EVIDENCE OF INSURANCE

MERIDIAN SERIES- BASIC

The Beacon/ Axis Series Group Insurance Trust (Anguilla)

This Evidence of Insurance issued by the Master Policy on behalf of the Master Policyholder, as so authorized by Certain Underwriting Members at Lloyd's who have hereunto subscribed their Names ("the Underwriters") to this Evidence of Insurance and the Master Policy; the **Beacon/Axis Series Group Insurance Trust (Anguilla).** As such certain Underwriters at Lloyd's authorize Azimuth Risk Solutions, LLC as the ("Scheme Administrator") of the Master Policy and all Evidence(s) of Insurance issued by the Master Policy.

MASTER POLICYHOLDER

Whereas the Master Policyholder has sought Insurance on behalf of its Members, the Master Policyholder is hereby recognized as the Beacon/Axis Series Group Insurance Trust (Anguilla). The Master Policyholder recognizes the Master Policy effective date is April 1, 2009, and shall remain in effect for a twelve (12) month period or until terminated by Underwriters in accordance to **section 16** below. The Master Policy is annually renewable unless otherwise expressed by Underwriters. The Master Policy shall issue Evidence(s) of Insurance; which shall be effective as of the Effective Date of Coverage as shown on the Declaration Page of Coverage, and shall remain in effect until terminated in accordance with **Section 15** below. This Evidence of Insurance is not part of the Insurance contract. The contract is the Master Policy (held by the Master Policyholder), the application, and any applicable rider(s). This Evidence of Insurance is merely a description of and evidence of the Member(s) rights and benefits under the contract.

PARTICIPATING MEMBERS(S)

The Master Policyholder hereby recognizes Azimuth Risk Solutions, LLC as its authorized agent and representative. Azimuth Risk Solutions, LLC as Scheme Administrator of the Master Policy and all Evidence(s) of Insurance issued by the Master Policy is hereby subject to all provisions set forth hereto. All communications, all notices, and payments that are required or permitted under the Master Policy and/or as described in this Evidence of Insurance issued by the Master Policy for its Members shall be transmitted through the Scheme Administrator, and receipt of the same by the Scheme Administrator shall be considered receipt by the Master Policyholder on behalf of Underwriters. The Master Policy is available at all times by request.

LLOYD'S BROKER

The Lloyd's Broker has negotiated on behalf of the Master Policyholder such Insurance, it is mutually understood and agreed between the Underwriters and the Master Policyholder, Azimuth Risk Solutions, LLC is recognized as the Scheme Administrator. The Underwriters hereby recognize BMS Intermediaries Ltd, One America Square, London as the Lloyd's Broker of record herein.

SCHEME ADMINISTRATOR

The Scheme Administrator may issue Evidence(s) of Insurance on behalf of the Master Policyholder, in accordance with the terms and conditions contained herein or otherwise agreed in writing by the Underwriters and endorsed hereon. Azimuth Risk Solutions, LLC is hereby recognized as the Scheme Administrator by the Master Policyholder, the Lloyd's Broker, and Underwriters. Azimuth Risk Solutions, LLC (Scheme Administrator), 55 Monument Circle #1128, Indianapolis, Indiana 46204, U.S.A., hereby agrees to uphold the promise made on behalf of the Master Policyholder, as stated below:

1.EVIDENCE(S) OF INSURANCE ISSUED

1.1 The Scheme Administrator will issue in respect of each Participating Member an identification number and Evidence of Insurance.
1.2 The Scheme Administrator shall retain a copy of all such Evidence(s) of Insurance and shall send a further copy to Participating Member(s).
1.3 The Scheme Administrator shall send on behalf of the Master Policyholder Evidence(s) of Insurance to the Participating Member(s) as soon as practicable, but in any event no later than 45 days after inception, or in accordance with local legislation.
1.4 The Scheme Administrator shall advise Underwriters of all additions and deletions of Evidence(s) of Insurance.

2. COVERAGE PERIODS EFFECTED IN ACCORDANCE WITH THE MASTER POLICY

2.1 The Master Policy is effective during the period from 04/01/2009 to 04/01/2010 both days inclusive and for one calendar month, if required, as may be mutually agreed upon.
2.2 No Evidence(s) of Insurance shall be bound hereunder for a period greater than
 2.2.1 twelve (12) months in respect to annual cover.
 2.2.2 thirty (30) days in respect to monthly cover.
2.3 Every Evidence(s) of Insurance issued shall commence during the currency of the Master Policy.
2.4 No Evidence(s) of Insurance shall be issued more than thirty (30) days in advance of its inception date.
2.5 In the event that the Master Policy is cancelled or terminated each Evidence(s) of Insurance issued hereunder shall run to its contractual expiry date, unless cancelled in accordance with its individual cancellation provision.
2.6 In the event of cancellation of any Evidence(s) of Insurance issued hereunder the Master Policyholder, the Scheme Administrator and Underwriters shall comply with any applicable provisions of law relating to the cancellation of such Evidence and to the return of premium, commission, fees and any other charges.

3. ACCEPTANCE BY THE UNDERWRITERS

3.1 As a condition precedent to the Underwriters liability hereunder, the insurance provided to Participating Member(s) pursuant to and in accordance with the Terms and Conditions of the Master Policy, as represented by the Evidence(s) of Insurance issued by the Master Policy

(such insurance being sometimes referred to herein as "this insurance" or "the plan".) The Master Policy, including the Application, the Evidence(s) of Insurance, the Declaration, and any Endorsements, shall constitute the entire agreement among the Policyholder, Underwriters, and the Participating Member(s). Underwriters hereby recognize Azimuth Risk Solutions, LLC as the Scheme Administrator. The Evidence(s) of Insurance issued by the Master Policy is an outline of the coverage provided by the Master Policy and agreed by Underwriters.

4. TERRITORIAL LIMITATION

4.1 The Scheme Administrator is hereby authorized to issue Evidence(s) of Insurance for Participating Member(s) domiciled Worldwide with the exception of U.S. Citizens residing in the U.S. or Anguillan Citizens residing in Anguilla.
4.2 The territorial limits of each Evidence(s) of Insurance issued hereunder shall be Worldwide, except:

4.2.1 When a U.S. Citizen purchasing an annual renewable policy while in the U.S.

5. MAXIMUM LIMIT OF LIABILITY/SUMS INSURED

5.1 The Scheme Administrator is authorized to issue Evidence(s) of Insurance in the following Sum Insured or Limits of Liability which shall not be exceeded in any circumstance. The below figures are always considered to be in U.S. dollars:

5.1.1 $50,000;
5.1.2 $100,000;
5.1.3 $250,000;
5.1.4 $500,000;
5.1.5 $1,000,000;
5.1.6 $2,000,000; and
5.1.7 $5,000,000

6. PREMIUMS, DEDUCTIBLES AND EXCESSES

6.1 All premiums for Evidence(s) of Insurance issued under the Master Policy shall be remitted to the Scheme Administrator:

6.1.1 on or before the Due Date(s) specified on the Declaration; and
6.1.2 prior to any Reinstatement of Insurance under Section 17, below; and
6.1.3 on or before any Renewal Date as specified in Section 19, below.

A grace period of seven (7) days (notwithstanding intervening Saturdays, Sundays or legal holidays) will be allowed for the payment of each installment of Premium except the first. If any Premium is unpaid at the end of the grace period, all insurance coverage and benefits under such Evidence(s) of Insurance shall lapse and terminate with effect from the initial Due Date of the unpaid Premium, and the Scheme Administrator shall have no liability to the Participating Member for any claims incurred on or after such date. Premium is considered paid on the date the payment is actually received by the Scheme Administrator.

6.2 All Deductibles and/or Excess for Evidence(s) of Insurance issued under the Master Policy are in U.S. dollars, as follows:

6.2.1 $0;
6.2.2 $100;
6.2.3 $250
6.2.4 $500;
6.2.5 $1,000;
6.2.6 $2,500;
6.2.7 $5,000;
6.2.8 $10,000; and
6.2.9 $20,000

7. CLAIMS PROCEDURES

7.1 Proof of Claim- When the Scheme Administrator receives notice of a claim for benefits under this insurance it will provide the Participating Member with forms ("Claim Form") for filing Proof of Claim. The Claim Form is provided with all fulfillment documents issued by the Scheme Administrator. The Claim Form is available at all times via the Scheme Administrator's website at www.azimuthrisk.com. The following items must be submitted to be considered a complete Proof of Claim eligible for consideration of coverage ("Proof of Claim"):

7.1.1 a duly completed and signed Claim Form; and
7.1.2 all original itemized bills from all Physicians, Hospitals and other healthcare or medical service providers involved with respect to the claim; and
7.1.3 all original receipts for any expenses that have been incurred or paid by or on behalf of the Participating Member(s) with respect to the claim.

All claims to be mailed to: **Azimuth Risk Solutions, LLC**
55 Monument Circle #1128
Indianapolis, IN 46204

The Participating Member(s) shall have ninety (90) days from the date a claim is incurred to submit a complete Proof of Claim, and the Scheme Administrator may deny coverage for Proofs of Claim submitted thereafter or for incomplete Proofs of Claims. All claim decisions

made by or on behalf of the Scheme Administrator are with the express consent of Underwriters.

7.2 CLAIM SETTLEMENT- Eligible and covered claims under this insurance that have previously been paid by or on behalf of the Participating Member at the time of the Scheme Administrator's adjudication thereof will be reimbursed directly to the Participating Member, by check, at his/her last known place of residence or mail forwarding address. While the Evidence of Insurance is in effect, the Participating Member shall undertake to promptly notify the Scheme Administrator of any change in such addresses subsequent to the Effective Date of Coverage. Eligible and covered claims that have not yet been paid by or on behalf of the Participating Member at the time of adjudication will be paid by check or wire transfer to the Participating Member at his/her last known place of residence or mail forwarding address, or, at the sole option and discretion of the Scheme Administrator (but without obligation to do so), and as an accommodation to the Participating Member, directly to the provider(s). All claim settlements are subject to the applicable Deductible and Coinsurance, and to the benefit limits and sub-limits and all other Terms of this insurance. No provider or other third-party shall have any direct or indirect claim or right of action against the Scheme Administrator under the Master Policy or any Evidence of Insurance issued by 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 Scheme Administrator, and notwithstanding the Scheme Administrator's exercise or failure to exercise any option or discretion under this Section regarding the method of claim payment. No provider or other third-party is intended to have or shall have any rights as a third-party beneficiary under this the Master Policy or Evidence of Insurance issued by the Master Policy.

