THE MERIDIAN SERIES CLEAR EVIDENCE OF INSURANCE
THE BEACON/AXIS SERIES GROUP INSURANCE TRUST (ANGUILLA)
UMR (B1284RE241360A)

This Evidence of Insurance is issued by the Master Policy on behalf of the Master Policyholder, as so authorized by Underwriting Members of 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 of Lloyd's authorize Azimuth Risk Solutions as the ("Scheme Administrator") of the Master Policy and all Evidence(s) of Insurance issued by the Master Policy.

MASTER POLICYHOLDER — Master Policy Number: A92355005, 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 as March 1, 2009, and shall remain in effect until terminated by the Underwriters in accordance to **Section 16** below. This Evidence of Insurance issued by the Master Policy is subject to annually Continuation of Coverage unless otherwise expressed. All Evidence(s) of Insurance issued by the Master Policy shall be effective as of the Effective Date of Coverage indicated on the Participating Members ID Card and shall remain in effect until terminated in accordance with **Section 15** below. The 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). The Evidence of Insurance is merely a description of and evidence of Member rights and Benefits under the contract. The Master Policyholder hereby recognizes Azimuth Risk Solutions, as its authorized agent and representative. Azimuth Risk Solutions as the 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, notices and payments that are required or permitted under the Master Policy and/or as described in the 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 consider receipt by the Master Policyholder on behalf of the Underwriters.

LLOYD'S BROKER — The Lloyd's Broker has negotiated such insurance on behalf of the Master Policyholder, it is mutually understood and agreed between the Underwriters and the Master Policyholder, that Azimuth Risk Solutions 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", as referred to herein; Azimuth Risk Solutions, 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.

QUESTIONS OR CONCERNS ABOUT THIS INSURANCE — In the event that Participating Member has any questions or concerns about this insurance or the handling of a claim the Participating Member can refer the matter to Azimuth Risk Solutions at the contact information below.

Azimuth Risk Solution
8520 Allison Pointe Blvd, Suite #220
Indianapolis, Indiana 46250
Email: service@azimuthrisk.com
Telephone: 317-644-6291 or 888-201-8050
Fax: 317-423-9620 or 888-201-8851

COMPLAINTS ABOUT THIS INSURANCE — However, if the Participating Member wishes to make a complaint, the Participating Member can do so at any time by referring the matter to either Azimuth Risk Solutions at the contact information below:

Azimuth Risk Solutions
Attn: Complaints Department
8520 Allison Pointe Blvd, Suite #220
Indianapolis, Indiana 46250

SPECIAL NOTIFICATIONS:

Sanction Limitation and Exclusion Clause — No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

Important Notice Regarding The Patient Protection and Affordable Care Act (PPACA) — This insurance is not subject to, and does not provide benefits as required by PPACA. As of January 1, 2014 PPACA requires U.S. citizens, U.S. nationals, and certain U.S. residents to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Please note penalties may be imposed on persons who are required to maintain PPACA compliant coverage but fail to do so. Eligibility to purchase, extend, or continue coverage for this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Note, it is the insured person's sole and exclusive responsibility to determine the insurance requirements applicable to them, and neither Underwriters nor Azimuth Risk Solutions shall have any liability whatsoever, including any penalties a person may incur for failure to obtain coverage required by any applicable law including without limitation PPACA. For information regarding PPACA and how it applies to you or if you are eligible to purchase products administered by Azimuth Risk Solutions, please contact us at: http://www.azimuthrisk.com/service@azimuthrisk.com or by calling 1-317-644-6291/1-888-201-8850.

1 EVIDENCE(S) OF INSURANCE ISSUED — This Evidence of Insurance replaces any other Evidence of Insurance previously issued covering the Insurance described herein. Please refer to your Application for details on the selected coverage amounts, Deductibles and Coinsurance.

1.1 The Scheme Administrator will issue in respect of each Participating Member an identification number and Evidence of Insurance; and

1.2 The Scheme Administrator shall retain a copy of all such Evidence(s) of Insurance and shall make available a copy to Participating Member(s) upon request; and

1.3 The Scheme Administrator shall make available 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 forty-five (45) days after inception, or in accordance with local legislation; and

1.4 The Scheme Administrator shall advise Underwriters of all additions and deletions of Evidence(s) of Insurance.

2 PERIOD OF INSURANCES EFFECTED IN ACCORDANCE WITH THE MASTER POLICY:

2.1 The Master Policy is effective during the period from December 01, 2017 through January 31, 2018, both days inclusive and for thirty (30) days, if required, as may be mutually agreed upon; and

2.2 No Evidence(s) of Insurance shall be bound hereunder for a period greater than three-hundred and sixty-four (364) days in respect to annual cover; and

2.3 Every Evidence(s) of Insurance issued shall commence during the currency of the Master Policy.

2.4 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; and

2.5 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 Premiums, commissions, fees and any other charges.

3 ACCEPTANCE BY THE UNDERWRITERS — 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, which would include the Application, the Evidence(s) of Insurance, the Declaration Page of Insurance, and any Endorsements, shall constitute the entire agreement among the Policyholder, Underwriters, and the Participating Member(s). Underwriters hereby recognize Azimuth Risk Solutions 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 US citizens residing in the US or Anguillan citizens residing in Anguilla; and

4.2 The territorial limits of each Evidence(s) of Insurance issued hereunder shall be worldwide, except;

4.2.1 When a US citizen purchasing a travel policy while residing in the US; or

4.2.2 When an Anguillan citizen purchasing a travel policy while residing in Anguilla.

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 figure is always considered to be in US dollars:

5.1.1 $2,000,000

6 PREMIUMS AND DEDUCTIBLES:

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 Effective Date of Coverage; and

6.1.2 Prior to any Continuation of Coverage Date under **Section 17**, below.

6.2 All Deductibles for Evidence(s) of Insurance issued under the Master Policy are in US dollars, as follows:

6.2.1 $250; or

6.2.2 $500; or

6.2.3 $1,000; or

6.2.4 $2,500; or

6.2.5 $5,000; or

6.2.6 $10,000.

