International Marine Medical Insurance℠

Platinum

Certificate of Insurance

IMPORTANT NOTICE REGARDING THIS INSURANCE*: This insurance is not subject to and does not provide certain insurance benefits required by the United States' Patient Protection and Affordable Care Act ("PPACA"). PPACA requires certain US citizens or US residents to obtain PPACA compliant health insurance, or "minimum essential coverage." PPACA also requires certain employers to offer PPACA compliant insurance coverage to their employees. Tax penalties may be imposed on U.S. residents or citizens who do not maintain minimum essential coverage, and on certain employers who do not offer PPACA compliant insurance coverage to their employees. In some cases, certain individuals may be deemed to have minimum essential coverage under PPACA even if their insurance coverage does not provide all of the benefits required by PPACA. You should consult your attorney or tax professional to determine whether the policy meets any obligations you may have under PPACA.*

Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is solely the Employee's responsibility to determine the insurance requirements that are applicable to him/her and the Company and IMG shall have no liability whatsoever, including for any penalties that the Employee may incur, for failure to obtain coverage required by any applicable law including without limitation PPACA

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BENEFIT SUMMARY

Coverage Limit / Maximum Amount for Eligible Medical Expenses	
Period of Coverage	Maximum Limit: 365 days
Calendar Year Maximum Limit	Refer to Declaration
Medical Concierge • Non-emergency services only	The Medical Concierge Service is a proprietary service of IMG that helps an Insured Person navigate the United States health care system to identify the highest quality providers for scheduled Inpatient and certain Outpatient Treatments. Refer to the MEDICAL CONCIERGE provision for further details.

Benefit Plan Features				
Benefit Levels	**United States**	**United States**	**United States**	**International**
	Medical Concierge	In-Network	Out-of-Network	International
Deductible for Eligible Medical Expenses				
Deductible	Refer to Declaration	Refer to Declaration	Refer to Declaration	Refer to Declaration
Family Deductible • Maximum 3 Deductibles per Family	Refer to Declaration	Refer to Declaration	Refer to Declaration	Refer to Declaration
Coinsurance for Eligible Medical Expenses				
Coinsurance • In addition to Deductible	Plan pays 100% Insured pays 0%	Plan pays 100% Insured pays 0%	Plan pays 80% Insured pays 20%	Plan pays 100% Insured pays 0%
Out of Pocket Maximum	$0	$0	$1,000	$0

Pre-certification

- Transplants: No coverage if Pre-certification requirements are not met.
- Interfacility Ambulance Transfer: No coverage if Pre-certification requirements are not met.
- Emergency Medical Evacuation: No coverage if Pre-certification requirements are not met. Refer to the EMERGENCY MEDICAL EVACUATION provision for further details and requirements.
- Maternity and Newborn Care: 50% reduction of Eligible Medical Expenses 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.
- Coinsurance is applied to remainder of the reduced amount.
- Refer to PRE-CERTIFICATION REQUIREMENTS provision for a complete list of services that require Pre-certification.

Pre-existing Conditions

Pre-existing Conditions are covered the same as any other Illness or Injury.

Inpatient or Outpatient Services

Subject to Deductible and Coinsurance unless otherwise noted
Eligible Medical Expenses are limited to Usual, Reasonable and Customary
Maximum Limits per Calendar Year or if indicated, per Lifetime

Benefit	Medical Concierge (Non-emergency)	In-Network	Out-of-Network	International
Eligible Medical Expenses	100%	100%	80%	100%
Physician Visits / Services	Not Applicable	100%	80%	100%

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limits per Calendar Year or if indicated, per Lifetime				
Benefit	**Medical Concierge** (Non-emergency)	**In-Network**	**Out-of-Network**	**International**
Teladoc Consultation	• Not subject to Deductible and Coinsurance • Mental or Nervous Disorders are not covered • 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.			
Hospital Emergency Room: United States • Injury: Not subject to Emergency Room Deductible • Illness: Subject to a $250 Deductible for each Emergency Room visit for Treatment that does not result in a direct Hospital admission	Not Applicable	100%	80%	Not Applicable
Hospital Emergency Room: International	Not Applicable	Not Applicable	Not Applicable	100%
Hospitalization / Room & Board • Average semi-private room rate • Includes nursing, miscellaneous and Ancillary Services	100%	100%	80%	100%
Intensive Care	100%	100%	80%	100%
Outpatient Surgical / Hospital Facility	100%	100%	80%	100%
Laboratory	Not Applicable	100%	80%	100%
Radiology / X-ray	100%	100%	80%	100%
Chemotherapy / Radiation Therapy	100%	100%	80%	100%
Pre-admission Testing	Not Applicable	100%	80%	100%
Surgery	100%	100%	80%	100%
Reconstructive Surgery • Surgery is incidental to and follows Surgery that was covered under the plan	100%	100%	80%	100%
Assistant Surgeon • 20% of the primary surgeon's eligible fee	100%	100%	80%	100%

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limits per Calendar Year or if indicated, per Lifetime				
Benefit	**Medical Concierge** (Non-emergency)	**In-Network**	**Out-of-Network**	**International**
Second Surgical Opinion • Payable at 100% if requested by the Company • 50% reduction of Eligible Medical Expenses for failure to obtain a Second Surgical Opinion when required by the Company	Not Applicable	100%	80%	100%
Anesthetists	100%	100%	80%	100%
Pregnancy and Newborn Care • After 10 months of continuous coverage • Result of Natural Insemination • Newborn routine care, diagnostic tests and routine immunizations for the first 31 days of life	Not Applicable	100%	80%	100%
Pregnancy Complications • After 10 months of continuous coverage	Not Applicable	100%	80%	100%
Durable Medical Equipment	Not Applicable	100%	80%	100%
Podiatry Care • Maximum Limit: $750	Not Applicable	100%	80%	100%
Chiropractic Care • Not subject to Deductible • Maximum Limit per visit: $75 • Maximum visits: 20 • Physician order not required	Not Applicable	100%	100%	100%
Chiropractic Care • Must be part of recovery Treatment plan for a covered Illness or Injury • Medical order or Treatment plan required	Not Applicable	100%	80%	100%
Physical Therapy and Occupational Therapy • Not subject to Coinsurance • Maximum Limit per visit: $75 • Medical order or Treatment plan required	Not Applicable	100%	100%	100%
Extended Care Facility • Upon direct transfer from acute care Facility	100%	100%	80%	100%
Home Nursing Care • Provided by a Home Health Care Agency • Upon direct transfer from an acute care Facility	100%	100%	80%	100%

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limits per Calendar Year or if indicated, per Lifetime				
Benefit	**Medical Concierge** (Non-emergency)	**In-Network**	**Out-of-Network**	**International**
Transplant • Lifetime Maximum: $1,000,000 • Per Period of Coverage Transplant Maximum Limit: 1 • Organ procurement & harvesting costs Lifetime Maximum: $10,000 • Travel & lodging Lifetime Maximum expense: $5,000 • Covered Transplants: cornea, heart, heart/lung, lung, kidney, kidney/pancreas, liver, allogeneic or autologous bone marrow • Subject to the TRANSPLANT PRE-CERTIFICATION provision and only when Treatment is provided within the Company's approved independent Managed Transplant System Network	100%	100%	80%	100%
Preventative Care NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limits per Calendar Year or if indicated, per Lifetime				
Adult Preventative Care • Ages 19 and over • Maximum Limit: $500 • Refer to the PREVENTATIVE CARE provision for further details and requirements	Not Applicable	100%	100%	100%
Child Preventative Care • Ages 18 and younger • Maximum Limit: $500 • Refer to the PREVENTATIVE CARE provision for further details and requirements	Not Applicable	100%	100%	100%
Vision Care NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limits per Calendar Year or if indicated, per Lifetime				
Routine Eye Examination • Available after 12 months of continuous coverage	Maximum Limit every 24 months: $100			
Corrective Lenses, Contacts, Frames • Available after 12 months of continuous coverage	Maximum Limit every 24 months: $150			

Prescriptions Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limits per Calendar Year or if indicated, per Lifetime	
United States Retail Pharmacy • Not subject to Deductible and Coinsurance • Copayments are per 30-day supply • Dispensing maximum: 90 days per prescription • Prescriptions $3,000 and higher will require Universal RX (URX) to obtain prior authorization from the Company • Any drug prescribed for usage that is directly or indirectly associated to an exclusion in this Certificate of Insurance may also be subject to Pre-Authorization	Universal RX (URX) Prescription Drug Card MUST be utilized for all Outpatient Prescription Drugs in the United States. Retail Pharmacy Copayments: Generic $5 Higher-cost Generic and Brand $15 Non-Preferred Brand Name $30
International Prescriptions	Coinsurance: 100% Subject to Deductible and Coinsurance Dispensing maximum: 90 days per prescription
International Prescriptions • Prescriptions $3,000 and higher will require Universal RX (URX) to obtain prior authorization from the Company • Any drug prescribed for usage that is directly or indirectly associated to an exclusion in this Certificate of Insurance may also be subject to Pre-Authorization	Expatriate Prescription Services Program Generic $5 Brand Name $15 Copayments are per 30-day supply Dispensing maximum: 180 days per prescription Contact Information: • Enroll via the provider's website www.expatps.com Prescription submission: • Email (scan prescription): concierge@expatps.com • Fax: +1.540.777.7184 Questions/Concerns: • Phone number: +1.540.777.1450 • Email: concierge@expatps.com

Mental or Nervous, Substance Abuse and Counseling Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limits per Calendar Year or if indicated, per Lifetime				
Benefit	**Medical Concierge** (Non-emergency)	**In-Network**	**Out-of-Network**	**International**
Lifetime Maximum	$20,000			
Inpatient Mental or Nervous / Substance Abuse	100%	100%	80%	100%
Outpatient Mental or Nervous / Substance Abuse • Maximum Limit per visit: $100 • Maximum visits: 52	Not Applicable	100%	80%	100%

Emergency Services NOT Subject to Deductible or Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limits per Calendar Year or if indicated, per Lifetime				
Benefit	**Medical Concierge** (Non-emergency)	**In-Network**	**Out-of-Network**	**International**
Emergency Local Ambulance • Subject to Deductible and Coinsurance • Injury • Illness resulting in an Inpatient Hospital admission	Not Applicable	100%	80%	100%
Emergency Medical Evacuation • Lifetime Maximum: $1,000,000 • Insured persons under 65 years of age • Approved in advance and coordinated by the Company	Not Applicable	100%	100%	100%
Emergency Reunion • Lifetime Maximum: $10,000 • Maximum days: 15 • Maximum Meal Limit per day: $25 • Reasonable and necessary travel costs and accommodations • Approved in advance by the Company	Not Applicable	100%	100%	100%
Interfacility Ambulance Transfer • Transfer must be a result of an Inpatient Hospital admission	Not Applicable	100%	100%	100%
Return of Mortal Remains • Maximum Limit: $25,000 • Local Burial / Cremation Maximum Limit: $10,000 • Return of Insured Person's Mortal Remains to Home Country • Approved in advance by the Company	Not Applicable	100%	100%	100%
Other Services NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limits per Calendar Year or if indicated, per Lifetime				
Accommodation Benefit • Maximum Limit: $2,500 • Refer to the ACCOMMODATION BENEFIT provision for further details and requirements	Not Applicable	100%	100%	100%
Amateur Sailboat Racing • Subject to Deductible and Coinsurance	Not Applicable	100%	80%	100%
Crew Member Return • Maximum Limit: $2,500	Not Applicable	100%	100%	100%
Emergency Dental • Subject to Deductible and Coinsurance • Accident related	Not Applicable	80%	80%	100%