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

7.4 FRAUDULENT CLAIMS- If any claim or request for benefits under this insurance shall be in any respect fraudulent or deceitful, or if the Participating Member or anyone acting for or on their behalf under this insurance uses any fraudulent or deceitful means or devices, all benefits and claims under this insurance shall be forfeited and waived, and the Scheme Administrator, Underwriters, and/or Master Policyholder shall have no liability for such benefits or claims.

7.5 ARBITRATION- No claim for benefits for which liability, eligibility, or coverage under this insurance has been denied in whole or in part by the Scheme Administrator nor any other dispute or controversy arising under or related to this insurance shall be arbitral or subject to arbitration under any circumstances or for any reason.

7.6 PATIENT ADVOCACY- Neither the Underwriters nor the Scheme 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 Participating Member or to make any medical Treatment decisions for or on behalf of the Participating Member, and all such decisions shall be made solely and exclusively by the Participating Member and/or his/her guardians, family members and treating Physicians and other healthcare providers. Subject to the foregoing, the Scheme Administrator may determine that a particular claim, benefit, Treatment, or diagnosis occurring under or relating to this insurance may be placed under the Scheme Administrator's "Patient Advocacy" program to ensure that Medically Necessary Treatment and supplies are provided in the most cost effective manner. In the event the Scheme Administrator determines that a claim, benefit, Treatment, or diagnosis meets the Scheme Administrator's Patient Advocacy program guidelines, the Scheme Administrator will notify the Participating Member as soon as reasonably practicable, and a Patient Advocate will be assigned to the Participating Member. Thereafter, the Patient Advocate may make recommendations of Treatment settings and/or procedures and/or supplies that may be more cost effective for the Scheme Administrator and/or the Participating Member. Such recommendations will be made with input from the Participating Member and/or the Participating Member's guardians, family members and treating Physicians and other healthcare providers, and will be made only when it can be reasonably demonstrated that the Medically Necessary Treatment and/or supplies can be provided in a more cost effective manner to the Scheme Administrator and/or the Participating Member.

The Scheme Administrator 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 Participating Member. The Participating Member is under no obligation to accept or follow any of the Scheme Administrator's recommendations. However, if the Participating Member accepts and follows any of the Scheme Administrator's recommendations, the Participating Member agrees to hold the Scheme Administrator harmless from same, and the Scheme Administrator shall not be held liable or otherwise responsible for any Treatment or supply provided to the Participating Member except for the payment of claims and benefits eligible for coverage under the Terms of this insurance. After the Participating Member has been notified that the claim, Treatment, benefit or diagnosis meets the Scheme Administrator's Patient Advocacy program guidelines, the Scheme Administrator reserves the right, at its option and in its sole discretion without liability, to:

7.6.1 make payment for Treatment and/or supplies which, although not expressly covered under this insurance, may be beneficial to the Participating Member and cost effective to the Scheme Administrator; and/or
7.6.2 deny coverage and/or benefits for any charges which exceed the amount the Scheme Administrator would have covered had the Participating Member accepted and followed the recommendations of the Patient Advocacy program.

8. ASSIGNMENT, CHANGE OR WAIVER

Notwithstanding any law, statute, judicial decision, or rule to the contrary which may be or may purport to be otherwise applicable within the jurisdiction, locale or forum state of any healthcare provider, no transfer or assignment of any of the Participating Member's rights, benefits or interests under this insurance shall be valid, binding on, or enforceable against the Scheme Administrator unless first expressly agreed and consented to in writing by the Scheme Administrator. Any such purported transfer or assignment not in compliance with the foregoing Terms shall be void and without effect as against the Scheme Administrator, and the Scheme Administrator 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 the Evidence(s) of Insurance issued by the Master Policy shall not be waived or changed except by the express written agreement of the Scheme Administrator.

9. SERVICE OF SUIT

It is agreed that in the event of the failure of Underwriters to pay any amount claimed to be due hereunder, Underwriters, at the request of the Participating Organization or Participating Member, will submit to the jurisdiction of a Court of competent jurisdiction within the United States. Nothing in this clause constitutes a waiver of Underwriters rights to commence an action in any court of competent jurisdiction in the United

States, to remove an action to a United States District Court, or to seek a transfer of a case to another Court as permitted by the laws of the United States or any state in the United States. In any suit instituted against Underwriters hereunder, Underwriters will abide by the final decision of such Court, or of any Appellate Court in the event of an appeal.

Further, pursuant to any statute of any state, territory or district of the United States which makes provision therefor, the Scheme Administrator hereby designates the Superintendent, Commissioner or Director of Insurance or other officer specified for that purpose in the statute, or his successor or successors in office, as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the Master Policy-holder or any Participating Organization or any Participating Member arising hereunder, and hereby reserves the right to designates an Attorney of the Scheme Administrators choice in conjunction with Underwriters, as its attorney-in-fact and agent for service of process to whom said officer or Commissioner is authorized to mail or serve such process or a true copy thereof.

10. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, and voluntary plan of arrangement with creditors or dissolution of the Master Policyholder or any Participating Member shall not impose upon the Scheme Administrator any liability or obligation other than that specifically included in this insurance.

11. SUBROGATION CLAUSE

The Participating Member undertakes to pursue in his/her own name and stead, and to fully cooperate with the Scheme Administrator in the prosecution of, any and all valid claims that he/she may have against any third party who may be liable arising out of any act, omission or occurrence which results or may result in a loss payment or coverage of claim by the Scheme Administrator under this insurance, and to account to the Scheme Administrator for any amounts recovered in connection therewith, on the basis that the Scheme Administrator shall be reimbursed and entitled to recover first in full for any sums paid by it before the Participating Member shares in any amount so recovered.

Should the Participating Member fail to so cooperate, account, or to prosecute any valid claims against any such third party or parties, and the Scheme Administrator thereupon or otherwise becomes liable to make payment under the Terms of this insurance, then the Scheme Administrator shall be fully subrogated to all rights and interests of the Participating Member with respect thereto and may prosecute such claims in its own name as subrogee. The Participating Member's submission of Proof of Claim or acceptance of coverage or benefits under this insurance shall be deemed to constitute an assignment of such subrogation rights by the Participating Member to the Scheme Administrator. Any amount recovered by the Scheme Administrator shall first be used to pay the costs and expenses of collection incurred by the Scheme Administrator, including reasonable attorneys' fees, and for reimbursement to the Scheme Administrator 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 Participating Member or other persons lawfully entitled thereto, as applicable.

12. MISREPRESENTATION

Any misstatement, omission, concealment or fraud, either in the Participating Member's Application which forms a part of the Master Policy or Evidence of Insurance issued by the Master Policy, or in relation to any statement, certification or warranty made by the Participating Member or their representatives, agents or proxies, whether in writing or otherwise, to the Scheme Administrator or their respective agents, employees or representatives, or in connection with the making of any claim under this insurance, shall render the Master Policy null and void and all claims and benefits under this insurance shall be forfeited and waived

13. RIGHT OF RECOVERY

In the event of overpayment by the Scheme Administrator of any claim for benefits under this insurance, for any reason, including without limitation because:

13.1all or part of the claim was not incurred by or paid by or on behalf of the Participating Member; or
13.2the Participating Member or any member of the Participating Member's family, whether or not the family member is or was a Participating Member under this insurance, is repaid or is entitled to be repaid for all or part of the claim by Other Coverage or by or from a source other than the Scheme Administrator; or
13.3all or part of the claim was not eligible for payment or coverage under the Terms of this insurance; or
13.4all or part of the claim was paid or reimbursed based on an incorrect or mistaken application of benefits under this insurance; or
13.5all or part of the claim has been excused, waived, abandoned, forfeited, discounted or released by the provider; or
13.6the Participating Member is not liable or responsible as a matter of law for all or part of a claim;

The Scheme Administrator shall have the right to a refund of and to recover the amount of overpayment from the Participating Member and/or the Hospital, Physician, or other provider of services or supplies, as the case may be. For overpayment of claims as specified under sections **13.1** through **13.6** above, the amount of the refund and recovery shall be the difference between: (i) the amount actually paid by the Scheme Administrator, and (ii) the amount, if any, that should have been paid by the Scheme Administrator under the Terms of this insurance. For all other overpayments, the amount of the refund and recovery shall be the amount overpaid. If the Participating Member or the Hospital, Physician or other provider of services or supplies does not promptly make any such refund to the Scheme Administrator, the Scheme Administrator 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 Scheme Administrator; and/or (ii) cancel any Evidence(s) of Insurance and all further coverage of the Participating Member under the Master Policy by giving thirty (30) days advance written notice by mail to the Participating Member's last known residence or mailing address, and offset against the amount of any refund of Premium due the Participating Member to the full extent of the refund due to the Scheme Administrator.

14. OTHER INSURANCE

The Scheme Administrator shall not be obligated to provide any benefits or to pay any claim under this insurance if there is any other insurance, membership benefit, government program, reimbursement or indemnification coverage, right of contribution, recoupment or recovery, contract, or other third-party obligation or provision of benefits ("Other Coverage") which would, or would but for the existence of this insurance, be available or obligated to provide such benefit or to pay such claim, except in respect of any excess beyond the amount payable

or provided under such Other Coverage had this insurance not been effected. The Scheme Administrator shall not be obligated to provide any benefit or to pay any claim in respect to Treatment or supplies furnished by any program or agency funded by any government.