7 CLAIM(S) PROCEDURES:

7.1 **PROOF OF CLAIM —** When the Scheme Administrator receives notice of a claim for Benefits under this insurance, and it will provide the Participating Member with form(s) ("Claim Form") for filing a 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 Itemized bills from all Physicians, Hospitals and other healthcare or medical service providers involved with respect to the claim(s); and

7.1.3 Receipts for any expenses that have been paid by or on behalf of the Participating Member(s) with respect to the claim(s); and

7.1.4 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 any Proof of Claim submitted thereafter or for an incomplete Proof of Claims. All claim decisions made by or on behalf of the Scheme Administrator are with the express consent of Underwriters. All Complete Proof of Claim(s) can be submitted as follows:

7.1.4.1 Mail
Azimuth Risk Solutions
PO Box 627
Indianapolis, IN 46206

7.1.4.2 Email
service@azimuthrisk.com

7.1.4.3 Fax –
1 (317) 423-9620/1 (888) 201- 8851 (outside of the US)

7.2 **CLAIM SETTLEMENT —** Eligible and covered claims under this insurance, which 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 in USD, 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 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, 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(s) 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 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 or 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 that, 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 that 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 that 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/her 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 Policyholder, Participating Organization or any Participating Member arising hereunder, and hereby reserves the right to designate an attorney of the Scheme Administrator's 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 and/or Underwriters 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 that results or may result in a loss of payment or coverage of claim by the Scheme Administrator and/or Underwriters under this insurance, and to account to the Scheme Administrator and/or Underwriters for any amounts recovered in connection therewith, on the basis that the Scheme Administrator and/or Underwriters 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 prosecute any valid claims against any such third party or parties, and the Scheme Administrator and/or Underwriters thereupon or otherwise becomes liable to make payment under the Terms of this insurance, then the Scheme Administrator and/or Underwriters 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 a Claim, 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 and/or Underwriters. Any amount recovered by the Scheme Administrator and/or Underwriters shall first be used to pay the costs and expenses of collection incurred by the Scheme Administrator and/or Underwriters, which would include reasonable attorneys' fees, and for reimbursement to the Scheme Administrator and/or Underwriters for any amount that it may have paid or became 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 Evidence of Insurance 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, which would include without limitation because:

13.1 All or part of the claim was not incurred by or paid by or on behalf of the Participating Member; or

13.2 The Participating Member or any member of the Participating Member's Family, whether or not the Family members was a Participating Member under this insurance plan, is repaid, is entitled to be repaid for all or part of the claim by Other Coverage, or from a source other than the Scheme Administrator; or

13.3 All or part of the claim was not eligible for payment or coverage under the Terms of this insurance; or

13.4 All or part of the claim was paid or reimbursed based on an incorrect or mistaken application of Benefits under this insurance; or

13.5 All or part of the claim has been excused, waived, abandoned, forfeited, discounted or released by the provider; or

13.6 The 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 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 **Subsections 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") that would, or that 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** — All cancellation requests must be submitted in writing to Azimuth Risk Solutions To be eligible for a full refund, the request must be received before the Participating Members requested Effective Date. Cancellation requests received after the requested Effective Date will be subject to the following:

15.1.1 A written request submitted to the Scheme Administrator by email, mail or fax; and

15.1.2 Request must be received prior to the requested cancellation date; and

15.1.3 Only the unused portion of the Premium cost will be refunded; and

15.1.4 If there are Pending claims that are Eligible, a refund will not be issued; and

15.1.5 A $25.00 cancellation fee

15.2 **Termination Of Coverage For Participating Member** — Coverage and Benefits for the Participating Member under this insurance will terminate effective at 11:59 PM, 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 indicated on the Declaration Page of Insurance for the Evidence of Insurance in in Section in Section Ⅱ; 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 date the Scheme Administrator and/or Underwriters, 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

15.2.6 The cancellation date specified by the Scheme Administrator and/or Underwriters pursuant to **Subsection 15.1**, above; or

15.2.7 The cancellation date specified by the Participating Member, or upon return to Home Country; or

15.2.8 The date specified by the Scheme Administrator and/or Underwriters in any notice of cancellation, forfeiture or rescission issued pursuant to or as a result of the circumstances described in **Sections 7, 12, 15** and 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 any time 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 or Benefits under this insurance accrued prior thereto. No Evidence of Insurance will be issued or a Continuation of Coverage accepted after the date the Master Policy is terminated.

17 **REINSTATEMENT OF COVERAGE —** In the event coverage under this insurance lapses or is terminated 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 of health, including any relative medical records; and

17.4 A written statement giving full details of the reason for the previous failure to pay Premium when due or to accept continuation terms in a timely manner; and

17.5 Payment of all Premiums due and $100.00 reinstatement fee.

18 APPLICABLE CURRENCY — All benefit amounts, coverages, monetary limits and Sub-Limits, and other amounts stated in the Master Policy, the Application, the Declaration Page of Insurance, the Evidence of Insurance, and in any Riders, which would include Premium, are in US dollars.

19 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, which would include 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 cooperate.

20 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, which would include 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, which would include 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, which would include without limitation filing a proper and complete Proof of Claim under **Subsection 7.1**, above.

21 SCHEDULE OF BENEFITS/LIMITS — Subject to the Terms of this insurance, which would include without limitation the Deductible and Coinsurance (unless otherwise expressly set forth to the contrary), and the various limits and Sub-Limits set forth below, the Scheme Administrator promises to provide the Participating Member the following Benefits and coverage arising out of Injury sustained or Illness suffered or charges, cost or Expenses Incurred while the Evidence of Insurance is in effect.