Other Services NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limits per Calendar Year or if indicated, per Lifetime				
Benefit	**Medical Concierge** (Non-emergency)	**In-Network**	**Out-of-Network**	**International**
Traumatic Dental Injury • Treatment at a Hospital Facility due to an Accident • Additional Treatment for the same Injury rendered by a Dental Provider will be paid at 100%	Not Applicable	100%	80%	100%
Hospital Indemnity • International Only • Benefit is not available when the Inpatient Hospital Treatment is part of the Medical Travel Management benefit • Inpatient Hospitalization only	• Overnight Maximum Limit: $100 • Maximum overnight limit: 20 • Maximum Limit: $2,000			
TELUS Health Consultation	Coverage for a TELUS Health 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 TELUS Health Consultation where the Illness or Injury is directly or indirectly related to any Pre-existing Condition or is otherwise excluded under this Certificate of Insurance			
Medical Travel Management • Must be approved in advance by the Company	Medically Necessary non-emergency Treatment, including Hospitalization and Surgery for approved procedures, the Company will offer Medical Travel as a means to manage the costs. If Medical Travel is approved, the Company will reimburse 10% of the cost savings, up to a maximum of $7,500 back to the Insured Person where such savings arise from Treatment outside of the United States. Meal allowance Maximum: $100 Refer to the MEDICAL TRAVEL MANAGEMENT provision for further details and requirements.			
Non-emergency Medical Evacuation • Lifetime Maximum: $1,000,000 • Insured Persons under age 65 • Approved in advance and coordinated by the Company	Not Applicable	100%	100%	100%
Recreational Underwater Activities • Subject to Deductible and Coinsurance	Not Applicable	100%	80%	100%
Supplemental Accident Benefit • Maximum Limit per covered Accident: $500	Not Applicable	100%	100%	100%

A. **BENEFIT SUMMARY**: Subject to the Terms of this insurance, including the AGREEMENT provision, 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.

B. **AGREEMENT**: Crum & Forster SPC (the Company) promises the Participating Organization 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 Participating Organization's Application, the eligible Employee's Enrollment Form, 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 January 1, 2024 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 shown on the Declaration and shall remain in effect until terminated in accordance with the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF GROUP CERTIFICATE provision. This Certificate is not part of the insurance contract. The contract is the Master Policy, the Application, the Declaration and any applicable Riders (such insurance being sometimes referred to herein as "this insurance" or "the plan"). 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; TRIAL BY COURT 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.

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, the Participating Organization and the Insured Person. This Certificate is an outline and evidence of the insurance provided by the Master Policy. This Certificate does not extend or change the coverage provided by the Master Policy. The insurance evidenced by this Certificate is subject to all Terms of the Master Policy, 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 or the first day of each month

(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 provision.

A grace period of thirty (30) 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 first day following the last period for which Premium has been received, 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 at the contact information below, or online at www.imglobal.com/member as soon as possible:

International Medical Group

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 International Medical Group (IMG) Claim Form as a necessary component of the Proof of Claim. An IMG Claim Form may be obtained from the form's library on IMG's website at www.imglobal.com or completed online via the MyIMG customer portal.

(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.

(v) If the claims are submitted electronically, copies of the above items are acceptable; however, the Company reserves the right to request the original documents.

(b) 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 any 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.

(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; TRIAL BY COURT**: No action at law or in equity can be brought by the Participating Organization or the 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 at law or in equity 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 Cayman Islands. Sole and exclusive jurisdiction and venue for any court action or administrative proceeding relating to this insurance shall be in Cayman Islands, for which the Insured Person expressly consents. The subjects, risks and benefits of insurance covered by the Master Policy and evidenced by this Certificate are not intended or considered by the Company or the Plan

Administrator to be resident, located or performed in any particular country, jurisdiction, state or political subdivision. Cayman Islands law shall govern all rights and claims raised under this Certificate of Insurance.

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 Participating Organization and/or 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 Cayman Islands , 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 courts of Cayman Islands . All trials regarding any dispute under this insurance shall be exclusively presented to and determined solely by the court as the trier of fact, without a jury. The Company reserves the right, acting by and through the Plan Administrator, 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 or controversy arising under 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 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, procedural and/or substantive choice of law, personal jurisdiction, or subject matter jurisdiction in any forum other than the courts in Cayman Islands, (ii) commence an action in any court of competent jurisdiction in or outside of Cayman Islands, as permitted by the laws of such forum or the laws of Cayman Islands, or (iii) seek transfer of a case to another court or forum as permitted by the laws of such forum or the laws of Cayman Islands, as applicable; 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 jurisdiction which makes provision thereof, the Company hereby designates the Cayman Islands Monetary Authority (CIMA) (or such other officer specified for that purpose in the statute), or his successor or successors in office, as its true and lawful attorney, under a special power of attorney, upon whom may be served any lawful process issued in connection with the initiation of any action, suit or proceeding instituted by or on behalf of the Insured Person arising out of this insurance, and hereby designates and appoints Fairmont Specialty Trust as Trustee of the ITA GlobalTrust, LTD, Suite 4210, 2nd Floor Canella Court, 48 Market St., Camana Bay, Grand Cayman KY1-1208, Cayman Islands, as its attorney-in-fact and agent for service of process to whom said officer or Director is authorized to mail or serve any such process or a true copy thereof.

(7) **ECONOMIC SANCTIONS**: Notwithstanding any other Terms under this insurance, the Company shall not provide coverage or make any payments or provide any service or benefit to any Insured Person, beneficiary, or third party who may have any rights under this insurance to the extent that such coverage, payment, service, or benefit would violate 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.

(8) **MISREPRESENTATION**: Any false representation, incomplete information, misleading statement, misstatement, omission, concealment or fraud, whether or not innocently made, either in the Participating Organization's Application or in the Insured Person's Enrollment Form, or in relation to any claim form, statement, certification or warranty made by the Participating Organization or any 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.

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

(10) **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 they 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.

Notwithstanding the foregoing, the Company's rights pursuant to this provision shall be waived with respect to claims made, pursuant to the Jones Act or other similar maritime law, against the Participating Organization's Protection and Indemnity or other similar insurer, but only to the extent that such claims are otherwise covered hereunder and not paid by or collected from the Participating Organization's Protection and Indemnity or other similar Insurer.

(11) **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. The Company shall not be liable or obligated to provide any benefit or to pay or reimburse any claim in respect to Treatment or supplies furnished by any program or agency funded by any government or governmental authority.

(a) **PROTECTION AND INDEMNITY**: The foregoing shall not apply to the extent such claims are actually paid by the Participating Organization's Protection and Indemnity (P&I) or other similar insurance.

(b) **MEDICARE**: Upon the Insured Person's attainment of Medicare eligibility, this insurance shall be primary to Medicare coverage in the following situations:

(i) when the Employee is over the age of sixty-five (65) years and Actively At Work Full-time and the Participating Organization employed twenty (20) or more employees on a typical business day during the Calendar Year preceding the date of service

(ii) when the Insured Person has end stage renal disease and is in the first twenty-one (21) months of Medicare eligibility that is due to renal dialysis. Provided, however, such twenty-one (21) month period is reduced to eighteen (18) months if the three (3) month waiting period for Medicare entitlement is waived due to the Insured Person's participation in a dialysis training program in a Medicare-approved training Facility before the third month after dialysis begins

(iii) when the Insured Person is under the age of sixty-five (65) years and is eligible for Medicare due to disability and the Participating Organization employed one hundred (100) or more employees on a typical business day during the Calendar Year preceding the date of service.

In all circumstances other than in the subparagraphs above, the Company shall not be obligated to provide any benefits or to pay or reimburse any claim for services incurred in the United States under this insurance except in respect of any excess beyond the amount payable under Medicare coverage.

If an Insured Person is entitled to Medicare Part A or Part B, benefits for services incurred in the United States will be calculated as though Medicare covered such Insured Person, whether or not such Insured Person has actually enrolled in Medicare. Therefore, failure to enroll in Medicare when eligible may result in extremely limited available benefits under this insurance. Medicare enrollment may be completed in person during the three (3) month period prior to a sixty-fifth (65^{th}) birthday, at a Social Security office or United States embassy, or by mail to any United States embassy.

Each Insured Person will be investigated thoroughly to determine Medicare order of benefit determination.

(c) **STACKED INSURANCE**: The Company reserves the right to cancel any and all coverage if it is determined an Insured Person has Stacked Insurance.

(12) **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).

(13) **COOPERATION**: The Participating Organization and 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 Participating Organization, 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.

(14) **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, in care of the Participating Organization at its last known mailing address. While this insurance is in effect, in order to effectuate proper administration, the Participating Organization 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 in care of the Participating Organization at its last known 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.

(15) **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.

(16) **ARBITRATION**: No claim for benefits for which liability, eligibility, or coverage under this insurance has been denied in whole or in part by the Company nor any other dispute or controversy arising under or related to this insurance shall be arbitrable or subject to arbitration under any circumstances or for any reason.

(17) **PARTICIPATING ORGANIZATIONS**: Sea-going vessels that employ a minimum of two (2) full-time Professional Marine Crew Members with the expectation of remaining outside US waterways for significant periods of time, thus reducing the group's eligibility for comprehensive medical insurance coverage through domestic US insurance carriers, and also meet the following requirements:

(a) it completes and submits to the Company, through the Plan Administrator, an Application to participate or renew participation under this insurance as a Participating Organization on a form approved and provided by the Company

(b) it is accepted as a Participating Organization by the Company and receives a Certificate issued by the Company

(c) it agrees to receive Premium invoices on behalf of Insured Persons and remit an up-to-date and accurate census along with one (1) payment per month for all Insured Persons' Premium

(d) it will at all times enroll in and maintain coverage under this insurance plan for at least eighty percent (80%) of its eligible Class I or II Employees under this insurance

(e) it will provide the Company notification, that all eligible Class I or II Employees and their respective Spouses and Dependents, with a completed Enrollment Form including Creditable Coverage documentation, if applicable, as evidence of Enrollment or written notification of declined Enrollment under this insurance

(f) it will provide each and every Insured Person a copy of this Certificate of Insurance

(18) **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 Participating Organization and 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 or renewals will be issued or further Applications accepted for the plan after the date the Master Policy is terminated.