15. CANCELLATION PROCEDURES IN RESPECT OF THE EVIDENCE(S) OF INSURANCE

15.1 CANCELLATION BY PARTICIPATING MEMBER-The Participating Member shall have seven (7) days from the Initial Effective Date of Coverage (the "Review Period") to review the benefits, conditions, limitations, exclusions and all other Terms of the Master Policy as evidenced and outlined by the Evidence of Insurance issued by the Master Policy. If not completely satisfied, the Participating Member may request cancellation of the Evidence of Insurance retroactive to the Initial Effective Date of Coverage by sending a written request to the Scheme Administrator by mail or fax and received by the Scheme Administrator within the Review Period, thereby qualifying to receive a full refund of Premium paid. Upon receipt of such cancellation and refund, neither the Scheme Administrator nor the Participating Member shall have any further rights, liabilities or obligations under this insurance.

After the Review Period, the Participating Member may request cancellation of the Evidence of Insurance as issued by the Master Policy by submitting such request in writing to the Scheme Administrator not less than sixty (60) days in advance of the requested effective date. Cancellation of the Evidence of Insurance is at the sole option of the Scheme Administrator, except when such cancellation is within (the "Review Period"). The Scheme Administrator may request and/or require the Participating Member to execute a release of claims as a condition to and/or in consideration of granting such cancellation. If the Scheme Administrator grants cancellation, coverage for the Participating Member under this insurance shall terminate with effect from the cancellation date specified by the Scheme Administrator. The Scheme Administrator shall calculate the amount of Premium earned upon the Declaration and Evidence of Insurance issued by the Master Policy through the requested date of cancellation (Short Rate Earned Premium) in accordance with the Short Rate Cancellation Table in effect as of the date of the request for cancellation. If the Participating Member has paid more than the Short Rate Earned Premium, the Scheme Administrator shall refund the difference between the amount actually paid and the Short Rate Earned Premium. If the Participating Member has paid less than the Short Rate Earned Premium, the Participating Member shall remit to the Scheme Administrator the difference between the Short Rate Earned Premium and the amount actually paid as a condition to cancellation as of such requested date, or the cancellation date will be established retroactive to the date through which and for which Premiums have actually been paid. The Scheme Administrator shall charge the Participating Members credit card on file for any additional premiums due it at cancellation and/ or request payment pay check, money order, or wire transfer as a condition of cancellation. Please note, Cancellation by Participating Member is ONLY cancellation of the Evidence of Insurance and is NOT considered Cancellation of the Master Policy or Cancellation of the Master Policyholder.

15.2 TERMINATION OF COVERAGE FOR PARTICIPATING MEMBER- Coverage and benefits for the Participating Member under this insurance will terminate effective at 12:01 AM, EST, on the earliest of the following dates:

15.2.1 the next day following the end of the period for which Premium has been fully and timely paid; or
15.2.2 the termination date as shown on the Declaration for the Evidence of Insurance; or
15.2.3 the date the Master Policy is terminated; or
15.2.4 the date the Participating Member first fails to meet or no longer meets the eligibility requirements for this insurance as set forth in the Master Policy and outlined in the Evidence of Insurance; or
15.2.5 the 30th day after the Effective Date of the Evidence of Insurance, if the Participating Member is not a citizen of the USA but is located in the USA at the time of Application and has not departed the USA prior to such 30th day, unless the Participating Member is not eligible for any other medical insurance plan which is available to individuals similarly situated and located in the USA and has provided the Scheme Administrator an Affidavit of Eligibility; or
15.2.6 the date the Scheme Administrator, at its sole option, elects to cancel from the Beacon/Axis Series Group Insurance Plan (sometimes referred to herein as "this insurance plan" or "the plan") all Participating Members of the same sex, age, class or geographic location as the Participating Member, provided the Scheme Administrator gives no less than thirty (30) days advance written notice by mail to the Participating Member's last known place of residence or mail forwarding address of its intent to exercise such option with or in conjunction and the express written consent of Underwriters; or
15.2.7 the cancellation date specified by the Scheme Administrator pursuant to Section 15.1, above; or
15.2.8 the date specified by the Scheme Administrator in any notice of cancellation, forfeiture or rescission issued pursuant to or as a result of the circumstances described in Sections 7, 12, 15 above, or section 16 below, or as otherwise permitted by the Terms of this insurance.

Coverage for the Participating Member shall remain in full force and effect unless terminated pursuant to the provisions of this Section, except as otherwise provided in the Master Policy or the Evidence of Insurance.

16. TERMINATION OF MASTER POLICY

The Master Policy can be terminated at anytime by Underwriters or the Master Policyholder by giving at least thirty (30) days written notice to the other, thus providing the same such notice to the Scheme Administrator and to the Participating Member. Such termination will have no effect on the Evidence of Insurance prior to the date of the termination, or on eligible coverage's or benefits under this insurance accrued prior thereto. No Evidence of Insurance will be issued or renewals accepted after the date the Master Policy is terminated.

17. REINSTATEMENT OF COVERAGE FOR PARTICIPATING MEMBER

In the event coverage under this insurance lapses or is terminated in accordance with Section 15 for failure to pay Premium, the Participating Member may apply to the Scheme Administrator for reinstatement ("Reinstatement"). Reinstatement is at the sole option of the Scheme Administrator, and shall be subject to the Scheme Administrator'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 Member must submit all of the following to the Scheme Administrator:

17.1 a written request for Reinstatement; and
17.2 a newly completed Reinstatement Application, which shall become a part of the Master Policy and any reinstated Evidence of Insurance; and
17.3 a written statement giving full details, as requested by the Scheme Administrator, of any claims incurred, diagnoses made, manifestations of symptoms or health conditions experienced, and/or Treatment or supplies received by the

Participating Member since the Initial Effective Date under this insurance; and
17.4 a written statement giving full details of the reason for the previous failure to pay Premium when due or to accept renewal terms in a timely manner; and
17.5 payments of all Premiums due.

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

18. REINSTATEMENT OF MAXIMUM LIMIT

After each Coverage Period, the Scheme Administrator will reinstate up to $5,000 of the Maximum Limit for the next Coverage Period for the Participating Member. This does not apply to Mental or Nervous Disorders, Maternity and Newborn care or Pre-existing Conditions limits, and such reinstatement will not apply where coverage for the Participating Member lapses or terminates. In no event shall the Maximum Limit exceed $5,000,000 in all, in any one Coverage Period.

19. RENEWAL; AMENDMENTS

Subject to the Terms in the Master Policy, the coverage under this insurance may be renewed from year to year in accordance with and subject to the Terms of this 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 Member otherwise continues to meet the applicable eligibility requirements of the plan. The Scheme Administrator's commitment and the Participating Member's ability to renew is also subject to termination upon thirty (30) days written notice to the other party prior to the expiration date of the then existing Coverage Period.

The Scheme Administrator reserves the right in its sole discretion to make changes, additions and/or deletions to the Terms of the Master Policy, the Evidence of Insurance, renewals or replacements of either, and/or to the Beacon/Axis Series Group 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 the Master Policy, upon no less than ninety (90) days prior written notice to Underwriters and the Participating Member ("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 Member's cancellation rights as set forth above, and shall be sent first class mail, postage pre-paid, to the last known place of residence or mail forwarding address of the Participating Member.

Upon issuance of the Notice of Amendment, Underwriters and/or the Participating Member shall have the right to request cancellation of the Evidence of Insurance pursuant to the provisions set forth in the Master Policy, at any time prior to the Change Date; provided, however that cancellation shall be at the option of the Participating Member, and coverage under this insurance shall terminate with effect from the cancellation date specified by the Participating Member(subject to the provisions of Section 15, above. If the Participating Member does not elect to cancel the Evidence of Insurance in accordance with the foregoing, the changes, additions and/or deletions as made by the Scheme Administrator and specified in said Notice of Amendment shall take effect as of the Change Date specified in the Scheme Administrator's Notice, and this insurance shall thereafter continue in effect in accordance with its Terms, as so amended and modified.

20. APPLICABLE CURRENCY

All benefit amounts, coverages, monetary limits and sub-limits, and other amounts stated in the Master Policy, the Application, the Declaration, the Evidence of Insurance, and in any Riders, including Premium, are in U.S. dollars.

21. COOPERATION

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

22. BORDEREAUX ACCOUNTS AND SETTLEMENTS

Unless agreed to the contrary by the Underwriters in writing the Scheme Administrator shall prepare the following monthly Bordereaux, (in a format agreed by the Underwriters), separately throughout the Coverage Period of the Master Policy and any subsequent periods:

22.1 premium bordereaux listing the premiums charged for all Evidence(s) of Insurance issued and any additional/return premiums effected during the bordereaux period; and
22.2 Paid claims bordereaux showing details of all losses and related expenses settled and any salvages and other recoveries collected during the bordereaux period; and
22.3 outstanding claims bordereaux listing all individual reserves required for all known claims and related expenses outstanding as at the end of the bordereaux period.
22.4 the Scheme Administrator shall render with the applicable bordereaux, a summary account showing the premium declared on the bordereaux, gross and net of commission, taxes and any other deductions, and the amount declared on the paid claims bordereaux.

Accounts shall be remitted via the Lloyd's Broker within sixty (60) days of the end of each bordereaux period. The Scheme Administrator shall render separate bordereaux for monthly and annual Evidence(s) of Insurance. All premium bordereaux with copy Evidence(s) of Insurance and claims bordereaux shall be transmitted to the Underwriters via the Lloyd's Broker within thirty days of the end of each bordereaux period. In the event of there being no activity during a particular bordereaux period, the Scheme Administrator shall provide a statement to that effect.

23. UNDERWRITING DECISIONS; EXPLANATION OR VERIFICATION OF BENEFITS

In the event of any verbal or telephone inquiry, every attempt will be made to help the Participating Member and his/her healthcare providers 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 Scheme Administrator will be deemed or construed as an estoppels or to create any liability

against the Scheme Administrator or be deemed or construed to bind the Scheme Administrator or to modify, replace, waive, extend or amend any of the Terms of the Master Policy or the Evidence of Insurance, unless expressly set forth in writing. Actual eligibility and/or acceptance determinations, final coverage decisions, and benefit or claim payments can be determined and adjudicated only at the time a proper and complete Application and/or Proof of Claim is submitted (as the case may be), an opportunity for reasonable investigation and/or review is provided, cooperation required hereunder received, and all facts and supporting information, including relevant medical records, are presented in writing. The Terms of the Master Policy govern all available 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 Participating Member or his/her provider may submit a written request to the Scheme Administrator, including all pertinent medical information and a statement from the attending Physician (if applicable), and a written reply will be sent by the Scheme Administrator and kept on file.