THE MERIDIANIES CLEAR SCHEDULE OF BENEFITS		
Maximum Limit	$2,000,000 Maximum Limit	
Deductibles	$500; $1,000; $2,500; $5,000; $10,000 per Participating Member per Coverage Period	
Coverage Area	Area 1- Worldwide Including US & Canada	Area 2- Worldwide Excluding US & Canada
Coinsurance – Claims incurred inside US or Canada	After the Deductible the Plan will pay 80% of the next $5,000 of Eligible Medical Expenses, then 100% to the Maximum Limit. Coinsurance will be waived if Eligible Medical Expenses are incurred within the Preferred Provider Organization Network	
Coinsurance – Claims incurred outside US or Canada	After the Deductible the Plan will pay 100% of Eligible Medical Expenses to the Maximum Limit	
Pre-notification Penalty	50% Eligible Medical Expenses	
Pre-existing Condition	$5,000 Sub-Limit per Coverage Period, $50,000 Maximum Sub-Limit (After 728 of continuous coverage)	
INPATIENT BENEFITS ONLY		
Hospital Room and Board – Coverage Area 1	$400 Sub-Limit per day, 240 day Maximum per Hospitalization (Includes ICU days)	
Hospital Room and Board – Coverage Area 2	$300 Sub-Limit per day, 240 day Maximum per Hospitalization (Includes ICU days)	
Intensive Care Unit – Coverage Area 1	$1,000 Sub-Limit per day, 240 day Maximum per Hospitalization (Includes Non-ICU days)	
Intensive Care Unit – Coverage Area 2	$800 Sub-Limit per day, 240 day Maximum per Hospitalization (Includes Non-ICU days)	
INPATIENT/OUTPATIENT BENEFITS		
Chemotherapy and Radiation	Usual, Reasonable, and Customary	
Surgical Consultant	$350 Sub-Limit per consultation prior to Surgery	
Surgeon/Surgery	Usual, Reasonable, and Customary	
Assistant Surgeon	20% of Surgeon benefit	
Anesthesiologist	20% of Surgeon benefit	
Diagnostic Laboratory	$250 per exam (Includes all procedures carried out on one specimen)	
Diagnostic Radiology	$250 per exam (Includes X-Rays, Ultrasounds, Sonograms and Diagnostic Mammograms)	
Diagnostic MRI, Scans and Scopes	$500 Sub-Limit per exam, (Includes MRI, CAT Scans, PET Scans, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cystoscopy)	
Physician	$70 Sub-Limit per visit, 15 visits per Coverage Period	
Physician Specialist	$70 Sub-Limit per visit, 15 visits per Coverage Period	
Physical Therapist	$50 Sub-Limit per visit, 15 visits per Coverage Period	
Local Ambulance	$1,500 Sub-Limit per Coverage Period when Illness or Injury results in Hospitalization	
OUTPATIENT BENEFITS ONLY		
Wellness - Adult	$250 Sub-Limit per Coverage Period for Participating Members age 30 and over, Not subject to Deductible or Coinsurance (After 728 of continuous coverage)	
Wellness - Dependent Child	$150 Sub-Limit per Coverage Period for Participating Members age 18 and under, Not subject to Deductible or Coinsurance (After 364 days of Continuous Coverage)	
Mental & Nervous Disorders	$50 Sub-Limit per visit, 15 visits per Coverage Period for Outpatient Treatment, After 364 days of Continuous Coverage	
Chiropractor	$50 Sub-Limit per visit, 15 visits per Coverage Period, Must be prescribed by a Licensed Medical Physician (After 364 days of Continuous Coverage)	
EMERGENCY BENEFITS		
Emergency Room - Illness/Accident	Usual, Reasonable, and Customary, Subject to additional $250 Deductible if Illness or Injury does not result in Hospitalization	
Emergency Medical Evacuation	$30,000 Maximum Sub-Limit	
Emergency Reunion	Reimbursement up to $7,500 for Expenses related to the Emergency Reunion of a relative or friend resulting from an Emergency Medical Evacuation of a Participating Member	
MATERNITY BENEFITS		
Maternity - Normal or Complicated Delivery	$10,000 Sub-Limit per Coverage Period, $50,000 Maximum Sub-Limit (After 728 day of Continuous Coverage)	
Newborn Care	Included as part of Maternity benefit for the first 31 days of life	
Midwife Services	$350 Sub-Limit per covered Pregnancy	
OTHER BENEFITS		
Human Organ/ Tissue Transplant	$250,000 Sub-Limit per Covered Transplants	
Return of Mortal Remains	Reimbursement up to $30,000 for the return of a Participating Members Mortal Remains to his/her Home Country, Not subject to Deductible or Coinsurance	
Prescription Drug Coverage	Reimbursement Only. Inpatient drugs are Usual, Reasonable and Customary. Prescription drugs are Subject to 20% Coinsurance in the US, Maintenance drugs are not covered	

Durable Medical Equipment	Usual, Reasonable and Customary charges, Limited to a standard Wheelchair and/or Hospital Bed

22 MERIDIAN CLEAR ELIGIBILITY — 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:

22.1 Compete 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

22.2 Pay the required Premium on or before the Due Dates; and

22.3 Receive written acceptance of Application or Continuation of Coverage from the Scheme Administrator; and

22.4 Be at least fourteen (14) days old but not yet seventy-five (75) years old; and

22.5 Not be Pregnant, Hospitalized or Disabled on the Effective Date of Coverage; and

22.6 Not be HIV+ on the Effective Date of Coverage; and/or

22.7 US Citizens:

22.7.1 Plan to reside outside of the US for at least one hundred (180) days of the next three hundred sixty four (364) days of the Participating Members Coverage Period;

22.7.2 Depart from the US not more than thirty (30) days after the Effective Date or Continuation of Coverage Date; or

22.8 Non-US Citizens:

22.8.1 Reside outside the US at time of Application or Continuation of Coverage Date; or must plan to reside outside of the US continuously for at least one hundred (180) days for the next three hundred sixty four (364) days of the Participating Members Coverage Period with departure from the US not more than thirty (30) days after the Effective Date or Continuation of Coverage Date; or

22.8.2 If located inside the US at the time of Application or Continuation of Coverage Date, must not be eligible for any other medical insurance plan which is available to individuals similarly situated and located in the US and must provide the Scheme Administrator an Affidavit of Eligibility.