(19) TERMINATION OF GROUP CERTIFICATE: The Participating Organization can terminate coverage under the Master Policy as evidenced by this Certificate by giving at least thirty (30) days prior written notice to the Company. Furthermore, coverage under the Master Policy as evidenced by this Certificate will terminate effective at 12:01 AM EST, on the earliest of one of the following dates:

(a) the date the Participating Organization no longer meets the requirements as set forth in the CONDITIONS AND GENERAL PROVISIONS, PARTICIPATING ORGANIZATIONS provision

(b) the end of the period for which Premium has been timely paid

(c) the date the Master Policy is terminated pursuant to the CONDITIONS AND GENERAL PROVISIONS, TERMINATION OF MASTER POLICY provision

(d) twelve (12) months following the Effective Date of this Certificate, or any anniversary thereof, unless the Participating Organization has applied for and been accepted for renewal of this Certificate, on such Terms as offered by the Company and on forms acceptable to the Company.

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

(a) the date the Master Policy and/or this Certificate is terminated pursuant to the TERMINATION OF MASTER POLICY or TERMINATION OF GROUP CERTIFICATE subparagraphs of the CONDITIONS AND GENERAL PROVISIONS

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

(c) the end of the period for which Premium has been timely paid

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

(e) the date the Insured Person retires

(f) for the covered Spouse or Dependents of an Insured Person who dies while covered by this Certificate, sixty (60) days from the end of the month following the death of the Insured Person

(g) 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) EXTENSION OF BENEFITS: If an Insured Employee becomes Totally Disabled, as herein defined, on or after the Employee's Effective Date of Insurance, the Employee shall be entitled to continue coverage hereunder, subject to all Terms, conditions, provisions and exclusions of this insurance, for a period not to exceed one hundred eighty (180) days, beginning on the first day of Total Disability. If, as of the one hundred eightieth (180th) day following the first day of Total Disability, the Employee has not returned to Actively at Work, as defined herein, then all insurance for the Employee and all Dependents of the Employee shall terminate as of that date, unless continued in accordance with the CONDITIONS AND GENERAL PROVISIONS, CONTINUATION OF BENEFITS provision. Concurrent periods of Total Disability shall be considered one (1) period of Total Disability beginning on the first day of the first Total Disability. Successive periods of Total Disability shall be considered separate periods of Total Disability, each beginning on the first day of said Total Disability provided that such periods of Total Disability are separated by a period or periods of no less than ninety (90) days during which the Employee continuously maintained Actively at Work status. If successive periods of Total Disability are not separated by a period or periods of no less than ninety (90) days during which the Employee continuously maintained Actively at Work status, then the period of Total Disability shall, for purposes of this insurance, be considered one (1) period of Total Disability beginning on the first day of the first Total Disability. If the Employee has Dependent(s) covered hereunder as of the first day of Total Disability, then the insurance for said Dependent(s) shall also be extended for the same period as that of the Employee.

(22) CONTINUATION OF BENEFITS: If coverage for an Employee is or will be terminated in accordance with the CONDITIONS AND GENERAL PROVISIONS, EXTENSION OF BENEFITS provision, and the Employee remains Totally Disabled as of the termination date, the Employee, at their option and expense, may continue coverage hereunder for a period of up to twelve (12) months, beginning on the date the Employee's coverage would have terminated in accordance with the CONDITIONS AND GENERAL PROVISIONS, EXTENSION OF BENEFITS provision. In order to elect to continue coverage, the Employee must:

(a) Notify the Company within thirty (30) days following termination in accordance with the CONDITIONS AND GENERAL PROVISIONS, EXTENSION OF BENEFITS provision, of its intent to elect continuation

(b) Pay the Premium specified in the Declaration of this Certificate as continuation Premium, on or before each due date specified in the Declaration. If any Premium remains unpaid as of the last day of the grace period specified herein, all insurance hereunder shall terminate with effect from the due date of the unpaid Premium.

If the Employee has Dependent(s) covered hereunder as of the date coverage is terminated in accordance with the CONDITIONS AND GENERAL PROVISIONS, EXTENSION OF BENEFITS provision, the Employee must continue coverage hereunder for themself and for all such Dependents. Dependent(s) coverage cannot be continued unless the Employee coverage is also continued.

(23) RENEWAL; AMENDMENTS: Subject to the Terms of the TERMINATION OF MASTER POLICY and TERMINATION OF GROUP CERTIFICATE subparagraphs of the CONDITIONS AND GENERAL PROVISIONS, a Participating Organization may request renewal prior to the expiration date of the then existing Period of Coverage in accordance with and subject to the Terms of the plan then in effect (including the Terms of the then applicable Master Policy) and so long as renewal Premium is paid when due and the Participating Organization and Insured Persons otherwise continue to meet the applicable eligibility requirements of the plan.

(a) Coverage under the insurance plan will renew without a signed renewal letter if and only if the Company provides a written notice to the Participating Organization at least thirty (30) days prior to the expiration date of the then existing Period of Coverage when no changes to the existing benefits are requested.

(b) Coverage under the insurance plan will renew with a signed renewal letter if and only if the Company provides a written notice to the Participating Organization at least thirty (30) days prior to the expiration date of the then existing Period of Coverage and requested changes were made to the existing benefits for the renewal Period of Coverage.

The Company's offer and the Participating Organization's ability to request renewal is also subject to termination upon written notice to the other party at least thirty (30) days prior to the expiration date of the then existing Period of Coverage. The Company reserves the right in its sole discretion to make changes, additions and/or deletions to the Terms of the Master Policy, Certificate, renewals or replacements of either and/or 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 Participating Organization ("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 Participating Organization's cancellation rights and shall be sent first class mail, postage prepaid, to the last known mailing address of the Participating Organization. Upon issuance of the Notice of Amendment, the Assured and/or the Participating Organization shall have the right to request cancellation of this Certificate at any time prior to the Change Date.

(24) REINSTATEMENT OF COVERAGE: In the event coverage under this insurance lapses or is terminated in accordance with the PREMIUM and/or TERMINATION OF GROUP CERTIFICATE subparagraphs of the CONDITIONS AND GENERAL PROVISIONS for failure to pay Premium, the Participating Organization 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 Participating Organization 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 or to accept renewal terms in a timely manner

(e) payment of all Premium due

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

(25) 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.

(26) 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.

(27) 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 / EFFECTIVE DATE OF COVERAGE:

(1) EMPLOYEE ELIGIBILITY: If an Employee is not eligible, this Certificate is void *ab initio* and all Premium paid will be refunded. In order to be eligible for coverage under this insurance, the Employee must be a Class I or II Employee of the Participating Organization, as defined herein and must be traveling outside of their Home Country.

(2) REGULAR ENROLLMENT OF ELIGIBLE EMPLOYEE: Only eligible Class I and II Employees may enroll for coverage hereunder. In order to enroll, the eligible Employee must:

(a) be listed by the Participating Organization as an Insured Person and an eligible Employee on the day immediately preceding the Participating Organization's initial Effective Date of this Certificate, and must be listed on the completed Enrollment Form received by the Company on or before the Effective Date of this Certificate, and not be Totally Disabled or Hospitalized on the Effective Date of the Certificate. The Enrollment Date is the Effective Date of the Certificate.

(b) for eligible Employees who are added after the Participating Organization's Initial Effective Date of this Certificate, must submit to the Company a completed Enrollment Form, including evidence of insurability (if required) within thirty (30) days beginning on the first day that the Employee is Actively At Work Full-time and not be Totally Disabled or Hospitalized on the date the Employee would become effective were they not Totally Disabled or Hospitalized. The Enrollment Date is the first day that the Employee is Actively At Work Full-time.

(c) if an eligible Employee does not enroll, or declines enrollment, in accordance with subparagraphs (a) or (b) above, the Employee may become eligible for Special Enrollment, in accordance with the SPECIAL ENROLLMENT PERIODS: ELIGIBLE EMPLOYEES AND ELIGIBLE DEPENDENTS and SPECIAL ENROLLMENT FOR CERTAIN DEPENDENT BENEFICIARIES provisions. The Enrollment Date is the date Company receives the completed Enrollment Form and Creditable Coverage documentation, if applicable.

(d) if an eligible Employee does not enroll, or declines enrollment, in accordance with subparagraphs (a) or (b) above, and the Employee is not eligible for Special Enrollment, in accordance with the SPECIAL ENROLLMENT PERIODS: ELIGIBLE EMPLOYEES AND ELIGIBLE DEPENDENTS and SPECIAL ENROLLMENT FOR CERTAIN DEPENDENT BENEFICIARIES provisions, the eligible Employee may request enrollment by contacting the Authorized Representative at the Participating Organization to submit to the Company a completed Enrollment Form, and Creditable Coverage documentation, if applicable. The eligible Employee will be considered a late enrollee and the Enrollment Date is the date the Company receives the completed Enrollment Form, and Creditable Coverage documentation, if applicable.

(3) EFFECTIVE DATE OF COVERAGE FOR ELIGIBLE EMPLOYEE: The Effective Date of Coverage is the date the Employee is entitled to receive benefits under this insurance. The Effective Date of Coverage for eligible Employees is the later of the following dates:

(a) the first day the Employee became an eligible Employee

(b) the Effective Date of this Certificate

(c) the Enrollment Date.

(4) DEPENDENT ELIGIBILITY: If an Insured Person is not eligible, this policy is void ab initio and all Premium paid will be refunded. In order for the Dependent to be eligible for coverage under this insurance, they must be a Dependent of an Actively At Work Class II Employee, as defined herein and must be traveling outside of their Home Country.

(5) REGULAR ENROLLMENT OF ELIGIBLE DEPENDENT: Only Dependents, as defined herein, of an eligible Class II Employee may enroll for coverage hereunder. In order to enroll, the eligible Dependent must:

(a) be listed by the Participating Organization as an Insured Person on the day immediately preceding the Participating Organization's Initial Effective Date of this Certificate, and must be listed on the completed Enrollment Form received by the Company, including evidence of insurability (if required) on or before the Effective Date of this Certificate, and not be Totally Disabled or Hospitalized on the Effective Date of this Certificate. The Enrollment Date is the Effective Date of the Certificate.

(b) if the Employee becomes eligible after the Participating Organization's Initial Effective Date of this Certificate, the eligible Dependent must submit to the Company a completed Enrollment Form, including evidence of insurability (if required), within thirty (30) days, beginning on the first day the Class II Employee becomes Actively At Work Full-time. The Enrollment Date is the first day the Employee is Actively At Work Full-time and the Enrollment Form is approved by the Company.

(c) if an eligible Dependent does not enroll or declines Enrollment in accordance with subparagraphs (a) or (b) above, the eligible Dependent may become eligible for Special Enrollment, in accordance with the SPECIAL ENROLLMENT PERIODS: ELIGIBLE EMPLOYEES AND ELIGIBLE DEPENDENTS and SPECIAL ENROLLMENT FOR CERTAIN DEPENDENT BENEFICIARIES provisions contained in the Master Policy. The Enrollment Date is the date the Company receives the completed Enrollment Form and Creditable Coverage documentation, if applicable.