If the Scheme Administrator elects to verify generally and/or preliminarily to a provider or the Participating Member 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 the Master Policy and or the Evidence of Insurance, any such verification of benefits does not guaranty either payment of benefits or the amount or eligibility of benefits. Final eligibility determinations, coverage decisions and actual reimbursement or payment of claims or benefits are subject to all Terms of this insurance, including without limitation filing a proper and complete Proof of Claim under Section 7, above.

24. SCHEDULE OF BENEFITS/LIMITS

The limits and sub-limits below are subject to the specific plan issued and full premium paid to the Scheme Administrator. The benefits, limits and sub-limits are subject to the Plan agreed upon by the Participating Member and Scheme Administrator, as defined by evidence of the Evidence of Insurance and the Declaration Page issued upon approval of the specific Plan.

THE MERIDIAN SERIES BASIC SCHEDULE OF BENEFITS		
Maximum Limit	$2,000,000 Maximum Limit	
Deductibles	$250, $500, $1,000, $2,500, $5,000, $10,000 per Member per Coverage Period	
Family Deductible	Maximum of 2 Deductibles per Family per Coverage Period	
Coverage Area	Area 1- Worldwide- Including U.S. & Canada	Area 2- Worldwide- Excluding US & Canada
Coinsurance- (Claims incurred in US or Canada)	After the Deductible the Plan will pay 80% of the next $5,000 of Eligible Expenses, then 100% to the Overall Maximum Limit. The Coinsurance will be waived if expenses are incurred within the PPO.	
Coinsurance- (Claims incurred outside US or Canada)	The Plan will pay 100% of Eligible Expenses to the Overall Maximum Limit.	
Benefit Period	6 months	
Pre-certification Penalty	50%	
Pre-existing Condition	$10,000 per Coverage Period (after24 months of continuous coverage). $50,000 Maximum Limit	
Maternity- Normal Delivery	**OPTIONAL RIDER 1- $7,500 per Coverage Period ($50,000 Maximum Limit) OPTIONAL RIDER 2- $5,000 per Coverage Period ($25,000 Maximum Limit)**	
Maternity- Complicated Delivery	**OPTIONAL RIDER 1- $10,000 per Coverage Period ($50,000 Maximum Limit) OPTIONAL RIDER 2- $ 7,500 per Coverage Period ($25,000 Maximum Limit)**	
Newborn Care	Included as part of Maternity benefits for first 31 days of life	
Human Organ/ Tissue Transplant	$500,000 Maximum Limit, covered Transplants	
Hospital Room and Board (Coverage Area 1)	Average Semi-Private room rate	
Hospital Room and Board (Coverage Area 2)	Average Semi-Private room rate	
Intensive Care Unit (Coverage Area 1)	Usual, Reasonable and Customary (URC)	
Intensive Care Unit (Coverage Area 2)	Usual, Reasonable and Customary (URC)	
Emergency Dental Due to Accident	$500 per Coverage Period	
Local Ambulance	$1,500 per covered event (not subject to Deductible or Coinsurance)	
Surgery	Usual, Reasonable and Customary (Subject to deductible and co-insurance)	
Prescription Medications	Usual, Reasonable and Customary	
Mental & Nervous Disorders	$10,000 per Coverage Period for Outpatient treatment only (after 24 months of continuous coverage).	
Wellness (Adult)	$150 per Males age 30 and over, per Coverage Period (after 12 months continuous coverage). Not subject to Deductible or Coinsurance.	
Wellness (Child)	$100 per Member age 18 and under, per Coverage Period (after 12 months continuous coverage). Not subject to Deductible or Coinsurance.	
All Other Medical Expenses	Usual, Reasonable, and Customary (URC)	
Emergency Room Illness	Usual, Reasonable and Customary (subject to additional $250 Deductible if not admitted).	

Emergency Room Accident	Usual, Reasonable, and Customary (URC)
Emergency Medical Evacuation	$50,000 Maximum Limit, $25,000 Maximum Limit for ages 65 and older.
Return of Mortal Remains	$25,000 Maximum Limit per Member (not subject to Deductible).
Emergency Reunion	$7,500 Maximum Limit

With regard to the foregoing Schedule of Benefits/Limits, the references to "continuous coverage" mean continuous unbroken coverage under the Beacon/Axis Series Group Insurance Trust (Anguilla). The applicable benefits described will become first available to the Participating Member only at the end of the continuous Coverage Period so specified.

25. ELIGIBILITY

If a Participating Member is not eligible, the Evidence of Insurance issued by the Master Policy will be Null and Void and all premiums paid will be refunded. In order to be eligible and qualified for coverage under this insurance, a Participating Member must:

25.1complete and sign an Application (or be listed thereon by proxy as an applicant and proposed Participating Member) with all questions answered truthfully and completely; and
25.2pay the required Premium on or before the Due Dates; and
25.3receive written acceptance of his/her Application or renewal from the Scheme Administrator; and
25.4be at least fourteen (14) days old but not yet seventy-five (75) years old; and
25.5not be Pregnant, Hospitalized or Disabled on the Initial Effective Date; and
25.6not be HIV+ on the Initial Effective Date; and
25.7i) if a United States citizen, must be residing outside of the USA as of the Effective Date (or renewal date) and plan to reside outside of the USA for at least six (6) of the next twelve (12) months thereafter; or (ii) if not a United States citizen: (A) must reside outside the USA at time of Application (or renewal); or (B) must plan to reside outside of the USA continuously for at least six (6) months during the Coverage Period with departure from the USA not more than thirty (30) days after the Initial Effective Date or renewal effective date; or (C) if located inside the USA at the time of Application (or renewal), must not be eligible for any other medical insurance plan which is available to individuals similarly situated and located in the USA and must provide the Scheme Administrator an Affidavit of Eligibility.

26. PRE-CERTIFICATION PROVISIONS/REQUIREMENTS

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

26.1 SPECIFIC REQUIREMENTS- The following Treatment and/or supplies must always be Pre-certified for Medical Necessity by the Scheme Administrator:

26.1.1 Inpatient Treatment of any kind; and
26.1.2 any Surgery or Surgical procedure; and
26.1.3 care in an Extended Care Facility; and
26.1.4 Home Nursing Care generally; and
26.1.5 Durable Medical Equipment; and
26.1.6 artificial limbs; and
26.1.7 all Covered Transplant Treatment.
26.1.8 Diagnostic testing such as MRI, CT Scan, PET Scan, and Ultrasounds

27. GENERAL REQUIREMENTS

To comply with the Pre-certification requirements of this insurance for the Treatment and services listed in Section 26.1, above, the Participating Member or his/her Physician must:

27.1 Contact the Scheme Administrator at the telephone numbers printed on the ID card, as follows: **Inside the United States:** 1-888-201-8850
Outside the United States: 1-317-644-6291 (Collect if necessary)
E-mail: service@azimuthrisk.com
Website: www.azimuthrisk.com **and**
27.2 As soon as possible before the Treatment is to be obtained; and

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

27.4 comply with the instructions of the Scheme Administrator and submit any information or documents required by the Scheme Administrator; and

27.5 Notify all Physicians, Hospitals and other healthcare providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Scheme Administrator.

28. LOSS OF COVERAGE/BENEFITS FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

If the Participating Member or his/her healthcare providers do not comply with the Pre-certification requirements:

28.1or the Treatment or supplies identified in subparagraph **26** through **26.1.8** above, or if such Treatment or supplies are not Pre- certified, Eligible Medical Expenses inured with respect to said Treatment and/or supplies will be reduced by fifty percent (50%); and

28.2for the Treatment or supplies identified in subparagraph **26** through **26.1.8**, or if such Treatment and/or supplies are not Pre-certified, all Covered Transplant benefits shall be forfeited and waived.

29. 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.

30. CONCURRENT REVIEW-

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

31. APPEAL PROCESS-

If the Participating Member disagrees with a Pre-certification decision of the Scheme Administrator, the Participating Member may ask the Scheme Administrator to reconsider the decision and may supply additional documentation to support the appeal. The Scheme Administrator may reconsider its decision based on review of the additional documentation and facts, if any. The Scheme Administrator will advise the Participating Member of its decision.

32. UNITED STATES PREFERRED PROVIDER ORGANIZATION (PPO)

If Treatment or supplies eligible for coverage under this insurance are received directly from the Scheme Administrator's approved list of independent PPO providers while the Participating Member is in the United States:

32. 1 The Scheme Administrator will reduce by fifty percent (50%) any part of the Deductible applicable to such claims, and

32. 2 The Scheme Administrator will waive any and all Coinsurance applicable to such claims. However, all 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 Participating Member may be eligible for the foregoing special benefit relating to Treatment or supplies received from PPO providers.

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

33. MANDATORY SECOND SURGICAL OPINION

Except in the case of an Emergency, if a Physician recommends one or more of the Surgeries listed below, the Scheme Administrator may require, as a condition to becoming eligible for benefits under this insurance, that the Participating Member consult with another independent Physician for a second opinion as to the Medical Necessity of the Surgery ("Second Surgical Opinion").

34. SECOND SURGICAL SPECIFIC SURGERIES

The Scheme Administrator will notify the Participating Member if a Second Surgical Opinion is required as soon as is reasonably possible after the Participating Member Pre-certifies such Surgery in accordance with the PRE-CERTIFICATION PROVISIONS/REQUIREMENTS set forth in this Evidence of Insurance. The specific surgeries that require a second surgical opinion are as follows: Cataract Removal; and

34.1Cholecystectomy; and

34.2Coronary Bypass; and

34.3Hemorrhoidectomy; and
34.4Herniorrhaphy; and
34.5Hysterectomy; and
34.6Knee Surgery; and
34.7Laminectomy; and
34.8Ligation and stripping of varicose veins; and
34.9Lithotripsy; and
34.10Sub mucous resection; and
34.11Septo-rhinoplasty; and
34.12Spinal Fusion; and
34.13Tonsillectomy and/or adenoidectomy; and
34.14any Covered Transplant.