23 PRE-NOTIFICATION PROVISIONS & REQUIREMENTS — Pre-notification 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-notification. The Scheme Administrator reserves the right to challenge, dispute and/or revoke a prior determination of Medical Necessity based upon subsequent information obtained. Pre-notification 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-notification 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 the Master Policy, which would include exclusions for Pre-existing Conditions and other designated exclusions, benefit limitations, and the requirement that claims be Usual, Reasonable and Customary. In addition, any consideration or determination of a Pre-notification 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-notification requirements of the Master Policy, 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, which would include the Deductible and Coinsurance. Eligibility for and payment of Benefits are subject to all of the Terms of this insurance.

23.1 **Specific Requirements —** The following treatment and/or supplies must always be Pre-certified for Medical Necessity by the Scheme Administrator, which would include:

- **23.1.1** Inpatient treatment of any kind; and
- **23.1.2** Any Surgery or Surgical procedure; and
- **23.1.3** Care in an Extended Care Facility; and
- **23.1.4** Home Nursing Care; and
- **23.1.5** Durable Medical Equipment; and
- **23.1.6** Artificial limbs; and
- **23.1.7** Diagnostic testing such as MRI, CT scan and PET scan; and
- **23.1.8** Chemo/Radiation Therapy; and
- **23.1.9** Emergency Medical Evacuation; and
- **23.1.10** Labor and Delivery.

23.2 **General Requirements —** To comply with the Pre-notification requirements of this insurance for the treatment and services listed in **Section 23**, healthcare provider and/or Participating Members must comply with the requirements below:

- **23.2.1** Contact the Scheme Administrator at the telephone numbers printed on the ID card and/or email the Pre-notification details, as follows:
  Inside the United States: (Ph.) 1-317-644-6291 (Collect if necessary)
  Outside the United States: (Ph.) 1-888-201-8850
  E-mail: service@azimuthrisk.com; and
- **23.2.2** As soon as possible before the treatment is to be obtained; and
- **23.2.3** Notify all Physicians, hospitals and other healthcare providers that this insurance contains Pre-notification requirements and ask them to fully cooperate with the Scheme Administrator; and
- **23.2.4** Comply with the instructions of the Scheme Administrator and submit any information or documents required by the Scheme Administrator.

24 **LOSS OF COVERAGE/BENEFITS FOR NON-COMPLIANCE WITH PRE-NOTIFICATION REQUIREMENTS —** If the Participating Member or his/her healthcare providers do not comply with the Pre-notification requirements or the treatment or supplies identified in **Section 23** through **23.2.4** above, or if such treatment or supplies are not Pre-certified, Eligible Medical Expenses Incurred with respect to said treatment and/or supplies will be reduced by fifty (50%) percent.

25 **EMERGENCY PRE-NOTIFICATION —** In the event of an Emergency Hospital admission, Pre-notification must be completed within forty-eight (48) hours after the admission, or as soon as is reasonably possible.

26 **CONCURRENT REVIEW —** For Inpatient treatment of any kind, the Scheme Administrator will Pre-notify a limited number of days of confinement based upon the medical condition. Thereafter, Pre-notification must again be requested and approved if additional days of Inpatient treatment are necessary.

27 **APPEAL PROCESS —** If the Participating Member disagrees with a Pre-notification 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.

28 **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, 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.

28.1 **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 US -based Physicians, hospitals and other healthcare and health service providers who are contracted separately and directly with the PPO and who may provide repricing, 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, which would include, without limitation, no power or authority to: (i) approve Applications or enrollments for initial, extended 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-notification, 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, which would include 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.azimutrisk.com to obtain such information.

29 **ELIGIBLE MEDICAL EXPENSES —** Subject to the Terms of this insurance, which would include without, limitation the Deductible, Coinsurance, Maximum Limits and Sub-Limits set forth in the Schedule of Benefits/Limits, **Section 21**, and the Exclusions set forth in **Section 30**, 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 suffered or Injury 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 Incurred are Usual, Reasonable and Customary:

29.1 Charges Incurred at a Hospital for Inpatient Care:

29.1.1 Daily room and board, and nursing services up to $400 inside the US or $300 outside the US for a semi-private room rate per day, up to a Maximum of two hundred and forty (240) days; and

29.1.2 Daily room and board, and nursing services not to exceed $1,000 inside the US or $800 outside US for charges Intensive Care Unit, up to a Maximum of two hundred and forty (240) days; and

29.1.3 Use of operating, treatment or recovery room; and

29.1.4 Services and supplies that are routinely provided by the Hospital to persons for use while Inpatient; and

29.2 Charges Incurred for at an Inpatient/Outpatient Treatment or Surgery:

29.2.1 Radiation therapy or Treatment, and chemotherapy; and

29.2.2 Up to $350 for charges for a surgical consult per consult prior to Surgery

2**9.2.3** Usual, Reasonable and Customary charges related to an Eligible Surgery**; and**

29.2.4 Usual, Reasonable and Customary charges of the Primary Surgeon related to an eligible surgery; and

29.2.5 Provided, however, that charges by or for an assistant surgeon will be limited and covered at the rate of twenty (20%) percent of the Usual, Reasonable and Customary charge of the primary surgeon; and