(d) if an Eligible Dependent does not enroll or declines enrollment, in accordance with subparagraphs (a) or (b) above, and if the Eligible Dependent is not eligible for Special Enrollment, in accordance with the SPECIAL ENROLLMENT

PERIODS: ELIGIBLE EMPLOYEES AND ELIGIBLE DEPENDENTS and SPECIAL ENROLLMENT FOR CERTAIN DEPENDENT BENEFICIARIES provisions contained in the Master Policy, the Eligible Dependent may request enrollment by contacting the Authorized Representative at the Participating Organization to submit to the Company a completed Enrollment Form and Creditable Coverage documentation, if applicable. The eligible Dependent will be considered a late enrollee and the Enrollment Date is the date the Company receives the completed Enrollment Form and Creditable Coverage documentation, if applicable.

(6) **EFFECTIVE DATE OF COVERAGE FOR ELIGIBLE DEPENDENT**: The Effective Date of Coverage for an eligible Dependent is the date the Dependent is entitled to receive benefits under this insurance. The Effective Date of Coverage for the Dependent with Regular Enrollment is the later of the following dates:

(a) the first day the Dependent became an eligible Dependent

(b) the Effective Date of this Certificate

(c) the Enrollment Date.

(7) **SPECIAL ENROLLMENT PERIODS: ELIGIBLE EMPLOYEES AND ELIGIBLE DEPENDENTS**:

(a) **SPECIAL ENROLLMENT CONDITIONS**: An eligible Class I or II Employee or an eligible Dependent is eligible for Special Enrollment under this insurance if one (1) of the following conditions are met:

(i) When the Employee declines enrollment for the eligible Employee or the eligible Dependent, the Participating Organization will provide notification that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment (provided that notification was required of the Employee and provided that the Employee was provided the requirements for such a notification at the time the Employee declined enrollment).

(ii) When the Employee declined enrollment for the eligible Employee or the eligible Dependent, the eligible Employee or eligible Dependent had COBRA continuation coverage under another plan and COBRA continuation coverage under that other plan has since been exhausted.

(iii) If the other coverage that applied to the eligible Employee or the eligible Dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated. For this purpose, loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause.

(iv) When the eligible Dependent is eligible for Special Enrollment at the time they become the eligible Employees eligible Dependent through marriage, birth, adoption, or court-ordered placement for adoption.

(v) If the eligible Employee declines enrollment, the eligible Employee is eligible for Special Enrollment when a person becomes the eligible Employee's Dependent through marriage, birth, adoption or court-ordered placement for adoption.

(vi) If the eligible Employee's Spouse declines enrollment, the eligible Employee's Spouse is eligible for Special Enrollment at the time the eligible Employee enrolls an eligible Dependent due to birth, adoption or court-ordered placement for adoption.

(b) **LENGTH OF SPECIAL ENROLLMENT PERIOD**: An eligible Employee is required to request enrollment for the eligible Employee or the eligible Dependents within thirty (30) days of the date the CONDITIONS FOR SPECIAL ENROLLMENT described in subparagraph (a), above, are met. In order to request enrollment under this provision, the eligible Employee or the eligible Dependent must request enrollment by contacting the Authorized Representative at the Participating Organization to submit to the Company with a completed Enrollment Form and Creditable Coverage documentation, if applicable, for receipt by the Company within thirty (30) days of the date the CONDITIONS FOR SPECIAL ENROLLMENT are met. In the event of Special Enrollment under this provision, the Enrollment Date is the date the Company receives a completed Enrollment Form including Creditable Coverage documentation, if applicable.

(c) **EFFECTIVE DATE OF COVERAGE FOR ELIGIBLE EMPLOYEE AND DEPENDENT WITH SPECIAL ENROLLMENT**: The Effective Date of coverage hereunder for an eligible Employee or eligible Dependent enrolled under this Special Enrollment provision will be:

(i) the first day of the calendar month following the date the Company receives the completed Enrollment Form and Creditable Coverage documentation

(ii) in the case of a Dependent's birth, the date of such birth

(iii) in the case of a Dependent's adoption or court-ordered placement for adoption, the date of such adoption or court order.

(8) **SPECIAL ENROLLMENT FOR CERTAIN DEPENDENT BENEFICIARIES**: Certain Dependent Beneficiaries are eligible for Special Enrollment provided they meet one (1) or more of the following conditions and provided that the Company

receives a completed Enrollment Form including Creditable Coverage documentation, if applicable, within thirty (30) days of meeting one of the following conditions:

(a) **SPECIAL ENROLLMENT OF AN ELIGIBLE EMPLOYEE WHO DECLINED REGULAR ENROLLMENT**: An eligible Employee who declined Regular Enrollment is eligible for Special Enrollment if the Employee has a person that becomes an eligible Dependent of the Employee through marriage, birth, adoption or placement for adoption.

(b) **SPECIAL ENROLLMENT OF A SPOUSE OF A COVERED EMPLOYEE**: An individual is eligible for Special Enrollment if the individual either:

(i) becomes a Spouse of a covered Employee

(ii) is a Spouse of a covered Employee and a Child becomes an eligible Dependent of the covered Employee through birth, adoption or placement for adoption.

(c) **SPECIAL ENROLLMENT OF AN ELIGIBLE EMPLOYEE WHO DECLINED REGULAR ENROLLMENT AND THE SPOUSE OF SUCH ELIGIBLE EMPLOYEE**: An eligible Employee who declined Regular Enrollment and an individual who is an eligible Dependent of such eligible Employee are eligible for Special Enrollment if either:

(i) the eligible Employee and the individual become married

(ii) the eligible Employee and the individual are married, and a Child becomes a Dependent of the eligible Employee through birth, adoption or placement for adoption.

(d) **SPECIAL ENROLLMENT OF A DEPENDENT OF A COVERED EMPLOYEE**: An individual who is a Dependent of a covered Employee who becomes an eligible Dependent of such covered Employee through marriage, birth, adoption or placement for adoption is eligible for Special Enrollment.

(e) **SPECIAL ENROLLMENT OF AN ELIGIBLE EMPLOYEE WHO DECLINED REGULAR ENROLLMENT AND A NEW ELIGIBLE DEPENDENT**: An eligible Employee who declined regular Enrollment and an individual who is an eligible Dependent of the eligible Employee is eligible for Special Enrollment if the individual becomes an eligible Dependent of the eligible Employee through marriage, birth, adoption or placement for adoption.

(f) **ENROLLMENT DATE FOR SPECIAL ENROLLMENT**: In the event of Special Enrollment under this provision, the Enrollment Date is the date the Company receives a completed Enrollment Form from the Authorized Representative at the Participating Organization for the eligible Employee or Dependent who is being added to the plan under Special Enrollment, including Creditable Coverage documentation, if applicable.

(g) **EFFECTIVE DATE OF COVERAGE FOR SPECIAL ENROLLMENT**: In the event of Special Enrollment under this provision, the Effective Date of Coverage shall be:

(i) in the case of marriage, the first day of the first calendar month beginning after the date the completed Enrollment Form is received by the Company

(ii) in the case of a Dependent's birth, the date of such birth

(iii) in the case of a Dependent's adoption or court-ordered placement for adoption, the date of such adoption or court order.

(9) **NEWBORNS**: Newborns of an Insured Person will be covered from the moment of birth for Injury or Illness, provided the infant is properly enrolled as a Dependent of the Insured Person within thirty-one (31) days of their date of birth, the mother is an Insured Person, the mother is entitled to Pregnancy benefits under this insurance, and the Newborn being enrolled was a covered birth under this insurance.

Newborns of an Insured Person whose pre-natal, delivery and post-natal care were ineligible or excluded under this plan, will be effective from the moment of birth for any Injury or Illness that does not directly or indirectly relate to the ineligible birth, provided the infant is properly enrolled as a Dependent of the Insured Person within thirty-one (31) days of their date of birth, the mother is an Insured Person, the mother is entitled to Pregnancy benefits under this insurance and the Newborn has been released from the Hospital.

If a Newborn or Child is acquired other than at the time of birth, due to a court order, decree, or marriage, they will be considered an eligible Dependent from the date of such court order, decree or marriage, provided that they are properly enrolled as such Dependent of the Employee within thirty-one (31) days of the court order, decree or marriage.

(10) **CLERICAL ERROR CLAUSE**: Inadvertent Clerical Error will not change the benefits or provisions of this insurance. Upon discovery of such error, any needed adjustments will be made.

E. **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 behalves) has any authority or obligation to select Physicians, Hospitals, or other healthcare providers for the Insured Person, or to make any diagnosis or medical Treatment decisions on behalf of the Insured Person, and all such decisions must be made solely and exclusively by the Insured Person and/or 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) Home Nursing Care

(d) Inpatient Hospitalization

(e) Interfacility Ambulance Transfer

(f) Maternity

(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) **MATERNITY PRE-CERTIFICATION REQUIREMENTS**: To comply with the Maternity Pre-certification requirements, the Insured Person must:

(a) contact the Company as soon as possible but always within sixty (60) days of expected delivery

(b) contact the Company as soon as diagnosed for multiple birth or a high-risk Pregnancy

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

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

If the Insured Person complies with the Maternity Pre-certification requirements and the expenses are Pre-certified, the Company will pay Maternity and Newborn Care benefits, subject to all Terms, conditions, provisions and exclusions herein. If the Insured Person does not comply with the Maternity Pre-certification requirements, or if the expenses are not Pre-certified, all Maternity and Newborn Care benefits are reduced by the amount shown in the BENEFIT SUMMARY, the Deductible will be subtracted from the remaining amount and Coinsurance will be applied. If for any reason after initial Maternity Pre-certification the Insured Person shall become aware of complications during Pregnancy, the Insured Person must Pre-certify again, in accordance with the General Requirements for Pre-certification.

(4) **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.

(5) **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

(c) Coinsurance will be applied.

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.

(6) **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.

(7) **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.

(8) **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

F. **UNITED STATES PREFERRED PROVIDER ORGANIZATION (PPO)**:

(1) **SPECIAL BENEFITS**: If Treatment or supplies eligible for coverage under this insurance are received directly from the Company's approved list of independent Preferred Provider Organization (PPO) providers while the Insured Person is in the United States, the Company will adjust the Deductible and/or Coinsurance applicable to such claims according to the amount shown in the BENEFIT SUMMARY. However, all claims for Treatment or supplies received in the United States from a non-PPO provider will remain subject to the applicable Deductible and Coinsurance, whether or not the Insured Person may be eligible for the foregoing special benefit relating to Treatment or supplies received from PPO providers.