35. THE PHYSICIAN PROVIDING THE SECOND OPINION MUST:

35.1 Not be a Relative of the Participating Member or the first recommending Physician; and
35.2 Not be financially or professionally or in any other way associated with the first recommending Physician; and
35.3 Provide the Scheme Administrator with a written opinion and any and all documents and records reasonably requested by the Scheme Administrator in support of such opinion.
35.4 If the second opinion is required by the Scheme Administrator, the Scheme Administrator will reimburse the Participating Member 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 Scheme Administrator will reimburse the Participating Member for Eligible Medical Expenses in accordance with the Terms of this insurance. If the second opinion differs from the recommending Physician, the Participating Member 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 35.1 through 35.3 immediately above.

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

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

If the Scheme Administrator does not require a second opinion, the Scheme Administrator will reimburse the Participating Member for Eligible Medical Expenses incurred in accordance with the Terms of this insurance.

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

36. ELIGIBLE MEDICAL EXPENSES

Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the Schedule of Benefits/Limits, Section **24**, and the exclusions set forth in Section **43**, below, the Scheme Administrator will reimburse the Participating Member for the following costs, charges and expenses incurred by the Participating Member with respect to an Illness or Injury suffered or sustained by the Participating Member while the Evidence of Insurance issued by the Master Policy is in effect, so long as the costs, charges or expenses are Usual, Reasonable and Customary ("Eligible Medical Expenses"):

36.1Charges incurred at a Hospital for:

36.1.1 daily room and board and nursing services not to exceed the average semi-private room rate; and
36.1.2 daily room and board and nursing services in Intensive Care Unit; and
36.1.3 use of operating, Treatment or recovery room; and
36.1.4 services and supplies which are routinely provided by the Hospital to persons for use while Inpatient; and Emergency Treatment of an Injury, even if Hospital confinement is not required; and
36.1.5 Emergency Treatment of an Illness; however an additional $250 deductible will be required unless the Participating Member is directly admitted to the Hospital as Inpatient for further Treatment of that Illness; and

37. CHARGES INCURRED FOR SURGERY AT AN OUTPATIENT SURGICAL FACILITY:

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

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

38. OTHER CHARGES INCURRED FOR SURGERY AT AN OUTPATIENT SURGICAL FACILITY INCLUDING SERVICES AND SUPPLIES;

38.1 dressings, sutures, casts or other supplies that are Medically Necessary; and
38.2 diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, behavioral and educational testing are not included); and
38.3 basic functional artificial limbs, eye or larynx or breast prostheses, but not the replacement or repair thereof; and
38.4 reconstructive Surgery which is directly related to a Surgery which is covered under this insurance; and
38.5 radiation therapy or Treatment, and chemotherapy; and
38.6 hemodialysis and the charges by a Hospital for processing and administration of blood or blood components, but not the cost of the actual blood or blood components; and
38.7 oxygen and other gasses and their administration; and
38.8 anesthetics and their administration by a Physician; and
38.9 drugs which require prescription by a Physician for Treatment of Illness or Injury, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, and for a maximum supply of ninety (90) days of any one prescription; and
38.10 care in a licensed Extended Care Facility upon direct transfer from an acute care Hospital; and
38.11Home Nursing Care in bed by a qualified licensed professional, provided by a Home Health Care Agency upon direct transfer from an acute care Hospital; and
38.12 Emergency local ambulance transport necessarily incurred in connection with Illness or Injury resulting in Hospitalization; and
38.13 For policies purchased more than ninety (90) days, Emergency Dental Treatment and Dental Surgery necessary to restore or replace sound natural teeth lost or damaged in an Accident that is covered under this insurance is $250 Maximum Limit per Coverage Period.
38.14 routine and Medically Necessary care of the Participating Member-mother and her Newborn during the first thirty-one (31) days of life, if the delivery of the Newborn and the charges incurred are eligible for coverage and are covered under the Terms of this insurance; and
38.15 Treatment of Mental or Nervous Disorders, provided the Participating Member has been continuously insured under this insurance plan for not less than twelve (12) months immediately preceding Treatment; and
38.16 physical therapy prescribed by a Physician and performed by a professional physical therapist, and necessarily incurred to continue recovery from a covered Injury or covered Illness; and

39.THE FOLLOWING CHARGES MADE BY A HOSPICE:

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

39.1.1 The Physician must certify that the Participating Member is terminally ill with 6 months or less to live; and services for the Participating Member must be received in an Inpatient Hospice facility or in the Participating Member's home.
39.1.2 Counseling for the patient and the patient's Family. Services must be rendered by a licensed social worker or a licensed pastoral counselor and are limited to $300 when the following condition applies:
39.1.3 Services must be received prior to or within 6 months after the patient's death; and payment will be limited to a total of 15 visits per Family; and

40.OTHER ELIGIBLE EXPENSES:

40.1 Medically Necessary rental of Durable Medical Equipment, up to the purchase price.
40.2 Charges incurred for vision care, including materials such as eyeglasses, contact lenses; and
40.3 Charges for any examination or fitting related to these devices set in the Schedule of Benefits and limits after (12) months of continuous coverage.

41. WELLNESS EXPENSES

Provided the Participating Member has been continuously insured under this Insurance plan for not less than twenty-four (24) months or as stated in the specific plan Schedule of Benefits and limits, and subject to the Terms of this insurance, the Scheme Administrator will reimburse the Participating Member for the following expenses incurred while the Coverage Period is in effect:

41.1.1 for Males thirty (30) years of age and older: one Routine Physical Exam, limited to $250 per Coverage Period, provided at least twenty-four (24) months have elapsed since the Participating Member's most recent Routine Physical Exam; and
41.1.2 for Females thirty (30) years of age and older: one Routine Physical Exam, limited to $250 per Coverage Period, including expenses for mammography exams and pap smears, provided at least twenty-four (24) months have elapsed since the Participating Member's most recent Routine Physical Exam; and
41.1.3 for a Child, limited to $150 per Coverage Period:
41.1.4 one Routine Physical Exam per Coverage Period, provided at least ten (10) months have elapsed since the Child's most recent Routine Physical Exam; and
41.1.5 routine inoculations and vaccinations commonly administered to children less than eighteen (18) years of age in accordance with standard medical practice.

42. TRANSPLANT EXPENSES

Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the Schedule of Benefits/Limits set forth in Section 24, above, the Pre-certification and mandatory second opinion provisions set forth in Sections 26 and 33, above, and the Exclusions set forth in Section 43 below, the Scheme Administrator will reimburse the Participating Member for the

following costs, charges and expenses incurred by the Participating Member with respect to a Covered Transplant obtained or received by the Participating Member while the Evidence of Insurance issued by the Master Policy is in effect, so long as such costs, charges or expenses are Usual, Reasonable, and Customary:

42.1 Eligible Medical Expenses incurred by a live donor will be treated as if they were the expenses of the Participating Member receiving a Covered Transplant if the Participating Member received an organ or tissue of the live donor; and
42.2 organ procurement and harvesting costs, excluding acquisition or purchase of the actual organ or tissue, up to a maximum of $10,000; and
42.3 Charges incurred for pre-transplant evaluation, the Covered Transplant procedure, re-transplantation (if incurred during the initial Covered Transplant Hospitalization), and post-transplant care; and
42.4 Reasonable travel and lodging expenses of the Participating Member if travel of more than fifty (50) miles is necessary to receive the Covered Transplant Treatment and supplies from a Managed Transplant System Network Provider, up to a maximum of $5,000. 42.5 Covered transplants: Heart, Heart/lung, Lung, Kidney, Kidney/Pancreas, Liver and Allogenic and Autologous Bone Marrow.

Transplant Pre-certification

To become eligible for the transplant benefits under this insurance, the transplant must be a Covered Transplant, the Participating Member must receive all Covered Transplant Treatment and supplies from an independent transplant network provider approved by the Scheme Administrator ("Managed Transplant System Network"), and the Covered Transplant **must be** Pre-certified by the Scheme Administrator in accordance with the Terms of this insurance.

If the Participating Member receives Covered Transplant Treatment and supplies from a provider that is not an approved member of the Scheme Administrator'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.** The Scheme Administrator shall not have any right, obligation, or authority of any kind to ultimately select Physicians, Hospitals, or other healthcare providers for the Participating Member or to make any medical Treatment decisions for or on behalf of the Participating Member regarding transplants, and all such decisions shall be made solely and exclusively by the Participating Member and/or his/her family members and treating Physicians and other healthcare providers. All claims for transplant benefits are subject to the Terms of this insurance.