29.2.6 Provided, however, that charges by the anesthesiologist will be limited and covered at the rate of twenty (20%) percent of the Usual, Reasonable and Customary charge of the primary surgeon; and

29.2.7 Provided, however, that charges by or for a registered nurse anesthetist will be limited and covered at the rate of twenty (20%) percent of the Usual, Reasonable and Customary charge of the primary anesthesiologist; and

29.2.8 Provided, further, that stand by availability of a Physician or surgeon will not be deemed to be a professional service and is not eligible for coverage; and

29.3 Other Charges Incurred For Inpatient/Outpatient Treatment or Surgery:

29.3.1 Service and supplies; and

29.3.2 Dressings, sutures, casts or other supplies that are Medically Necessary; and

29.3.3 Up to $250 per Diagnostic laboratory services, which would include all procedures carried out on one specimen; and

29.3.4 Up to $250 per Diagnostic Radiology service, which would include x-rays, ultrasounds, sonograms and diagnostic mammograms; and

29.3.5 Up to $500 per MRI, CAT Scans, PET Scans, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cystoscopy; and

29.3.6 Up to $70 per visit, 15 visits per Coverage Period for General Physician visits

29.3.7 Up to $70 per visit, 15 visits per Coverage Period for Specialist Physician visits

29.3.8 Up to $50 per visit, 15 visits per Coverage Period for Physical therapy prescribed by a Physician and performed by a licensed physical therapist, and necessarily incurred to continue recovery from a covered Injury or covered Illness; and

29.3.9 Up $1,5000 for Emergency local ambulance transport necessarily incurred in connection with Illness or Injury resulting in Hospitalization; and

29.3.10 Reconstructive Surgery when directly related to a Surgery that is eligible and covered under this insurance; and

29.3.11 Basic functional artificial limb(s) or eye(s), but not the replacement or repair thereof; and

29.3.12 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

29.3.13 Oxygen and other gasses and their administration; and

29.3.14 Care in a licensed Extended Care Facility upon direct transfer from an acute care Hospital; and

29.4 Other Outpatient Benefits:

29.4.1 Wellness —or as specified in **Section 21** Schedule of Benefits/Limits, and subject to the Terms and conditions of this insurance, the Scheme Administrator will reimburse the Participating Member for the following Expenses Incurred while the Coverage Period is in effect:

29.4.2.1 For Participating Members age thirty (30) years and older: one Routine Physical Exam, limited to $250 per Coverage Period, which would include Expenses Incurred for mammography exams and pap smears, provided the Participating Member has Continuously Coverage under this Insurance plan for not less than seven hundred and twenty-eight (728) days; and

29.4.2.2 For Participating Members eighteen (18) years of age or younger: one Routine Physical Exam, limited to $150 per Coverage Period, which would include Routine inoculations and vaccinations commonly administered to Dependent Children less than eighteen (18) years of age in accordance with standard medical practice, provided the Participating Member has Continuously Coverage under this Insurance plan for not less than three hundred and sixty-four (364) days; and

29.4.3 Mental or Nervous Disorders — $50 per visit, 15 visit per Coverage period for Outpatient Treatment provided the Participating Member has been continuously insured under this insurance plan for not less than three hundred and sixty-four (364) days immediately preceding Treatment; and

29.4.4 Chiropractor — $50 per visit, 15 visit per Coverage period, must be prescribed by a Licensed Medical Physician, provided the Participating Member has been continuously insured under this insurance plan for not less than three hundred and sixty-four (364) days immediately preceding Treatment; and

29.5 Emergency Benefits:

29.5.1 Emergency Room Treatment — Usual, Reasonable and Customary charges, 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 or Injury; and

29.5.2 Emergency Medical Evacuation — 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 that are not within the direct control of the Scheme Administrator, which would include, 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. The Participating Member agrees to hold the Scheme Administrator, its agents and representatives harmless from, and agrees that the Scheme Administrator, 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, which would include, without limitation, the events and circumstances set forth above. 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. Subject to the Maximum Sub-Limit set forth in the Schedule of Benefits/Limits and the other Terms of this insurance, which would include the Conditions and Restrictions set forth below:

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

29.5.2.2 Emergency ground transportation necessarily preceding Emergency air transportation and from the destination airport to the Hospital where the Participating Member will receive treatment; and

29.5.2.3 The Participating Member must be in compliance with all Terms of this insurance; and

29.5.2.4 The Scheme Administrator will provide Emergency Medical Evacuation Benefits only when the Illness or Injury giving rise to the Emergency Medical Evacuation is covered under the Terms of this insurance; and

29.5.2.5 Medically Necessary Treatment cannot be provided locally to prevent Participating Member(s) loss of life; and

29.5.2.6 Transportation by any other method would result in loss of the Participating Member's life; and

29.5.2.7 Emergency Medical Evacuation is recommended by the attending Physician who certifies to the matters in subsections **29.5.2.5** and **29.5.2.6** above; and

29.5.2.8 Emergency Medical Evacuation is agreed to by the Participating Member or a Relative of the Participating Member; and

29.5.2.9 Emergency Medical Evacuation is approved in advance and all arrangements are coordinated by the Scheme Administrator; and

29.5.2.10 The Illness or Injury 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 that would have caused a prudent person to seek medical attention prior to the onset of the Emergency; and

29.5.3 **Emergency Reunion —** Subject to the Terms of this insurance, Emergency Reunion Expenses Incurred 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, Coinsurance, Maximum Limits and Sub-Limits as specified in the Schedule of Benefits/Limits, and subject to the following Expenses Incurred in respect of travel by a

Relative or friend of the Participating Member upon the recommendation and prior approval of the Scheme Administrator and the Conditions and Restrictions set forth below:

