecutive months.

Physician: A duly educated, trained and licensed practitioner of the medical arts. A Physician must be currently and appropriately licensed by the state or country in which the services are provided, and the services must be within the scope of that license, training, experience, competence, and health professions standards of practice.

Plan Administrator: The Plan Administrator for this insurance is International Medical Group®, Inc., 9200 Keystone Crossing, Suite 800, Indianapolis, Indiana, 46240, Telephone Number +1.317.655.4500, or +1.800.628.4664, Fax Number +1.317.655.4505, Website: <http://www.imglobal.com>, Email: insurance@imglobal.com. As the Plan Administrator, International Medical Group, Inc., acts solely as the disclosed and authorized agent and representative for and on behalf of the Company, and does not have, and shall not be deemed, considered or alleged to have any, direct, indirect, joint, several, separate, individual, or independent liability, responsibility or obligation of any kind under the Master Policy, the Declaration, any Riders or this Certificate to the Insured Person or to any other person or entity, including without limitation to any Physician, Hospital, Extended Care Facility, Home Health Care Agency, or any other health care or medical service provider or supplier.

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

Pre-existing Condition: Any Illness, Injury, sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment that was symptomatic, Treated or diagnosed at any time prior to the Application or Initial Effective Date of this insurance.

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

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

Proof of Claim: Duly completed and signed claim form, authorization to release medical information, Physician, Hospital and other healthcare provider's statement detailing the cost and services rendered and proof of payment for services rendered. Refer to the PROOF OF CLAIM provision for further details.

Public Health Emergency of International Concern: A formal declaration by the World Health Organization (WHO) of an extraordinary event which is determined to constitute a public health risk through the international spread of disease, Epidemic, Pandemic and potentially requires a coordinated international response.

Qualified Facility: A medical Facility that can perform the needed procedure or Treatment.

Radiology: Specialty services that use medical imaging to diagnose and treat diseases seen within the body. Imaging techniques used in Radiology include X-ray, radiography, ultrasound, computed tomography (CT), nuclear medicine including positron emission tomography (PET), and magnetic resonance imaging (MRI).

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

Regulatory Body or Authority: A government agency or independent organization responsible for enforcing laws, regulations, and rules within a specific sector or industry.

Relative: A parent, legal guardian, Spouse, son, daughter, or immediate Family member of the Insured Person.

Renewal Premium: The first Premium payment of each Period of Coverage. The Renewal Premium does not apply to the first Period of Coverage.

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

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

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

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

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

Stacked Insurance: Purchasing the same or like insurance product through the Company, for the same area of coverage, for the same or similar coverage period, and for the same coverage intent to increase a claims payout.

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

Superbill: An itemized list of all services provided to the Insured Person by a Physician or medical provider.

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

Teladoc Consultation: A phone or video consultation provided by the vendor, Teladoc Physicians, PA, a network of board-certified providers in the United States available on-demand twenty-four (24) hours a day, seven (7) days a week, three

hundred sixty-five (365) days a year to diagnose, treat and prescribe medication (when necessary) for non-emergency medical issues. Teladoc does not replace existing primary care Physician relationships but supplements them.

Teleconsultation: Treatment of an Illness or Injury involving the Insured Person and a Physician at different locations, and who are connected by video, audio and computers.

Telehealth: The distribution of health-related services and information via electronic information and telecommunication technologies. It allows long-distance patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions.

Telemedicine: A process where an Insured Person is teleconferenced for a Teleconsultation with a qualified Physician but is attended at the remote point by a Telepresenter. This Telepresenter may be equipped with either an exam camera or a stethoscope, and possibly other medical equipment as well, for the purpose of using those medical devices to gather and relay data to the Physician's office or to the Treating Physician.

Telepresenter: A medical assistant who is present with the Insured Person during a Teleconsultation led by a remote Physician.

Terms: All Terms, provisions, conditions, definitions, Deductibles, Coinsurance, limits, sub-limits, limitations, wordings, restrictions, requirements, qualifications and/or exclusions that bind the Insured Person as set forth in the Master Policy, Application and any Riders.

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

Traumatic Dental Injury: An injury that includes:

- (a) Trauma involving the face, skull, neck and/or jaws which resulted in loss of teeth or a serious dental Injury; and
- (b) Injury requiring evaluation and Treatment in a Hospital Emergency room or a Hospital confinement setting.

Travel Warning; Emergency Travel Advisory: A published statement, warning or advisory, including any website document, issued by the United States Centers for Disease Control & Prevention (CDC), United States Department of State, United States Bureau of Consular Affairs, or similar government or non-governmental agency of the Insured Person's Home Country or Host Country, warning that travel to Affected Areas poses serious risks to health, safety and security or exposes the Insured Person to a greater likelihood of life-threatening risks, including all United States Department of State Travel Advisories or Warnings Levels "3 - reconsider travel" and "4 -do not travel" and CDC Travel Advisories or Warnings Level "3 – avoid nonessential travel" or any higher level. When multiple government or non-governmental agencies have issued different levels of warnings or advisories, the highest warning or advisory applicable to the Insured Person's Home Country or Host Country will be considered for coverage under this insurance. For the avoidance of doubt, a Travel Warning covers all specified Affected Areas, including the United States of America as applicable.

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

Treating Physician: A Physician who provides Treatment to an Insured Person.

Unexpected: Sudden, unintentional, not expected and unforeseen.

Universal Billing Form: UB 04 and CMS 1500 forms, which are standard and uniform forms in the healthcare industry to submit insurance claims to Medicare or other health insurance companies for reimbursement.

Urgent Care Clinic: A standalone Facility or a Facility located inside a Hospital that staffs Physicians, nurse practitioners (NP) or physician assistants (PA). Urgent Care Clinics provide medical services for non-life-threatening Injuries or Illnesses. Urgent Care Facilities have onsite x-ray equipment and provide Treatment for more severe urgent care services such as broken bones, burns and other non-emergent conditions that Convenience Clinics are unable to treat.

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

Virtual Physician Visit: A live consultation conducted over the internet or phone between Physician and the Insured Person.

Worsening: Deterioration of an Insured Person's medical condition, symptoms or diagnosis that may lead to further complications following a Discharge Against Medical Advice or an increased likelihood or need for readmission.

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Standard
Certificate of Insurance

Plan Administered by:



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