43. EXCLUSIONS

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

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

43.1.1 war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war;
43.1.2 mutiny, riot, strike, military or popular uprising, insurrection, rebellion, revolution, military or usurped power;
43.1.3 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; martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege; or
43.1.4 Terrorism: For the purpose of this insurance, an "Act of Terrorism" means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s) committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear. All other Terms, clauses and conditions remain unchanged.
43.1.5 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 Scheme Administrator shall not be liable under the Evidence of Insurance, except to the extent that the Participating Member shall prove that such claim, Charges, Illness, Injury or other consequence

43.2 **Pre-existing Conditions-** Charges resulting directly or indirectly from or relating to any Pre-existing Condition are excluded from coverage under this insurance until the Participating Member has maintained coverage under this insurance plan continuously for at least twenty-four (24) months, and thereafter such Charges are limited in coverage as provided in Section 24, Schedule of Benefits/Limits, above; and

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

43.4 Maternity and Newborn Care- Charges for pre-natal care, delivery, post-natal care, and care of Newborns, are excluded from coverage under this insurance unless part of a covered maternity benefit subject to schedule of benefits and limits; and

43.5 Mental or Nervous Disorders- Charges for Treatment of Mental or Nervous Disorders are excluded from coverage under this insurance until the Participating Member has maintained coverage under this insurance plan continuously for at least twelve (12) months or as defined in the schedule of benefits and limits; and

43.6 Wellness- Charges for Routine Physical Exams are excluded from coverage under this insurance until the Participating Member has maintained coverage under this insurance plan continuously for at least twelve (12) months, and except as otherwise expressly provided in the Master Policy and/or any Evidence of Insurance issued by the Master Policy. In no event will the Scheme Administrator reimburse the Participating Member for more than one Routine Physical Exam during any twelve (12) month period; and

43.7 Charges for any Treatment or supplies that are:

43.7.1 not incurred, obtained or received by a Participating Member during the Coverage Period; and/or
43.7.2 not presented to the Scheme Administrator for payment by way of a complete Proof of Claim within ninety (90) days of the date such Charges are incurred; and/or
43.7.3 not administered or ordered by a Physician; and/or
43.7.4 not Medically Necessary; and/or
43.7.5 provided at no cost to the Participating Member or for which the Participating Member is not otherwise liable; and/or
43.7.6 in excess of Usual, Reasonable, and Customary; and/or
43.7.7 incurred by a Participating Member who was HIV + at the Initial Effective Date of this insurance; whether or not the Participating Member had knowledge of his/her HIV status at that time and whether or not the Charges are incurred in relation to or as a result of said status; and/or
43.7.8 provided by or at the direction or recommendation of a chiropractor, unless ordered in advance by a Physician; and/or
43.7.9 performed or provided by a Relative of the Participating Member; and/or
43.7.10 not expressly included as Eligible Medical Expenses as defined in Section 36 above; and/or
43.7.11 provided by a person who resides or has resided in the Participating Member's home; and/or
43.7.12 required or recommended as a result of complications or consequences arising from or related to any Treatment, Illness, Injury, or supply excluded from coverage or which is otherwise not covered under this insurance; and
43.7.13 Charges incurred for telephone consultations or due to a failure to keep a scheduled appointment; and

43.8 Charges incurred for Surgeries or Treatment or supplies which are:

43.8.1Investigational, Experimental, or for Research Purposes, and/or
43.8.2related to genetic medicine or genetic testing, including without limitation amniocentesis, genetic screening, risk assessment, prevention and/or to determine pre-disposition, genetic counseling, and/or gene therapy; and

43.9 Charges incurred while confined primarily to receive Custodial Care, Educational or Rehabilitation Care; and

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

43.10.1 weight modification or any Inpatient, Outpatient, Surgical or other Treatment of obesity (including without limitation morbid obesity), including without limitation wiring of the teeth and all forms of bariatric Surgery by whatever name called, or reversal thereof, including without limitation intestinal bypass, gastric bypass, gastric banding, vertical banded gastroplasty, biliopancreatic diversion, duodenal switch, or stomach reduction or stapling; and/or
43.10.2 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 Participating Member (such as but not limited to sex-change Surgery or Surgery relating to sexual performance or enhancement thereof); and/or
43.10.3 cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is Medically Necessary and is directly related to and follows a Surgery which was covered under this insurance; and/or
43.10.4 any Injury or Illness sustained while taking part in mountaineering activities where specialized climbing equipment, ropes or guides are normally or reasonably should have been used, Amateur Athletics, Professional Athletics, aviation (except when traveling solely as a passenger in a commercial aircraft), hang gliding and parachuting, snow skiing except for recreational downhill and/or cross country snow skiing (no cover provided whilst skiing in violation of applicable laws, rules or regulations; away from prepared and marked in Âbound territories; and/or against the advice of the local ski school or local authoritative body), racing of any kind including by horse, motor vehicle (of any type) or motorcycle, spelunking, and sub aqua pursuits involving underwater breathing apparatus (except as otherwise expressly set forth in Section 56 Recreational underwater Activities). Practice or training in preparation for any excluded activity which results in injury will be considered as activity while taking part in such activity; and/or
43.10.5 any Illness or Injury sustained while participating in any sporting, recreational or adventure activity where such activity is undertaken against the advice or direction of any local authority or any qualified instructor or contrary to the rules, recommendations and procedures of a recognized governing body for the sport or activity; and/or
43.10.6 any Illness or Injury sustained while participating in any activity where such activity is undertaken against medical advice; and/or
43.10.7 any Injury or Illness sustained as a result of being under the influence of or due wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician but not for the Treatment of Substance Abuse; and/or
43.10.8 any Injury or Illness sustained while operating a moving vehicle after consumption of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician. For purposes of this exclusion, "vehicle" shall include both motorized devices for which a driver or operator license is required (including watercraft and aircraft) and non-motorized bicycles and scooters for which no permit or license is required; and/or
43.10.9 any willfully self-inflicted Injury or Illness; and/or
43.10.10 any venereal disease; and/or
43.10.11 any testing for the following: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS; and/or
43.10.12 any Illness or Injury resulting from or occurring during the commission of a violation of law by the Participating Member, including, without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations; and/or
43.10.13 any Substance Abuse; and/or
43.10.14 speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy; and/or
43.10.15 orthoptics, visual therapy or visual eye training; and/or

43.11 The feet, including without limitation:

43.11.1 orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; Treatment of weak, strained, flat, unstable or unbalanced feet; metatalgia, bone spurs, hammertoes or bunions; and any Treatment or supplies for corns, calluses or toenails; provided, however, that claims for Treatment or supplies for the feet may be eligible for coverage under this insurance at the sole option of the Scheme Administrator and subject to all other Terms of this insurance when related to:

43.11.1.1 an Injury to the foot arising from an Accident covered hereunder; or

43.11.1.2 an Illness for which foot Surgery is Medically Necessary and determined to be the only appropriate method of Treatment; and/or

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

43.13 any sleep disorder; and/or

43.14 any exercise program, whether or not prescribed or recommended by a Physician; and/or

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

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

43.16.1 any artificial, non-human organs, or mechanical devices designed to replace human organs temporarily or permanently; and/or

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

43.16.3 any transplant expenses incurred outside the Scheme Administrator's approved independent Managed Transplant System Network; and/or

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

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

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

43.19 Charges incurred for Dental Treatment, except for Emergency Dental Treatment necessary to repair or replace sound natural teeth lost or damaged in an Accident covered hereunder or as necessary treatment of sudden, unexpected pain to sound natural teeth, and subject to the limits set forth in the Schedule of Benefits/Limits; and

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

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

43.22 Charges incurred for Treatment of the temporomandibular joint; and

43.23 Charges incurred by the Participating Member for the Treatment of his/her Newborns (or for supplies related thereto); and

43.24 Charges incurred for any immunizations and/or routine physical exams except for the eligible benefits and covered expenses provided for under Section 41, or as otherwise expressly provided for hereunder; and

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

43.26Any taxes, assessments, charges, fees or surcharges imposed by any governmental agency or authority:

43.26.1 arising out of or as a result of any Treatment or supplies received by the Participating Member, or

43.26.2 based upon the Scheme Administrator's election hereunder, if any, to pay benefits directly to providers, or

43.26.3 for any other reason; and

43.27 Unless otherwise expressly included under Sections 48 and 49, Complementary Medicine Benefit, Charges or expenses incurred for nonprescription drugs, medicines, vitamins, food extracts, or nutritional supplements; IV vitamin or herbal therapy; drugs or medicines not approved by the U.S. Food and Drug Administration or which are considered "off-label" drug use; and for drugs or medicines not prescribed by a Physician.

44. EMERGENCY MEDICAL EVACUATION BENEFIT

Subject to the Maximum Limit set forth in the Schedule of Benefits/Limits, and the other Terms of this insurance, including the Conditions and Restrictions set forth below, the Scheme Administrator will reimburse the Participating Member for the following expenses incurred by the Participating Member arising out of or in connection with an Emergency Medical Evacuation occurring while the Evidence of Insurance is in effect:

44.1 Emergency air transportation to a suitable airport nearest to the Hospital where the Participating Member will receive Treatment; and

44.2 Emergency ground transportation necessarily preceding Emergency air transportation and from the destination airport to the Hospital where the Participating Member will receive Treatment.

45. CONDITIONS AND RESTRICTIONS

To be eligible for coverage for Emergency Medical Evacuation benefits the Participating Member must be in compliance with all Terms of this insurance. The Scheme Administrator 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 Scheme Administrator will provide Emergency Medical Evacuation benefits only when all of the following conditions are met:

45.1 Medically Necessary Treatment cannot be provided locally; and
45.2 transportation by any other method would result in loss of the Participating Member's life; and
45.3 Emergency Medical Evacuation is recommended by the attending Physician who certifies to the matters in subparagraphs 44.1 and 44.2 above ; and
45.4 Emergency Medical Evacuation is agreed to by the Participating Member or a Relative of the Participating Member; and
45.5 Emergency Medical Evacuation is approved in advance and all arrangements are coordinated by the Scheme Administrator; and 45.6 the condition, Illness, Injury or occurrence giving rise to the Emergency Medical Evacuation occurred suddenly and/or spontaneously, and without: (i) advance warning, (ii) advance Treatment, diagnosis or recommendation for Treatment by a Physician, or (iii) prior manifestation of symptoms or conditions which would have caused a prudent person to seek medical attention prior to the onset of the Emergency.

The Scheme Administrator will arrange Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary Treatment to prevent the Participating Member's loss of life. The Scheme Administrator will use its best efforts to arrange with independent, third-party contractors any Emergency Medical Evacuation within the least amount of time reasonably possible. The Participating Member understands and agrees that the timeliness, duration, and outcome of an Emergency Medical Evacuation can be affected by events and/or circumstances which are not within the direct control of the Scheme Administrator, including but not limited to: availability and performance of competent transportation equipment and staff; delays or restrictions on flights or other modes of transportation caused by mechanical problems, government officials, telecommunications problems, and/or geographical and weather conditions; and other acts of God.

The Participating Member agrees to hold the Scheme Administrator and its agents and representatives harmless from, and agrees that the Scheme Administrator and its agents and representatives shall not be held liable for, any delays, losses, damages or other claims that arise from or are caused by the acts or omissions of such independent third-party contractors, or that arise from or are caused by any acts, omissions, events or circumstances that are not within the direct and immediate control of the Scheme Administrator and/or its authorized agents and representatives, including without limitation the events and circumstances set forth above.