29.5.3.1 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

29.5.3.2 Reasonable and necessary travel, meals (maximum of $25 per day), transportation and accommodation Expenses Incurred in relation to the Emergency Reunion (but excluding entertainment); and

29.5.3.3 The Coverage Period for the Emergency Reunion shall not exceed fifteen (15) days, including travel days; and

29.5.3.4 The Emergency Reunion must be due to an Emergency Medical Evacuation covered under the Terms of this insurance; and

29.5.3.5 The attending Physician must deem the Illness or Injury as a threat to the Participating Members life 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

29.5.3.6 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; and

29.6 Maternity Benefits:

29.6.1 Maternity — Treatment for routine and Medically Necessary Maternity care of the Participating Member, if the Normal or Complicated Delivery of the Newborn and the charges incurred are eligible for coverage and are covered under the Terms of this insurance the plan will pay up to $10,000 Sub-Limit per Coverage Period up to $50,000 Maximum Sub-Limit, provided the Participating Member has Continuously Coverage under this Insurance plan for not less than seven hundred and twenty-eight (728) days; and

29.6.2 Newborn Care — Newborn care will be covered under the maternity benefit up to the Maximum Limit an/or for during the first thirty-one (31) days of life. Subject to all Term, conditions, limitations and exclusion set forth in **Section 29.6.1**; and

29.6.3 Midwife Service — covered under the maternity benefit up to $350 per covered pregnancy. Subject to all Term, conditions, limitations and exclusion set forth in **Section 29.6.1**; and

29.7 Other Covered Benefits:

29.7.1 Human Organ & Tissue Transplants — Subject to the Terms of this insurance, which would include without limitation the Deductible, Coinsurance, and Sub-Limits set forth in the Schedule of Benefits/Limits set forth in **Section 21**, above, the Pre-notification provisions set forth in **Section 29.7.2**, below, and the Exclusions set forth in **Section 30** below, the Scheme Administrator will reimburse the Participating Member up to $250,000 Sub-Limit 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 Incurred are Usual, Reasonable, and Customary:

29.7.1.1 Eligible Medical Expenses Incurred by a live donor will be treated as if they were the Eligible Medical Expenses of the Participating Member receiving a Covered Transplant if the Participating Member received an organ or tissue of the live donor; and

29.7.1.2 Organ procurement and harvesting costs, excluding acquisition or purchase of the actual organ or tissue, up to a maximum of $10,000; and

29.7.1.3 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

29.7.1.4 Reasonable travel and lodging Expenses Incurred for 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; and

29.7.2 Transplant Pre-notification — 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 or a Managed Transplant System Network approved by the Scheme Administrator, 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; and

29.7.3 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; and

29.7.4 Prescription Drugs — After the Deductible the Scheme Administrator will reimburse the Participating Member eighty (80%) percent of charges for prescription drugs prescribed

by a Licensed Physician for treatment of a covered Illness or Injury, but not for Maintenance drugs, the replacement of lost, stolen, damaged, expired or otherwise compromised drugs; and

29.7.5 Durable Medical Equipment (DME) — Rental of DME when Medically Necessary, limited to a standard Hospital bed and/or standard wheelchair; and

29.7.6 Charges Incurred for Hospice Care — Room and board charged by the Hospice and part-time nursing by a Registered Nurse when the following conditions apply:

29.7.6.1 The Physician must certify that the Participating Member is terminally ill with six (6) months or less to live; and

29.7.6.2 Services for the Participating Member must be received in an Inpatient Hospice facility or in the Participating Member's home.

30 EXCLUSIONS — All charges, costs, expenses and/or (collectively, "Charges") incurred by the Participating Member and directly or relating to or arising from or in connection with any of the following acts, omissions, events, conditions, charges, consequences, claims, treatment (which would include 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:

30.1 War, Military Action or Act of 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"):

30.1.1 War, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not) or civil war; and/or

30.1.2 Mutiny, riot, strike, military or popular uprising, insurrection, rebellion, revolution, military or usurped power; and/or

30.1.3 Any act of any person acting on behalf of or in connection with any organization with activities directed toward 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 that determine the proclamation or maintenance of martial law or state of siege; and/or

30.1.4 Act of Terrorism; and

30.2 Pre-Existing Condition — Any Illness, Injury, Mental or Nervous Disorder, sickness, disease, physical, or any other condition or ailment for which medical advice , diagnosis, care, or treatment (which would include but not limited to receiving services and supplies, consultations, diagnostic tests, or prescription medications) was recommended or received during the 730 days immediately preceding the Effective Date of Coverage ; any condition that manifested itself (whether known or unknown) in such a manner that would cause a reasonably prudent person to seek medical attention, treatment, advice, diagnosis, or care that with reasonable medical certainty; and

30.3 Wellness/Routine — 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 ninety (90) days, 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 three hundred sixty four (364) day Coverage Period; and

30.4 Charges Incurred for Surgery, Treatment or Supplies —

30.4.1 Investigational, Experimental, or for Medical Research purposes; and/or

30.4.2 Charges for any Participating Member under the age of fourteen (14) days; and/or

30.4.3 Any treatment for or related to any congenital condition; and/or

30.4.4 Any charges that are not incurred by a Participating Member during his/her Coverage Period; and/or

30.4.5 Charges that are not submitted within the timely filing limits; and/or

30.4.6 Treatment, services or supplies that are not Medically Necessary; and/or

30.4.7 Related to genetic medicine or genetic testing, which would include, without limitation, amniocentesis, genetic screening, risk assessment, prevention and/or to determine pre-disposition, genetic counseling, and/or gene therapy; and/or

30.4.8 Psychometric, behavioral and Educational testing; and/or

30.4.9 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 Effective Date of Coverage: 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/or