(2) **PPO INFORMATION**: The Company, through the Plan Administrator, endeavors to maintain a contractual arrangement with one (1) or more independent Preferred Provider Organizations (PPO) that has established and maintains a network of United States-based Physicians, Hospitals and other healthcare and health service providers who are contracted separately and directly with the PPO and who may provide re-pricings, discounts or reduced Charges for Treatment or supplies provided to the Insured Person. Neither the Company nor the Plan Administrator has any authority or control over the operations or business of the PPO, or over the operations or business of any provider within the independent PPO network. Neither the PPO nor providers within the PPO network, nor any of their respective agents, employees or representatives has or shall have any power or authority whatsoever to act for or on behalf of the Company or the Plan Administrator in any respect, including without limitation no power or authority to 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.

It is not a requirement of this insurance that the Insured Person seek Treatment or supplies exclusively from a provider within the independent PPO network. However, the Insured Person's use or non-use of the PPO network may affect

the scope and extent of benefits available under this insurance, including without limitation any applicable Deductible, Coinsurance and benefit reduction, as set forth above.

An Insured Person may contact the Company through the Plan Administrator and request a PPO directory for the area where the Insured Person will be receiving consultation or Treatment (therein listing the Physicians, Hospitals and other healthcare providers within the PPO network by location and specialty), or an Insured Person may visit the Plan Administrator's website at www.imglobal.com/member to obtain such information.

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

The Insured Person must notify the Company immediately in the event a non-emergency Surgery or Covered Transplant is recommended by a Physician. The Company will promptly advise the Insured Person whether or not it will require a second opinion. Upon receipt of a second opinion that differs from the recommending Physician, the Company will promptly advise the Insured Person whether or not it will require a third opinion.

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

(2) The Physician providing the second opinion must meet all of the following criteria:

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

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

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

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

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

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

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

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

If the Insured Person obtains three (3) opinions, the Company will reimburse the Insured Person for Eligible Medical Expenses incurred in accordance with the Terms of this insurance based on the concurring recommendations of two (2) of the three (3) Physicians' opinions. If the Insured Person elects not to follow the recommendations of the two (2) concurring Physicians, all benefits otherwise available under this insurance for reimbursement of Eligible Medical Expenses which are directly or indirectly related to or arise as a consequence of the Surgery, or which are directly or indirectly related to or arise as a consequence of the Insured Person's refusal to undergo the recommended Surgery, shall be reduced by fifty percent (50%).

H. **MEDICAL CONCIERGE SERVICE**: The Medical Concierge Service is a proprietary service of IMG that helps an Insured Person navigate the United States health care system to identify the highest quality providers for scheduled, non-emergency Inpatient and certain Outpatient Treatments. With the Medical Concierge Service, an Insured Person scheduling Inpatient or Outpatient Treatment receives important information to help them choose their medical provider of eligible medical conditions, including information on the cost and quality of Hospitals, thereby maximizing the benefits provided under this insurance plan.

For non-emergency, Inpatient Treatment incurred within the United States, use of the Medical Concierge Service will provide the Insured Person with a list of qualified providers within the geographical area where the Insured Person is located when Treatment is Medically Necessary.

Special Benefit when using the Medical Concierge Service: When the Insured Person obtains Treatment and incurs Eligible Medical Expenses under the insurance plan shown in the Declaration from a Physician, other health care provider or Hospital chosen by the Insured Person through use of our Medical Concierge Service, irrespective of whether the provider

is within the United States Preferred Provider Organization (PPO), the Company will adjust the Coinsurance and out-of-pocket expenses to the amount shown in the BENEFIT SUMMARY.

To qualify for these benefits, the Insured Person must contact the Company immediately upon the recommendation by a health care provider that the Insured Person be admitted or receive any of the following:

(1) Colonoscopy

(2) Computerized Axial Tomography (CAT scans)

(3) Cystoscopy

(4) Echocardiography

(5) Endoscopy

(6) Gastroscopy

(7) Home Nursing Care

(8) Inpatient Care in an Extended Care Facility or rehabilitation Facility

(9) Inpatient status on non-emergency Treatment or Surgery

(10) Magnetic Resonance Imaging (MRI)

(11) Outpatient Surgery

(12) Receiving Covered Transplant Treatment or supplies.

Contact the Company as soon as possible PRIOR to the scheduling of Treatment as follows:

Inside the United States: +1.877.654.6229

Email: mcs@imglobal.com

Outside the United States: +1.317.655.4500 (Collect if necessary)

Website: www.imglobal.com/member

I. **PRIVACY STATEMENT**: We know that Your privacy is important to You and We strive to protect the confidentiality of Your non-public personal information. We do not disclose any non-public personal information about Our Insured Persons or former Insured Persons to anyone, except as permitted or required by law. We maintain appropriate physical, electronic and procedural safeguards to ensure the security of Your non-public personal information. You may obtain a detailed copy of Our privacy policy by calling, email or mailing Us at the following:

Telephone: Inside the United States: +1.317.655.4500 / Toll-free: +1.800-638.4664

Email: DPO@imglobal.com

Mail: International Medical Group, Inc., 2960 North Meridian Street, Indianapolis, IN USA 46208-4715

J. **COMPLAINTS**: In the event that You remain dissatisfied and wish to make a complaint You can do so by sending Your complaint to:

International Medical Group

Attn: Complaints

2960 N. Meridian Street

Indianapolis, IN 46208

USA

K. **DATA PROTECTION**: Please note that sensitive health and other information that You provide may be used by Us, Our representatives, the insurers and industry governing bodies and regulators to process your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited, or no data protection laws). We have taken steps to ensure Your information is held securely. Where sensitive personal information relates to anyone other than You, You must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to Us and its use as set out above. Information We hold will not be shared with third parties for marketing purposes. You have the right to access your personal records.

L. **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, and Ancillary Services not to exceed the average semi-private room rate. A private room will be considered when no semi-private room is available or if medical necessity warrants this type of room. The private room rate is not to exceed the average private room rate.

(b) daily room and board, nursing services, 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 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 shown in the BENEFIT SUMMARY will be required for use of the Emergency Room, unless the Insured Person is directly admitted to the Hospital as Inpatient for further Treatment of that Illness or the condition had manifested itself by acute signs or symptoms which could reasonably result in placing life or limb in danger if medical attention is not provided within twenty-four (24) hours

(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 by a resident or intern under Physician supervision

(5) 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) Implant devices that are Medically Necessary; however, any Implants provided outside the PPO 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

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

(e) reconstructive Surgery when the Surgery is incidental to and follows Surgery which was covered hereunder

(f) radiation therapy or Treatment, and chemotherapy

(g) hemodialysis and the Charges by a Hospital for processing and administration of blood or blood components

(h) oxygen and other gases and their administration

(i) anesthetics and their administration by a Physician

(j) drugs purchased at a participating pharmacy within the Universal RX (URX) program or from a pharmacy located outside of the United States which require a prescription by a Physician for Treatment of Illness or Injury up to the amount shown in the BENEFIT SUMMARY, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs

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

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

(m) Emergency Local Ambulance Transport necessarily incurred in connection with:

(i) an Injury

(ii) an Illness resulting in Hospital confinement as an Inpatient.

(n) 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

(o) Treatment of Mental or Nervous Disorders and Substance Abuse

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

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

(r) Durable Medical Equipment, as defined herein, deemed to be Medically Necessary

(s) routine and Medically Necessary care of a Newborn during the first thirty-one (31) days of life, if the delivery of the Newborn and the Charges incurred are eligible for coverage and are covered under the Terms of this insurance

(t) pre-natal care, delivery of a Newborn, and post-natal care including complications thereof, provided by a Physician assuming:

(i) the Insured Person is an eligible Class II Employee or Spouse of an eligible Class II Employee

(ii) the Insured Person has been continuously covered under the Terms of the insurance for no less than the number of months shown in the BENEFIT SUMMARY

(iii) the Charges incurred for the Newborn's birth are covered under the Terms of this insurance

(iv) the Pregnancy is the result of Natural Insemination

(v) the Pregnancy is not a result of in vitro fertilization (IVF), artificial insemination or infertility Treatment by the Insured Person, Spouse of Insured Person or the father of the Newborn

(vi) Charges incurred by a Newborn or Child after discharge from the Hospital are not for an ongoing or subsequent Illness or Injury that is a consequence of in vitro fertilization (IVF) Pregnancy, artificial insemination or infertility Treatment by the Insured Person, Spouse of Insured Person or the father of the Newborn

(u) 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 a disabling congenital condition or an Illness or Injury

(6) Charges incurred for a Teladoc Consultation subject to the limitations set forth in the BENEFIT SUMMARY

(7) Charges incurred for a Teleconsultation or Virtual Physician Visit

(8) Charges incurred for a TELUS Health Consultation subject to the limitations set forth in the BENEFIT SUMMARY

(9) Emergency Dental Treatment as follows:

(a) Charges for Treatment following Traumatic Dental Injury from a covered Accident that resulted in physical Injury to the Insured Person

(b) Charges incurred for non-emergency Dental Treatment necessary due to an Accident covered hereunder

(10) Charges for speech therapy services to restore speech lost or impaired due to one of the following:

(a) covered Surgery, radiation therapy or other Treatment that affects the vocal chords

(b) cerebral thrombosis (cerebrovascular Accident)

(c) the Insured Person suffers Accidental Injury while covered under this insurance.

(11) Charges made by a chiropractor for Treatment or manual manipulation of subluxations and all related services, including, but not limited to, office visits, x-rays, and laboratory tests ordered by a chiropractor will be subject to the amount and visits shown in the BENEFIT SUMMARY. However, Charges for chiropractic Treatment that are initiated at the request of the Treating Physician as a part of a Treatment plan for the recovery of an Illness or Injury will not be subject to the amount shown in the BENEFIT SUMMARY

(12) Charges incurred for Treatment at an Urgent Care Clinic

(13) Charges incurred for Treatment at a Walk-in Clinic

(14) Charges for Podiatry Care up to the amount shown in the BENEFIT SUMMARY

(15) Charges for Treatment of an Injury to the foot due to an Accident covered hereunder

(16) Charges for Treatment of an Illness for which foot Surgery is Medically Necessary and determined to be the only appropriate method of Treatment

(17) Charges for value-added tax (VAT) or like tax incurred on Eligible Medical Expenses.

M. **ACCOMMODATION BENEFIT**: Subject to the Terms of this insurance, Accommodation expenses will be reimbursed to the Employee, up to the amount shown in the BENEFIT SUMMARY or until released to travel, for reasonable lodging and food approved in advance by the Company for a covered medical condition when the Employee has not been released to travel by their Treating Physician, immediately following a serious Illness, Injury, Hospitalization, or Surgery.

(1) **CONDITIONS AND RESTRICTIONS**: The Company will provide Accommodation benefits only when all of the following conditions and restrictions are met:

(a) must be approved in advance by the Company

(b) must submit a written statement, including diagnosis, from the Treating Physician explaining why the Employee is unable to travel and the diagnosis must coincide with current Treatment of a covered Illness or Injury where claims have been submitted to the Company for payment

(c) must submit receipts for reasonable lodging and food (excluding alcohol)

(d) must submit a written release from the Treating Physician indicating when the Employee was able to resume travel.