46. EMERGENCY REUNION

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

46.1 the cost of an economy air ticket for one Relative or friend to the airport serving the area where the Participating Member is Hospitalized as a result of the Emergency or is to be Hospitalized as a result of the Emergency Medical Evacuation, and return from either of such locations to the point of their original departure; and
46.2 reasonable and necessary travel, meals (maximum of $25 per day), transportation and accommodation expenses incurred in relation to the Emergency Reunion (but excluding entertainment).
46.3 Conditions and Restrictions:

46.3.1 the Coverage Period for the Emergency Reunion shall not exceed fifteen (15) days, including travel days; and
46.3.2 the Emergency Reunion must be due to an Emergency Medical Evacuation covered under the Terms of this insurance; and the Participating Member must be so seriously ill that the attending Physician deems it necessary and recommends the presence of a Relative or friend to either the location where the Participating Member is being evacuated from or the destination of the evacuation, whichever is considered by the attending Physician and the Scheme Administrator to be the more reasonable; and all Emergency Reunion travel, transportation and accommodation arrangements and benefits must be coordinated and approved in advance by the Scheme Administrator in order to be eligible for coverage under this insurance.

47. RETURN OF MORTAL REMAINS

In the event of the death of the Participating Member as a result of an Illness or Injury covered under this insurance while the Participating Member is outside of his/her Home Country, the Scheme Administrator will reimburse the estate of the Participating Member up to US $30,000 for the return of the Participating Member's Mortal Remains to his/her Home Country (but not including any costs of burial); provided, however, that the Scheme Administrator must coordinate and approve all costs related to the return of the Participating Member's Mortal Remains in advance as a condition to this benefit.

48. COMPLEMENTARY MEDICINE BENEFIT

Subject to the Deductible and Coinsurance and Limited to the Maximum of $175 for any one service per Coverage Period, and the other Terms of this insurance, including without limitation the Conditions and Limitations set forth below, the Scheme Administrator will reimburse the Participating Member up to the amounts indicated below for charges incurred by the Participating Member for the following ("Complementary Medical Services"):

49. SCHEDULE AND LIMITS OF COMPLEMENTARY MEDICINE BENEFIT

49.1	Acupuncture	Up to $175 per Coverage Period per Participating Member.

49.2	Aroma Therapy	Up to $175 per Coverage Period per Participating Member.
49.3	Herbal Therapy	Up to $175 per Coverage Period per Participating Member.
49.4	Massage Therapy	Up to $175 per Coverage Period per Participating Member.
49.5	Vitamin Therapy	Up to $175 per Coverage Period per Participating Member.

50. CONDITIONS AND LIMITATIONS

In order to be eligible for reimbursement of the Complementary Medical Services described above, the Participating Member must:

50.1 be seeking Medically Necessary Treatment for a specific medical Illness which has been diagnosed, is being treated by a licensed Physician, and is otherwise covered by the Terms of this insurance; and
50.2 submit a written plan approved by the attending Physician for Complementary Medical Services to the Scheme Administrator in advance of obtaining any Complementary Medical Service; and
50.3 have the plan for Complementary Medical Services approved by the Scheme Administrator in writing in advance of obtaining any Complementary Medical Service; and
50.4 not be seeking Complementary Medical Services for any Mental or Nervous Disorder.

51. BENEFIT PERIOD

The Scheme Administrator will pay Eligible Medical Expenses, as defined herein, for up to 180 days (Benefit Period) beginning on the first day of diagnosis or Treatment of a covered Injury or Illness while the Participating Member is outside his/her Home Country and if the Evidence of Insurance was in effect at the time of the covered Injury or Illness. In the event a Participating Member begins a Benefit Period while the Evidence of Insurance is in effect, and the Evidence of Insurance terminates if and when the Participating Member returns to his/her Home Country, the Scheme Administrator will pay Eligible Medical Expenses, as defined herein, which are incurred in the Participating Member's Home Country during the Benefit Period.

Home Country Coverage applies only to Eligible Medical Expenses related to the initial Benefit Period for a covered Injury or Illness.

52. HOME COUNTRY COVERAGE (End of Trip)

He Scheme Administrator agrees to provide the Participating Member with free End of Trip Home Country coverage under this insurance; If:

52.1 The Participating Member purchased six (6) months of coverage and is covered hereunder continuously for six (6) months outside his/her Home Country, the Scheme Administrator will provide fifteen (15) days of free Home Country coverage;
52.2 he Participating Member purchased twelve (12) months of coverage and is covered hereunder continuously for twelve (12) months outside his/her Home Country, the Scheme Administrator will provide thirty (30) days of free Home Country coverage. Home Country Coverage applies only to Eligible Medical Expenses.

53. QUICK TRIP HOME COUNTRY COVERAGE

The Scheme Administrator will provide Quick Trip Home Country coverage to a Participating Member if he/she purchased at least three (3) months of coverage. Home Country coverage is for Medical Expenses only during a Quick Trip to the Participating Member's Home Country, totaling no more than 14 days duration per three-month Coverage Period. A Quick Trip Home must be used within the three-month period earned, and the Participating Member must continue his/her international trip in order to be eligible for this benefit. Return to the Participating Member's Home Country must not be taken for the purpose of obtaining Treatment of an Illness or Injury that began while traveling. Quick Trip Home Country Coverage is Subject to a minimum three (3) months purchase and is not available as end of trip coverage.

54. TRIP DELAY/MISSED CONNECTION

Additional Transportation Cost to join the Covered Trip or return home, including up to $100 per day for Maximum of 48 hours or two (2) days for reasonable accommodations and meals, if Your delay requires an unplanned overnight stay; and/or unused non-refundable portion of the prepaid expenses as long as the expenses are supported by proof of purchase and are not reimbursable by any other source. Delay must be twelve (12) hours or more and certified due to the following reasons:

54.1 delay of Common Carrier (which is certified by the Common Carrier);
54.2 a traffic accident while en-route to the point of departure (substantiated by a police report);
54.3 Organized Labor Strike, or you or Your Traveling Companion being hijacked or quarantined;
54.4 stolen passports, travel documents and (substantiated by a police report).

55. HIGH SCHOOL SPORTS INJURY

Subject to the Terms of this insurance, High School Sports Injury medical expenses incurred will be reimbursed to the Participating Member as outlined in the Schedule of Benefits/Limits in cases where there has been an injury sustained while participating in a sanctioned High School Sport(S) Game **ONLY**. The Maximum benefit is listed in the Schedule of Benefits/Limits and the exclusions set forth in Sections **24** and **43**.

56. RECREATIONAL UNDERWATER ACTIVITIES

Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the Schedule of Benefits/Limits, and the Exclusions set forth in Section 24 and 43 above, and the Special Exclusions and Limitations below, the Scheme Administrator will reimburse the Participating Member for Eligible Medical Expenses incurred by the Participating Member with respect to an Illness or Injury suffered or sustained by the Participating Member while engaged in Sports Diving during the Coverage Period, so long as the same is carried out in strict accordance with the guidelines, codes of good practice, and recommendations for safe diving practices as laid down by an Authoritative Diving Body.

56.1 Special Exclusions and Limitations:

In addition to the Exclusions set forth in Section 43 above, this insurance does not cover any charges, costs, expenses and/or claims incurred by the Participating Member relating to, arising from, as a consequence of, or in connection with, directly or indirectly, any of the following acts, omissions, events, occurrences or conditions:

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

It is a condition precedent to the Scheme Administrator'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 Participating Member should refrain from participating in S.C.U.B.A. diving until medical advice and approval has been obtained from a qualified Physician.

57. TERRORISM

Scheme Administrators will pay Eligible Medical Expenses for Treatment of Injuries and Illnesses resulting from an Act of Terrorism, up to the limit set forth in SCHEDULE OF BENEFITS AND LIMITS, provided all of the following conditions are met:

57.1 The Injury or Illness does not result from the use of any biological, chemical, Radioactive or nuclear agent, material, device or weapon; and
57.2 The Member has no direct or indirect involvement in the Act of Terrorism; and
57.3 The Act of Terrorism is not in a country or location where the United States government has issued a travel warning that has been in effect within the 6 months immediately prior to the Member's date of arrival; and
57.4 The Member has not unreasonably failed or refused to depart a country or location following the date a warning to leave that country or location is issued by the United States government.

58. LOST CHECKED LUGGAGE

Subject to the benefits and Limits set forth in the SCHEDULE OF BENEFITS AND LIMITS in Section 24, the Scheme Administrator will consider paying for the replacement of clothing and hygiene items not to exceed $100 for any one item if the following provisions are met:

58.1 The Participating Member(s) must be in compliance with all conditions and restrictions of this coverage.
58.2 Lost checked luggage must have been checked, in accordance with routine luggage checking procedures of the carrier, for transportation with the member(s), on board a regularly scheduled commercial airline or cruise line, upon which the Participating Member(s) was a fare-paying passenger
58.3 The Participating Member(s) must file a formal claim for lost checked luggage with the transportation carrier, and follow all instruction and take all measures as directed by the transportation carrier to locate and retrieve all lost checked luggage.
58.4 The Participating Member(s) must provide the Scheme Administrator with copies of all documentation of the claim filed with the transportation carrier, and a written statement from the transportation carrier that the luggage was checked and after careful search, the luggage remains missing.
58.5 The Lost Checked Luggage must be lost as of the date of payment by the Scheme Administrator and as of that date must have been lost for 10 days

59. ACCIDENTAL DEATH AND DISMEMBERMENT

Subject to the benefits and Limits set forth in the SCHEDULE OF BENEFITS AND LIMITS in Section 24, the Scheme Administrator will consider paying as follows:

59.1 Accidental Death- The Scheme Administrator will pay the Principal Sum of $30,000 for the Participating Member or the Participating Member's spouse, or $6,000 for Dependent Child(ren). The Scheme Administrator will pay a reduced benefit of 50% to any Participating Member age 70-74 ($15,000); and for ages 75 and older a further reduction of 50% ($7,500).
59.2 Accidental Dismemberment Schedule -
    59.2.2 Loss of 2 or more Limbs or both eyes- Principal Sum ($30,000)
    59.2.3 Loss of 1 limb or eye- one-half of Principal Sum ($15,000)
59.3 The Principal Sums for Accidental Dismemberment shall reduce by 50% for Participating Members age 70-74 and by an additional 50% for Participating Members 75 and older.