30.4.10 When Treatment is not administered or ordered by a Physician; and/or

30.4.11 Charges in excess of Usual, Reasonable, and Customary; and/or

30.4.12 Treatment performed or provided by a Relative of the Participating Member; and/or

30.4.13 Not expressly included as Eligible Medical Expenses as defined in **Section 29** above; and

30.4.14 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/or

30.4.15 Charges incurred for telephone consultations or due to a failure to keep a scheduled appointment; and/or

30.5 Charges Incurred While Confined Primarily to Custodial Care, Educational, or Rehabilitation Care; and/or

30.6 Charges Incurred For Any Surgery, Treatment, or Supplies Relating To, Arising From or In Connection With, for, or as a Result of:

30.6.1 Weight modification or any Inpatient, Outpatient, Surgical or other treatment of obesity (which would include, without limitation, morbid obesity), which would include, without limitation, wiring of the teeth and all forms of bariatric Surgery by whatever name called, or reversal thereof, which would include, without limitation, intestinal bypass, gastric bypass, gastric banding, vertical banded gastroplasty, biliopancreatic diversion, duodenal switch, or stomach reduction or stapling; and/or

30.6.2 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

30.6.3 Cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is Medically Necessary and is directly related to and follows a Surgery that was covered under this insurance; and/or

30.6.4 Medical expenses for Injury or Illness resulting from Amateur Athletics, Contact Sports, intercollegiate, interscholastic, intramural, and club sports or athletic activities and Professional Sports which would include practice; mountaineering at elevations of 7,000 meters or higher, avalanche training, rock climbing, and caving; aviation (except when traveling solely as a passenger in a commercial aircraft), and hot air ballooning as a pilot; base-jumping, hang-gliding, parachuting, paragliding, parasailing, kite-surfing, sky surfing, bungee jumping, absailing, and zip lining; heli-skiing, snow skiing, or snowboarding, recreational downhill and/or cross country snow skiing or snowboarding, bobsleigh, skeleton or luge, and ice climbing; sub aqua pursuits involving underwater breathing apparatus unless PADI/NAUI certified, or accompanied by a certified instructor at depths of less than 10 meters; white water rafting, spelunking or cave diving, surfing, body boarding, waterskiing, wakeboarding, windsurfing, knee boarding, kayaking, and jet skiing; off-road motorized vehicles which would include all-terrain vehicles, snowmobiles, motorized dirt bikes, and tractors; racing by any animal, skateboarding, BMX biking, mountain biking, and speed trials and speedway; any type of boxing or martial arts, powerlifting, and wrestling; big game hunting, wild safaris, running with the bulls, and horseback riding; Aussie rules football, jousting, modern pentathlon, and quad biking outdoor endurance events; and/or

30.6.5 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

30.6.6 Any Illness or Injury sustained while participating in any activity where such activity is undertaken against medical advice; and/or

30.6.7 Any Injury sustained or Illness suffered after the consumption of intoxicating liquor or drugs. This would include Illness or Injuries sustained while operating a moving vehicle after consumption of intoxicating liquor or drugs, other than Prescription 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 which would include watercraft, aircraft and non-motorized bicycles and scooters for which no permit or license is required; and/or

30.6.8 Any willfully self-inflicted Injury or Illness; and/or

30.6.9 Any venereal disease; and/or

30.6.10 Treatment by a chiropractor; and/or

30.6.11 Orthoptics, visual therapy or visual eye training; and

30.6.12 Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy; and/or

30.6.13 Telephone consultations or failure to keep a scheduled appointment; and/or

30.6.14 Any testing for the for: HIV**,** seropositivity to the AIDS virus, AIDS-related Illnesses, ARC Syndrome and AIDS; and/or

30.6.15 Any Illness or Injury resulting from or occurring during the commission of a violation of law by the Participating Member, which would include, without limitation, the engaging in an illegal occupation or act; and/or

30.6.16 Any Substance Abuse; and/or

30.6.17 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

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

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

30.6.20 Any transplant Expenses Incurred outside the Scheme Administrator's approved independent Managed Transplant System Network; and/or

30.6.21 Any Covered Transplant in excess of one (1) during any three hundred sixty four (364) day period of coverage under this insurance plan, except re-transplantation Charges if incurred during the initial Covered Transplant Hospitalization; and

30.6.22 Allergy testing; and

30.6.23 Treatment or complications resulting from the Zika Virus; and

30.6.23 The Coronavirus/COVID-19, Coronavirus disease (COVID-19), Severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2), any mutation or variation of SARS-CoV-2 or any fear or threat or complications thereof; and

30.6.24 Pandemics, Epidemics, Public Health Emergencies- Any Illness or Injury incurred in the Destination Country as a result of epidemics, pandemics, public health emergencies, Natural Disasters, or other disease outbreak conditions that may affect a person's health when, prior to the Participating Member's entry into the Destination Country any of the following were issued regarding the Destination Country:

30.6.24.1 The United States Centers for Disease Control & Prevention issued a Warning Level 3 (avoid nonessential travel); or

30.6.24.2 The World Health Organization issued an Emergency Travel Advisory; or

30.6.24.3 A similar governmental agency of the Participating Member's Country of Residence had published, communicated or issued a Travel Warning or Emergency Travel Advisory restriction or official declaration informing the public about such health issued before the Participating Member traveled to the Destination Country; and

30.7 The Feet, Which Would Include, Without Limitation:

30.7.1 Orthopedic shoes, prescribed orthopedic devices to be attached to or placed in shoes; and/or

30.7.2 Treatment of weak, strained, flat, unstable or unbalanced feet; and/or

30.7.3 Metatarsalgia, bone spurs, hammertoes or bunions; and

30.7.4 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 company and subject to all other Terms of this insurance when related to:

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

30.7.4.2 An Illness for which foot Surgery is Medically Necessary and determined to be the only appropriate method of treatment; and