N. **AMATEUR SAILBOAT RACING**: Subject to the Terms of this insurance, the Company will pay Eligible Medical Expenses in the event that the Insured Person sustains bodily Injury as a result of an Accident while participating in Amateur Sailboat Racing as defined herein.

O. **CREW MEMBER RETURN**: Subject to the Terms of this insurance, Crew Member Return expenses will be reimbursed to the Insured Person, as shown in the BENEFIT SUMMARY, when there has been an Inpatient medical stay that did not require Emergency Medical Evacuation but that did cause the Insured Person to miss the scheduled departure on their assigned vessel. Upon approval, the Company will reimburse up to the maximum limits as shown in the BENEFIT SUMMARY for transportation expenses incurred to reunite the Insured Person with their departed vessel or to return to the Insured Person's Home Country.

P. **EMERGENCY MEDICAL EVACUATION**:

(1) Subject to the applicable Maximum Limit set forth in the BENEFIT SUMMARY, and the other Terms of this insurance, including the EXCLUSIONS provision and the CONDITIONS AND RESTRICTIONS subparagraph below, the Company will reimburse the Insured Person for the following transportation costs, when the Company or Plan Administrator arranges such transportation, and expenses incurred by the Insured Person arising out of or in connection with an Emergency Medical Evacuation occurring while this Certificate is in effect and during the Period of Coverage:

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

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

(c) Return ground and air transportation, upon medical release by the attending Physician, to the country where the evacuation initially occurred or to the Insured Person's Home Country, at the Insured Person's option.

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

(a) Medically Necessary Treatment cannot be provided locally

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

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

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

(e) Emergency Medical Evacuation is provided by designated, licensed, qualified, professional emergency personnel acting within the scope of such license and approved in advance and all arrangements are coordinated by the Company

(f) the condition, Illness, Injury or occurrence giving rise to the need for the Emergency Medical Evacuation:

(i) occurred outside the Insured Person's Home Country suddenly, Unexpectedly, and spontaneously, and without: (1) advance warning, or (2) advance Treatment, diagnosis or recommendation for Treatment by a Physician, or (3) prior manifestation of symptoms or conditions which would have caused a reasonably prudent person to seek medical attention prior to the onset of the Emergency

(g) The Company will cover reimbursement for the above-described costs and expenses and will arrange Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary Treatment to prevent the Insured Person's loss of life or limb.

The Insured Person may select a different Hospital in their Home Country at their option, but in such event the Insured Person shall be solely responsible for all costs and expenses in excess of the amounts that would have been incurred had the Insured Person used the nearest qualified Hospital. If a Hospital other than the nearest qualified Hospital is selected by the Insured Person, then the attending Physician, Insured Person, or a Relative of the Insured Person shall certify to the Company the Insured Person's understanding and acknowledgement of such responsibility for excess costs and expenses in addition to the matters set forth in the CONDITIONS AND RESTRICTIONS subparagraph, above. In all cases the Company will make the necessary arrangements for the Emergency Medical Evacuation and will use its best efforts to arrange with independent, third-party contractors any Emergency Medical Evacuation within the least amount of time reasonably possible.

By acceptance of this Certificate and request for Emergency Medical Evacuation benefits hereunder, the Insured Person understands, acknowledges and agrees that the timeliness, duration, occurrences during, and outcome of an Emergency Medical Evacuation can be directly and indirectly affected by events and/or circumstances which are not

within the supervision or control of the Company, including but not limited to: the availability, limitations, physical condition, reliability, maintenance and training schedules and procedures, and performance or non-performance of competent transportation equipment, supplies and/or staff of such third-party contractors; delays or restrictions on flights or other modes or means of transportation caused by mechanical problems, government officials, telecommunications problems, non-availability of routes, and/or other travel, geographical or weather conditions; and other acts of God and unforeseeable and/or uncontrollable occurrences.

The Insured Person agrees to release and to hold the Company, the Plan Administrator and their agents and representatives harmless from, and agrees that the Company, the Plan Administrator and their agents and representatives shall not be held liable or responsible for, any delays, losses, damages, further Injuries or Illnesses, or any other claims that arise from or are caused in whole or in part by the acts or omissions of such independent third-party contractors or their agents, employees or representatives, or that arise from or are caused in whole or in part by any acts, omissions, events or circumstances that are not within the direct and immediate supervision and control of the Company, the Plan Administrator and/or their authorized agents and representatives, including without limitation the events and circumstances set forth above.

The Insured Person further agrees that upon seeking an Emergency Medical Evacuation, they will cooperate fully as required by the CONDITIONS AND GENERAL PROVISIONS, COOPERATION provision. Failure to so cooperate and/or failure to use or accept Emergency Medical Evacuation once it has been arranged by the Company or Plan Administrator will require the Insured Person to reimburse the Company for costs incurred for any Emergency Medical Evacuation that was arranged, but not used, by the Insured Person. Furthermore, the Insured Person may be required to arrange for payment of any subsequent Emergency Medical Evacuation and seek reimbursement thereafter for eligible costs associated with that subsequent Emergency Medical Evacuation.

Q. **EMERGENCY REUNION**:

(1) Subject to the Terms of this insurance, including without limitation the CONDITIONS AND RESTRICTIONS subparagraph below, Emergency Reunion expenses will be reimbursed to an Insured Person as outlined in the BENEFIT SUMMARY, in cases where there has been an Emergency Medical Evacuation covered under the Terms of this insurance. Subject to the applicable Deductible and Coinsurance and other limits and sub-limits as specified in the BENEFIT SUMMARY, and subject to the CONDITIONS AND RESTRICTIONS subparagraph below, the following costs and expenses incurred in respect of travel by a Relative or friend of the Insured Person will be reimbursable to the Insured Person upon the recommendation and prior approval of the Company:

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

(b) reasonable and necessary travel costs, meals (up to the amount shown in the BENEFIT SUMMARY), transportation and accommodation expenses incurred in relation to the Emergency Reunion (but excluding entertainment).

(2) **CONDITIONS AND RESTRICTIONS**:

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

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

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

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

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

R. **HOSPITAL INDEMNITY**: Subject to the Terms of this insurance and in the event the Insured Person has been Hospitalized in a Facility outside the United States, during the Period of Coverage, the Company will pay the Insured Person the amount shown in the BENEFIT SUMMARY for each overnight Hospitalization as an Inpatient, so long as the Treatment received during the overnight Hospitalization is considered to be an Eligible Medical Expense.

This benefit is not payable if the Inpatient Hospital Treatment is part of the MEDICAL TRAVEL MANAGEMENT benefit.

To claim this benefit, the Insured Person should ask the Hospital to sign and stamp the claim form.

S. **MEDICAL TRAVEL MANAGEMENT**: When an Insured Person requires Medically Necessary non-emergency Treatment, including Hospitalization and Surgery for approved procedures, the Company will offer Medical Travel as a means to

manage the costs. Upon approval of Medical Travel, the Company will designate a case manager to work with the Insured Person to coordinate related care prior to any Treatment being rendered. Failure to comply with the required approval process could result in services or reimbursement of cost savings to Insured Person as ineligible.

(1) Medical Travel is designed for the following types of elective non-emergency Treatment:

(a) joint replacement

(b) cardiac procedures

(c) hysterectomies

(d) spinal Surgeries

(e) or other services as approved by the Company.

(2) Case managers provide the following assistance to the Insured Person:

(a) assist the Insured Person in locating a qualified healthcare provider

(b) calculate the cost effectiveness of proposed travel

(c) coordinate services with the Insured Person, Physician, and Facility including patient care, travel, scheduling and housing if necessary

(d) determine the appropriateness of Medical Travel

(e) designate a travel agent or coordinate airfare and other travel arrangements

(f) provide assistance with transfer and receipt of medical records before and after Treatment

(g) provide follow up and monitor medical needs after return of the Insured Person to country of residence or place of departure.

(3) Medical Travel Management of costs only applies to Treatment the Company, at its sole discretion, determines will result in a minimum savings. Treatment outside the United States must result in an overall savings of ten thousand dollars ($10,000 USD) including all travel expenses, over costs for the same Treatment at a Facility if rendered in the United States. This benefit can only be approved in situations where the Insured Person is determined by their Treating Physician to be capable of traveling safely for the purposes of Treatment.

(4) The Company will designate what costs will be included in the determination of savings, including round trip airfare, or other travel expenses necessary to transport the Insured Person to the place where Treatment is performed and costs associated with housing of the Insured Person and any designated companion during such travel.

(5) When an Insured Person elects and is approved to use Medical Travel and meets all the necessary requirements, the following reimbursement becomes available to the Insured Person. The Company will reimburse ten percent (10%) of the cost savings, up to the maximum amount shown in the BENEFIT SUMMARY, back to the Insured Person where such savings arise from Treatment outside of their Host Country and excluding the United States.

(6) Eligible Charges will be considered at one hundred percent (100%) and not subject to Deductible or Coinsurance. Eligible Charges under the Medical Travel benefit include the following:

(a) cost of Hospitalization or Facility

(b) Physician fees

(c) diagnostic and laboratory

(d) physical therapy

(e) Durable Medical Equipment and medical supplies

(f) round trip air and ground travel costs to and from location of service for the Insured Person and approved designated companion

(g) hotel accommodations for the Insured Person and designated companion

(h) meal allowance up to the amount shown in the BENEFIT SUMMARY per day as approved by the Company

(i) other Medically Necessary Charges as approved in advance by the Company.

T. <u>NON-EMERGENCY MEDICAL EVACUATION</u>:

(1) Subject to the applicable Maximum Limit set forth in the BENEFIT SUMMARY, and the other Terms of this insurance, including the EXCLUSIONS provision and the CONDITIONS AND RESTRICTIONS subparagraph below, the Company will reimburse the Insured Person for the following transportation costs, when the Company or Plan Administrator arranges such transportation, and expenses incurred by the Insured Person arising out of or in connection with a non-emergency medical evacuation occurring while this Certificate is in effect and during the Period of Coverage:

(a) air transportation to one (1) of the following destinations as chosen by the Insured Person and approved and coordinated by the Company or Plan Administrator:

(i) the Insured Person's Home Country

(ii) the place stipulated by a collective agreement

(iii) the place at which the Insured Person entered into the employment contract with the Participating Organization

(iv) any other such place that was mutually agreed upon by the Insured Person and the Participating Organization at the time of the initial employment contract

(b) ground transportation necessarily preceding air transportation and from the destination airport to the location where the Insured Person will be recovering.

(2) **CONDITIONS AND RESTRICTIONS**: To be eligible for coverage for non-emergency medical evacuation benefits the Insured Person must be in compliance with all Terms of this insurance. The Company will provide non-emergency medical evacuation benefits only when all of the following conditions and restrictions are met:

(a) the Insured Person has been deemed medically Unfit for Duty

(b) the non-emergency medical evacuation is agreed upon by the Insured Person or a Relative of the Insured Person

(c) the non-emergency medical evacuation is approved in advance and all arrangements are coordinated by the Company.