60. COMMON CARRIER ACCIDENTAL DEATH AND DISMEMBERMENT

Subject to the benefits and Limits set forth in the SCHEDULE OF BENEFITS AND LIMITS in Section 24, the Scheme Administrator will consider paying the Principal Sum of $50,000 for Participating Members age 18 and over, or $30,000 for Participating Members under 18 years of age if the following provisions are met:

60.1 The Participating Member must be in compliance with all conditions and provisions of this insurance.
60.2 The accident giving rise to the Accidental Death must occur while the Participating Member is a fare paying passenger on a regularly scheduled trip on board a commercial airline or cruise line. The Maximum Benefit for any one Family is $250,000.

61. HOSPITAL INDEMNITY

Subject to the benefits and Limits set forth in the SCHEDULE OF BENEFITS AND LIMITS in Section 24, the Scheme Administrator will consider paying $150 for each night the Participating Member spends in the Hospital if the following provisions are met:

61.1 The Participating Member must be in compliance with all conditions and provisions of this insurance.
61.2 The Participating Member must be hospitalized as Inpatient for treatment of an Injury or Illness covered under this insurance; and
61.3 The Scheme Administrator will only provide Hospital Indemnity benefits following receipt of verification of an eligible Inpatient hospitalization.

62. DEFINITIONS

Certain words and phrases used in the Master Policy and the Evidence(s) of Insurance issued by the Master Policy are defined below. Other words and phrases may be defined elsewhere in the Master Policy or Evidence(s) of Insurance issued by the Master Policy, including where they are first used.

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

Accidental Death: A sudden, unintentional, and unexpected death of a Participating Member resulting from physical bodily injury and not the result of murder or suicide; Illness or Treatment.

Accidental Dismemberment: A sudden, unintentional, and unexpected occurrence caused by external, visible means and resulting in the permanent loss by physical separation of a hand at or above the wrist or of a foot at or above the ankle and includes permanent total and irrecoverable loss of use of hand, arm, leg or one or both eyes.

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

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

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

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

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

Beneficiary: The person(s), executers or administrators entitled to receive payment of Benefits.

Canada: A federated country in North America made up of ten provinces and three territories, (Canada).

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

Complicated Delivery: A delivery in which some condition puts the mother, the developing fetus, or both at higher-than-normal risk for complications during or after the delivery.

Coverage Period: The period beginning on the Effective Date of Coverage of the Evidence of Insurance and ending on the earliest of the following dates: (i) the termination date specified in the Declaration, or (ii) the termination date as determined in accordance with Section **15** above. The Coverage Period can be no more than twelve (12) consecutive months.

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

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

Death: Complete and irreversible cessation of life.

Declaration: The Declaration of Insurance issued by the Scheme Administrator to the Participating Member contemporaneously with the Evidence of Insurance (and/or upon renewal or Reinstatement hereof) evidencing the Participating Member's insurance coverage under the Master Policy as evidenced by the Evidence of Insurance, which Declaration shall be incorporated in and become a part of the Master Policy. The Declaration serves as a descriptive document highlighting the coverage limits, deductible(s), coverage dates, amendments and/ or riders, and names of Participating Members for all Evidence of Insurance issued by the Scheme Administrator on behalf of the Master Policyholder

and Underwriters.

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

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

Dependent Child/Children: A Participating Member who is less than eighteen (18) years of age at time of Application and shares your home for at least half the year (if divorced, the child may live with former spouse); and must **not** provide over one-half of his/her own support (scholarships excluded); or must be less than 24 years of age at time of Application and a full-time student and claim your residence as his/her official residence while away at school; and must **not** provide over one-half of his/her own support (scholarships excluded); and must be your biological, step, or legally adopted child/children.

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

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

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

Effective Date; Effective Date of Coverage: The date coverage for the Participating Member begins under the Terms of the Master Policy and the Evidence of Insurance, as indicated on the Declaration.

Eligible Medical Expenses: As defined in Section **36** above.

Emergency: A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Participating Member's life or limb in danger if medical attention is not provided within twenty-four (24) hours.

EST: U.S. Eastern Standard Time.

Evidence of Insurance: The document issued by the Master Policyholder to the Participating Member, which describes and provides an outline and evidence of eligible coverages and benefits payable to or for the benefit of the Participating Member under the Master Policy, and which includes the Participating Member's Application and any Riders attached thereto.

Expenses Incurred: Expenses rendered by a Participating Member that have or may not yet have been paid by the responsible parties.

Experimental: Any Treatment that includes completely new, untested drugs, procedures, or services, or the use of which is for a purpose other than the use for which they have previously been approved; new drug procedure or service combinations; and 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; is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a Physician and the direct supervision of a Registered Nurse; maintains a daily record on each patient; provides each patient with a planned program of observation prescribed by a Physician; provides each patient with active Treatment of an Illness or Injury. Extended Care Facility does not include a facility primarily for rest, the aged, Substance Abuse, Custodial Care, nursing care, or for care of Mental or Nervous Disorders or the mentally incompetent.

Family: A Participating Member and his/her spouse who is covered as a Participating Member under this insurance plan and his/her dependent Child or Children (**see definition of Dependant Child**; **Children**) who are under the age of eighteen (18) or less than twenty-four (24) years of age at time of Application and a full-time student and claim your residence as his/her official residence while away at school and covered as Participating Members under this insurance plan.

High School Sports Injury: Injury and or Injuries resulting from an Accident while participating in a High School sanctioned game by a properly enrolled High School student.

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

Home Country: The country of which the Participating Member is a citizen or national; or maintains his/her residence or usual place of abode; or the country of which the Participating Member is the possessor of a validly issued passport.

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

Home Nursing Care: Services, provided by a Home Health Care Agency and supervised by a Registered Nurse, which are directed toward the personal care of a patient, provided always that such care is in lieu of Medically Necessary Inpatient care.

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

Hospital: An institution which operates as a hospital pursuant to law; 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 Inpatients; provides 24-hour nursing service by Registered Nurses on duty or call; has a staff of one or more Physicians available at all times; provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical or mental/nervous conditions on its premises; and is not primarily a long-term care facility, Extended Care Facility, nursing, rest, Custodial Care, or convalescent home, a place for the aged, drug addicts, alcoholics or runaways; or similar establishment.

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

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

Initial Effective Date: The date (most recent, if more than one) the Participating Member first obtains coverage under the Beacon/Axis Series family of Insurance plans and maintains continuous unbroken coverage thereafter.

Injury: Bodily injury resulting from an Accident.

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

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

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

Master Policyholder: The Beacon/Axis Series Group Insurance Trust, (Anguilla).

Maximum Limit: The cumulative total dollar amount of benefit payments and/or reimbursements available to a Participating Member under this insurance during the Participating Member's Coverage Period. When the Maximum Limit is reached, no further benefits, reimbursements or payments will be available under this insurance.

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

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

Mortal Remains: The bodily remains or ashes of a Participating Member.

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

Normal Delivery: A Vaginal delivery with no unexpected complications before or after delivery.

Other Insurance: As defined in Section **14** above.

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

Participating Member: The person(s) named as the Participating Member(s) on the Declaration.

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

Pre-certification; Pre-certify: A general determination of Medical Necessity, only, made in reliance and based upon the completeness and accuracy of the information provided at the time thereof. Pre-certification is not an assurance, authorization, or verification of coverage, a verification of benefits, or a guarantee of payment. See Section **26** above, for further details.

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

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

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

Primary Beneficiary: The Beneficiary (ies) named by the Participating Member as the first party entitled to Benefits.

Principal Sum: The Benefit based upon the attained age of the Participating Member.

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

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

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

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

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

Scheme Administrator: The "Scheme Administrator", as referred to herein; Azimuth Risk Solutions, LLC, acts solely as the disclosed and authorized agent and representative for and on behalf of the Master Policyholder and Underwriters, and has and shall have no direct, indirect, joint, several, separate, individual, or independent liability or obligation of any kind under the Master Policy or the Evidence of Insurance to the Participating Member or to any other person or entity. Azimuth Risk Solutions, LLC 55 Monument Circle, #1128, Indianapolis, Indiana 46204, USA. Telephone Number 317-644-6291 or 888-201-8050, Fax Number 317-423-9620 or 888-201-8851, Website: www.azimuthrisk.com, Email: service@azimuthrisk.com.

Short Rate Cancellation Table: The table used by the Scheme Administrator to calculate Short Rate Earned Premium in the event of cancellation. A copy of this table is available to the Participating Member upon request.

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

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

Sudden Onset of a Pre-Existing Condition: An unexpected outbreak or recurrence of a Pre-existing Condition, which occurs unexpectedly and without advance warning, either in the form of Physician recommendation or symptoms which would have caused a prudent person to seek medical attention prior to the outbreak or recurrence. Treatment must be obtained within 24 hours of the sudden and unexpected occurrence of pain.

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

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

Terrorism: A*n act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s) committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear. All other Terms, clauses and conditions remain unchanged.*

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

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

U.S.: The United States of America and or any of its territories.

Usual, Reasonable and Customary: The most common charge for similar services, medicines, or supplies within the area in which the charge is incurred, so long as those charges are reasonable. The Scheme Administrator reserves the right to determine, in the reasonable exercise of its discretion, whether charges are Usual, Reasonable and Customary. In determining whether a charge is Usual, Reasonable and Customary, the Scheme Administrator may consider one or more of the following factors, without limitation: 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 severity or nature of the Illness or Injury being treated; the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged 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; and such other factors as the Scheme Administrator, in the reasonable exercise of its discretion, determines are appropriate.