The Company will cover reimbursement for the above-described costs and expenses and will arrange non-emergency medical evacuation to one (1) of the destinations identified in subparagraphs (a)(i) through (iv) above, as chosen by the Insured Person. In all cases the Company will make the necessary arrangements for the non-emergency medical evacuation and will use commercially reasonable efforts to arrange with independent, third-party contractors any non-emergency medical evacuation within the least amount of time reasonably possible.

By acceptance of this Certificate and request for non-emergency medical evacuation benefits hereunder, the Insured Person understands, acknowledges and agrees that the timeliness, duration, occurrences during, and outcome of a non-emergency medical evacuation can be directly and indirectly affected by events and/or circumstances which are not within the supervision or control of the Company, including but not limited to: the availability, limitations, physical condition, reliability, maintenance and training schedules and procedures, and performance or non-performance of competent transportation equipment, supplies and/or staff of such third-party contractors; delays or restrictions on flights or other modes or means of transportation caused by mechanical problems, government officials, telecommunications problems, non-availability of routes, and/or other travel, geographical or weather conditions; and other acts of God and unforeseeable and/or uncontrollable occurrences.

The Insured Person agrees to release and to hold the Company, the Plan Administrator and their agents and representatives harmless from, and agrees that the Company, the Plan Administrator and its agents and representatives shall not be held liable or responsible for, any delays, losses, damages, further injuries or Illnesses, or any other claims that arise from or are caused in whole or in part by the acts or omissions of such independent third-party contractors or their agents, employees or representatives or that arise from or are caused in whole or in part by any acts, omissions, events or circumstances that are not within the direct and immediate supervision and control of the Company, the Plan Administrator and/or their authorized agents and representatives, including without limitation the events and circumstances set forth above.

The Insured Person further agrees that upon seeking a non-emergency medical evacuation, they will cooperate fully as required by the CONDITIONS AND GENERAL PROVISIONS, COOPERATION provision. Failure to so cooperate and/or failure to use or accept non-emergency medical evacuation once it has been arranged by the Company or Plan Administrator will require the Insured Person to reimburse the Company for costs incurred for any non-emergency medical evacuation that was arranged, but not used, by the Insured Person. Furthermore, the Insured Person may be required to arrange for payment of any subsequent non-emergency medical evacuation and seek reimbursement thereafter for eligible costs associated with that subsequent non-emergency medical evacuation.

U. **PREVENTATIVE CARE**: 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 expenses incurred while this Certificate is in effect:

(1) **ADULT**: Males and Females nineteen (19) years of age and older:

(a) Routine Physical Examinations

(b) mammography examinations and pap smear

(c) Routine inoculations and vaccinations commonly administered in accordance with standard medical practice.

(2) **CHILD**: Males and Females under nineteen (19) years of age:

(a) Routine Physical Examinations

(b) routine inoculations and vaccinations commonly administered to Children less than nineteen (19) years of age in accordance with standard medical practice.

V. **RECREATIONAL UNDERWATER ACTIVITIES**: Notwithstanding anything contained herein to the contrary, this insurance is extended to cover the Insured Person while engaging in recreational underwater activities requiring the use of artificial breathing apparatus provided always that the sports diving is carried out in accordance with the guidelines and recommendations for safe diving practices set forth by the Authoritative Diving Bodies as defined, and subject to the following Terms.

This insurance does not cover claims directly or indirectly arising from, happening through or in consequence of:

(1) Diving by the Insured Person without holding a recognized certificate issued by an Authoritative Diving Body for the type of diving being undertaken, or not under professional instruction

(2) Diving without proper and well-maintained equipment in good working order and/or contrary to the guidelines, codes of good practice and/or recommendations set forth by the Authoritative Diving Body under which the Insured Person has been certified

(3) Diving to depths greater than forty (40) meters, or diving requiring decompression stops

(4) Solo diving

(5) Any form of cave diving

(6) Diving for hire, reward, or treasure

(7) Flying within twenty-four (24) hours of the last dive or diving within ten (10) hours of flying

(8) Diving while suffering from a cold, influenza or obstruction of the sinuses or ears

(9) Diving by an Insured Person under twelve (12) years of age or over sixty-five (65) years of age

(10) Willfully Self-inflicted Injury or Illness, the effects of alcohol or drugs (other than as prescribed by a registered medical practitioner in full awareness of the Insured Person's sub-aqua activities) and any self-exposure to needless peril (unless in an attempt to save human life)

(11) Diving with breathing apparatus containing any gas other than compressed air and Nitrox.

It is a condition precedent to the Company's liability under this insurance that any prospective diver applying for coverage under this insurance is medically fit to dive. If in any doubt the Insured Person should refrain from participating in Sports Diving until medical advice has been obtained from their doctor.

W. **RETURN OF MORTAL REMAINS**: In the event of the death of the Insured Person during the Period of Coverage as a result of an Illness or Injury covered under this insurance while the Insured Person is outside of their Home Country, the Company will reimburse the authorized personal representative or the estate of the Insured Person up to the amount shown in the BENEFIT SUMMARY for the costs and expenses incurred to return the Insured Person's Mortal Remains to their Home Country and thereafter to the place of burial or other final disposition (but not including any costs of burial or other disposition); provided, however, that the Company must approve all costs and expenses related to the return of the Insured Person's Mortal Remains in advance as a condition to the availability of this benefit; or up to the amount shown in the BENEFIT SUMMARY for preparation, local burial or cremation of the Insured Person's Mortal Remains at the place of death in accordance with the commonly accepted cultural and religious beliefs practiced by the Insured Person. Coverage is not provided for burial and cremation costs incurred for religious practitioners, flowers, music, food or beverages.

X. **SUPPLEMENTAL ACCIDENT BENEFIT**: In the event of an Accident which gives rise to benefits covered under the Terms of this insurance, as a supplemental benefit the Company will also reimburse the Insured Person up to the amount shown in the BENEFIT SUMMARY related to the Treatment of an Injury resulting from such Accident, before applying any Deductible.

Y. **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 a Managed Transplant System Network Provider, 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 an independent

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

Z. VISION CARE: Subject to the Terms of this insurance and provided the Insured Person has been continuously covered under this Plan for at least twelve (12) months, the Company will reimburse the Insured Person:

(1) EYE EXAMINATION: Up to the amount shown in the BENEFIT SUMMARY every twenty-four (24) months for a routine eye examination

(2) CORRECTIVE: Up to the amount shown in the BENEFIT SUMMARY every twenty-four (24) months for corrective lenses, contacts to correct vision and frames.

AA. 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: Notwithstanding any other Terms under this insurance, the Company shall not provide coverage or make any payments or provide any service or benefit to any Insured Person, beneficiary, or third party who may have any rights under this insurance to the extent that such coverage, payment, service, or benefit would violate 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.

(2) WAR; MILITARY ACTION; TERRORISM: 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 the Insured Person's active and voluntary planning or coordination of or participation in any of the following acts or event 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) martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege

(d) 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

(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)

(f) any 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 they were a victim, innocent bystander, and there was no contributory fault chargeable to the Insured Person.

(3) MATERNITY AND NEWBORN CARE: Charges for pre-natal care, delivery, post-natal care, and care of Newborns, including complications of Pregnancy, miscarriage, complications of delivery and/or of Newborns are excluded from this insurance

(a) until the Insured Person has maintained coverage hereunder continuously for ten (10) months

(b) if Charges incurred are for a non-eligible Employee or Spouse

(c) if the Pregnancy is a result of in vitro fertilization (IVF), artificial insemination or infertility Treatment by the Insured Person, Spouse of Insured Person or the father of the Newborn

(d) Charges incurred by a Newborn or Child after discharge from the Hospital for an ongoing or subsequent Illness or Injury that is a consequence of in vitro fertilization (IVF) Pregnancy, artificial insemination or infertility Treatment by the Insured Person, Spouse of Insured Person or the father of the Newborn.

(4) 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) related to Hospice Care

(h) provided by or at the direction or recommendation of a chiropractor and outside of the limitations set forth in the BENEFIT SUMMARY, unless ordered in advance by a Physician

(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 excluded from coverage or which is otherwise not covered under this insurance

(m) for Congenital Disorders and conditions arising out of or resulting therefrom

(5) Telehealth or Telemedicine services not considered Medically Necessary as determined by the Company under the plan

(6) 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

(7) Charges incurred for failure to keep a scheduled appointment

(8) Charges incurred for Surgeries, Treatment or supplies which are Investigational, Experimental, and for research purposes

(9) Charges incurred related to Genetic Medicine, genetic testing, surveillance testing and/or wellness screening procedures for genetically predisposed conditions indicated by Genetic Medicine or genetic testing, including, but not limited to amniocentesis, 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

(10) Charges incurred for Custodial Care

(11) 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, except as otherwise expressly provided for in this insurance

(12) 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

(13) 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)

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

(15) any Treatment which is incurred by an Insured Person who was HIV+ on or before the Effective Date of this insurance; 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; 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

(16) 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

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

(18) 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; and spelunking

(19) 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

(20) any Illness or Injury sustained while taking part in, practicing or training for Professional Athletics

(21) 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

(22) any Illness or Injury sustained while illegally Off-piste Snow Skiing, Off-piste Snowboarding, Backcountry Snow Skiing and Backcountry Snowboarding

(23) 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

(24) any Illness or Injury sustained while taking part in Collision Sports

(25) 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

(26) 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

(27) 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

(28) any willfully Self-inflicted Injury or Illness

(29) any testing for the following when not Medically Necessary: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS

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

(31) Charges incurred for hearing aids, hearing implants and Charges for any Treatment, supply, examination or fitting related to these devices

(32) biofeedback, acupuncture, or vocational, recreational, sleep or music therapy

(33) orthoptics, visual therapy or visual eye training

(34) 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

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

(36) any sleep disorder, including without limitation sleep apnea

(37) any exercise and/or fitness program or equipment, whether or not prescribed or recommended by a Physician

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

(39) Charges for Treatment of an Injury which happens during work at any job for pay or profit, except for work performed for the Participating Organization

(40) any organ or tissue or other transplant or related services, Treatment or supplies except as otherwise expressly set forth

(41) any artificial or mechanical devices designed to replace human organs temporarily or permanently

(42) animal to human transplants

(43) any transplant expenses incurred outside the Company's approved independent Managed Transplant System Network

(44) any efforts to keep a donor alive for a transplant procedure

(45) 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

(46) 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 except as otherwise expressly provided for hereunder

(47) 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

(48) 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

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

(50) Charges or expenses incurred for nonprescription drugs, medicines, vitamins, food extracts, or nutritional supplements; IV vitamin or herbal therapy; drugs or medicines not approved by the U.S. Food and Drug Administration or which are considered "off-label" drug use; and for drugs or medicines not prescribed by a Physician

(51) 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)

(52) Charges incurred at a Hospital or Facility when the Insured Person checks himself or herself out Against Medical Advice of their Physician or leaves before reaching a Medically Necessary specified endpoint of Treatment

(53) 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

(54) any drug purchased at a United States pharmacy eligible under the Universal RX (URX) Card Program

(55) Charges for education, job training, Treatment of learning disabilities, developmental delay, conduct disorders, or behavioral problems of attention deficit disorders whether or not provided by a Facility that also provides medical or psychiatric Treatment

(56) Charges for or in connection with counseling services of the following types: marriage, Family, Child, career, social adjustment, pastoral or financial

(57) Charges incurred for massage therapy

(58) Charges for Treatment of an Illness or Injury for which payment is made or available through a workers' compensation law or a similar law unless this insurance is primary to the Participating Organization's Protection and Indemnity (P&I) insurance

(59) Charges incurred for Emergency Dental Treatment, except as specifically provided for hereunder

(60) 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

(61) Dental Injury without associated face, skull, neck and/or jaws Injury or that can be evaluated and Treated in a dental office

(62) Dental Treatment for services which provide oral care maintenance including tooth repair by fillings, root canals, tooth removal and x-rays

BB. 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.

Actively At Work Full-time: An Employee shall be considered Actively At Work if they are either onboard a vessel belonging to the Participating Organization, having reported for duty, and working or available for working for at least seven (7) hours per twenty-four (24) hour period onboard such vessel or on a regularly scheduled vacation, holiday or leave from work on board a vessel belonging to the Participating Organization, provided that resumption of work on board a vessel belonging to the Participating Organization for at least seven (7) hours per twenty-four (24) hour period is scheduled to occur.

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.

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 himself or herself out of a Hospital against the advice of their Physician.

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

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

Amateur Sailboat Racing: The pastime or leisure pursuit of racing sailboats in competitions where the competition or activity carries no substantive financial reward.

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 Participating Organization 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/Participating Organization 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.

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

Assured: Fairmont Specialty Trust, ITA GlobalTrust, LTD , Suite 4210, 2nd Floor Canella Court, 48 Market St, Camana Bay, Grand Cayman KY1-1208, Cayman Islands.

Authoritative Diving Bodies: Authoritative Diving Bodies are defined as recognized national controlling organizations or organizations affiliated to Confédération Mondiale des Activités Subaquatiques / The World Underwater Federation (CMAS) who provide guidelines and recommendations to their membership for safe diving practice. This extension is subject to the Terms, conditions, exclusions and warranties that appear in the Master Policy unless these have been specifically amended by the Master Policy.

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.

Authorized Representative: An individual chosen by the Participating Organization to act on their behalf.

Backcountry Snow Skiing/Snowboarding: Skiing or snowboarding on unmarked or unpatrolled area outside a ski resort's boundaries.

Calendar Year: The twelve (12) months beginning on January 1 and ending on December 31, annually.

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 I Employee: An Actively At Work Full-time Employee whose job responsibilities are routine to the daily operation of the vessel as determined by the Participating Organization.

Class II Employee: An Actively At Work Full-time Employee whose job responsibilities are vital to the daily operations of the vessel as determined by the Participating Organization.

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.

Clerical Error: A minor mistake or inadvertence and not one that occurs from judicial reasoning or determination.

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; We; Our; Us: The Company, as referred to in the Master Policy and this Certificate, is Crum & Forster SPC . The Master Policy and this Certificate is not subject to United States jurisdiction. 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.

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

Creditable Coverage: Creditable Coverage means:

(a) For United States citizens and United States residents, bona fide evidence of at least twelve (12) months of health coverage not interrupted by a significant break in coverage under any of the following: a group health plan provided by a U.S. employer or Health Insurance Issuer; individual major medical health insurance provided by a Health Insurance Issuer; Medi-Share; comprehensive student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps insurance program; other Public Health Plan (any comprehensive health plan established or maintained by a State or the U.S. government); Children's Health Insurance Program (CHIP); or a state health insurance high risk pool

(b) For non-United States citizens who are not United States residents, considered on a case-by-case basis and accepted in the Company's sole discretion, bona fide evidence of at least twelve (12) months of health coverage not interrupted by a significant break in coverage under any of the following: any of the coverages listed in subparagraph (a) above; a group health plan provided by an employer or health insurer; individual major medical health insurance provided by a health insurer; a comprehensive Public Health Plan established and maintained by a foreign country; or other insurance coverage maintained by the Insured Person and accepted as Creditable Coverage by the Company in its sole discretion.

A significant break in coverage generally occurs when an individual has no health coverage for sixty-three (63) days or more.

Creditable Coverage does not include non-medical coverages or coverage consisting solely of "limited benefits" or "excepted benefits" such as (without limitation) coverage solely for limited-scope medical, dental, vision, specified disease, catastrophic, or workers' compensation benefits. Days in a waiting period during which an individual has no other coverage are not considered Creditable Coverage, nor are these days taken into account when determining if there is a significant break in coverage. Any health coverage an individual had before a significant break in coverage is not counted toward Creditable Coverage.

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 Participating Organization and the Insured Person contemporaneously with this Certificate (and/or upon renewal or Reinstatement hereof) evidencing the Participating Organization and 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 Calendar Year prior to receiving benefits or coverage under this insurance, and not including any applicable Coinsurance.

Dental Provider; Dentist: A person duly licensed to practice dentistry in the state or country in which the dental service is rendered.

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.

Dependent: A Child who meets either of the following conditions: (a) is under age twenty-six (26) and younger than the Insured Person (or spouse if filing jointly), or (b) any age if Disabled and such incapacity occurred prior to attaining twenty-six (26) years of age or while a covered Dependent under this plan of insurance.

The term "Dependent" excludes an individual who is married or on active military duty or who is eligible for military medical care benefits and/or any person who is also an Insured Person.

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. This type of care includes, but is not limited to job training, counseling, vocational or occupational therapy, and speech therapy.

Effective Date; Effective Date of Coverage: The date coverage for the Insured Person begins under the Terms of the Master Policy 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 Medical Evacuation: Emergency transportation from the Hospital or medical Facility where the Insured Person is located to a non-local Hospital or medical Facility following the recommendation by the attending Physician who certifies, to a reasonable medical certainty, that the Insured Person has experienced:

(a) a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within twenty-four (24) hours; and

(b) where Medically Necessary Treatment cannot be provided locally, either in the Facility of the attending Physician or another local Facility.

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.

Employee: A paid worker who the Participating Organization controls or has the right to control what the worker does and how the worker does his job; a worker whose business aspects of the job are controlled by the Participating Organization (e.g. how worker is paid, whether expenses are reimbursed, who provides tools/supplies, etc.); a worker who may have entered into a written employment or volunteer contract with the Participating Organization; a worker who is entitled to employee type benefits (i.e. pension plan, insurance, vacation pay, etc.); a worker whose relationship will continue indefinitely; and the worker performs services that are a key aspect of the Participating Organization's business.

Enrollment Date: The Enrollment Date is the date the Company receives the completed Enrollment Form, and Creditable Coverage documentation if applicable.

Enrollment Form: The form provided by the Company to be completed by the Authorized Representative of the Participating Organization, and provided to the Company as evidence of the Insured Person's including any Spouse's and Dependent's desire to become covered under this insurance.

EST: United States Eastern Standard Time.

Experimental: Any Treatment that includes completely new, untested drugs, procedures, or services, or the use of which is for a purpose other than the use for which they have previously been approved 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: The study of the etiology, pathogenesis, and natural history of diseases and disorders that are fully or partially genetic in origin and the application of genetics to medicine or to medical practice, including the prevention, screening, diagnosis, surveillance, and Treatment of these diseases.

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.

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: For United States citizens, the Home Country is the United States. For non-United States citizens, the Home Country is the country of which the Insured Person is a citizen or national; including any country where the Insured Person maintains their primary residence or usual place of abode and any country of which the Insured Person is the possessor of a validly issued passport. In the event there is more than one (1) Home Country under the above-listed criteria, the Home Country is the country meeting the above-listed criteria and listed by the Insured Person as their country of residence on the Application.

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

Home Nursing Care: Services 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.

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: The country or countries other than the Home Country that the Insured Person is traveling to or within.

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 which 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 date the Insured Person originally obtains 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; You; Your: 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 within the same country 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) / European Medicines Agency including an Emergency Use Authorization by the FDA.

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.

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 Participating Organization and/or 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.

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

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.

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

Natural Insemination: Insemination or impregnation of a female by sexual intercourse with a male.

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

Off-piste Snow Skiing/Snowboarding: Skiing or snowboarding that is situated or taking place away from prepared ski runs or ski resort.

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.

Participating Organization: The entity or group named in the group Application for coverage, which Application forms a part of this Certificate.

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.

Podiatry Care: Care of the feet, including Treatment of for corns, calluses or toenails, weak, strained, flat, unstable or unbalanced feet, metatarsalgia, bone spurs, hammer toes or bunions.

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.

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

Premium: The Premium payments required to effectuate and maintain the Participating Organization's and 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.

Professional Marine Crew Member: A crew member who is currently or usually working aboard or employed by a vessel as a full-time, sea-going crew member for hire, and who expects to spend a significant period of time during the Period of Insurance sailing outside of United States territorial waters in such capacity. This definition does not include any individual who is currently or is planning to make a living through prize money, endorsements or other compensation which is

specifically related to the racing of sailboats.

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.

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.

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.

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

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 country of residence 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 TELADOC HEALTH INTERNATIONAL, S.A.U., a Teladoc Health Group company, incorporated in Spain, a network of board-certified providers 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.

TELUS Health Consultation: TELUS Health will provide 24/7 counseling services through a master's level counselor. Through virtual counseling services, individuals are able to get immediate counselling in crisis situations. Additional services available through the EAP program include an in-person counseling option while within the United States, TELUS Health services, legal and financial advice, management consultations, and access to many other support resources.

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.

Totally Disabled; Total Disability: The inability, due to Illness or Injury, of an individual to work or earn income. The medical condition must significantly limit the ability to do basic work activities, prevent the individual from being able to do the work they did before the Illness or Injury, or prevent the individual from being able to do other work. With respect to Children, it is the inability, due to Illness or Injury, to engage in any substantial gainful activity because of a physical or mental condition. A qualified Physician must certify that the Child's condition has lasted or can be expected to last continuously thru the end of the Period of Coverage or more, or that the condition can be expected to result in death.

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.

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 providing Treatment to an Insured Person.

Unexpected: Sudden, unintentional, not expected and unforeseen.

Unfit for Duty: The inability of an Insured Person to perform the normal and routine responsibilities as a Crewmember, as certified by a Physician, due to an Injury or Illness.

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 that are not 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 Walk-in 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.

Walk-in 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.

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.

International Marine Medical Insurance℠
Platinum
Certificate of Insurance

Plan Administered by:

Plan Underwritten by Crum & Forster SPC