30.8 Hair Loss:

30.8.1 Which would include without limitation, wigs; and/or

30.8.2 Hair transplants; and/or

30.8.3 Any drug that promises to promote hair growth, whether or not prescribed by a Physician; and

30.9 **Any Sleep Disorders**; and

30.10 **Any Exercise Programs —** Whether or not prescribed or recommended by a Physician; and

30.11 **Nuclear or Atomic Radiation —** Any exposure to any medical or non-medical radioactive material(s); and

30.12 **Any Artificial or Mechanical Device —** Designed to replace human organs temporarily or permanently; and

30.13 **Fertility/Infertility —** Charges incurred for treatment or supply that either promotes, prevents or attempts to promote or prevent conception; which would include, but not limited, to;

30.13.1 Artificial insemination; and

30.13.2 Oral contraceptives; and

30.13.3 Treatment for infertility or impotency; and

30.13.4 Vasectomy or reversal of vasectomy; and

30.13.5 Sterilization or reversal of sterilization; and

30.14 **Sexual Dysfunction** — 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

30.15 **Dental Treatment** — Charges incurred but not limited to;

30.15.1 Routine or general dental care; and

30.15.2 Charges incurred for treatment of the temporomandibular joint; and

30.16 **Vision** — Charges incurred but not limited to;

30.16.1 Eye Surgery, included, but not limited to, radial keratotomy, when the primary purpose is to correct or attempt to correct nearsightedness, farsightedness or astigmatism; and

30.16.2 Charges for Treatment of cataracts or glaucoma

30.17 **Hearing —** Hearing aids, hearing implants and charges for any Treatment, supply, examination or fitting related to these devices; and

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

30.19 **Taxes and Other Miscellaneous Fees —** Any taxes, assessments, charges, fees or surcharges imposed by any governmental agency or authority:

30.19.1 Arising out of or as a result of any treatment or supplies received by the Participating Member; or

30.19.2 Based upon the Company's election hereunder, if any, to pay Benefits directly to providers; or

30.19.3 For any other reason; and

30.20 **Non-Prescription and Over-The-Counter Medicine —** Charges or Expenses Incurred for non-prescription drugs, medicines, vitamins, food extracts, or nutritional supplements; or IV vitamin; drugs or medicines not approved by the US Food and Drug Administration or which are considered "off-label" drug use and for drugs or medicines not prescribed by a Physician, or that can otherwise be purchased over the counter; and

30.21 **Disease Outbreak —** Diagnosis, testing or treatment of Injury or Illness resulting from a disease outbreak in a country or location for which the United States Center for Disease Control and Prevention (CDC) has issued a Warning Level 3 if:

30.21.1 The warning has been in effect within one-hundred and eighty (180) days immediately prior to the Participating Member(s) date of arrival; and

30.21.2 Within ten (10) days following the date the warning is issued the Participating Member(s) has failed to depart the country or location; and

30.22 Against Medical Advice — Any Charges and or services related to Inpatient, Outpatient or Emergency room services in which the Participating Member chooses not to comply with recommended treatment and or where the Participating Member terminates such services, or leaves the facility against medical advice (AMA); and

30.23 Rare Condition/Defect — Any claim, Charges, Illness, Injury or other consequence happening or arising during the existence of Rare Conditions/Defect (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 happened independently of the existence of such Rare Conditions/Defect; and

30.24 Mental or Nervous Disorders — Charges for Inpatient Treatment of Mental or Nervous Disorders are excluded from coverage under this insurance.

30.25 Motorized Vehicle — Charges incurred for Injuries/Illness sustained while operating or riding on a two, three or four wheel cycle, bike, scooter, moped or Segway will be excluded when the following terms are not met:

30.25.1 Participating Members age sixteen (16) or older must have a valid drivers license; and

30.25.2 Participating Member must be wearing a safety helmet; and

30.25.3 The motorized vehicle must have active auto insurance.

31 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.

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 into, Continuation 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 Syndrome: AIDS related complex, term is defined by the United States Centers for Disease Control.

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 a mother, the developing fetus, or both at higher-than-normal risk for complications during or after the delivery.

Continuous Coverage: 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

Continuation of Coverage: When a Participating Member continues coverage under the Beacon/Axis Series Group Insurance Plan beyond the original Coverage Period. At the end of each Coverage Period, a Participating Member is generally invited to continue his/her coverage.

Continuation of Coverage Date: The date a Participating Members new Coverage Period begins after his/her Continuation of Coverage under the Beacon/Axis Series Group Insurance. This date is indicated on Declaration Page of Insurance in Section Ⅱ.

Coverage Period: The period beginning on the Effective Date of Coverage indicated on the Participating Members ID Card or the Continuation of Coverage Date indicated of the Participating Members Declaration Page of Insurance in Section Ⅱ and ending on the earliest of the following dates: (i) the date specified on the Declaration Page of Insurance, or (ii) the termination date as determined in accordance with **Section 15** above. The Coverage Period can be no more than three hundred sixty four (364) consecutive days.

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 Page of Insurance: The Declaration Page of Insurance issued by the Scheme Administrator to the Participating Member contemporaneously with the Evidence of Insurance (and/or upon Continuation of Coverage or Reinstatement hereof) evidencing the Participating Member's insurance coverage under the Master Policy as evidenced by the Evidence of Insurance, which Declaration Page of Insurance shall be incorporated in and become a part of the Master Policy. The Declaration Page of Insurance 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 on the Declaration Page of Insurance, 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, which would include 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 Dependent 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 twenty-six (26) 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 Dependent Child/Children. A policy in which the only Participating Member on the policy is eighteen (18) years of age or younger at the time of application will be considered a Dependent Child for the purposes of the Dependent Child Wellness Benefit.

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: 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 of Coverage: The date the Participating Member first obtains coverage under the Beacon/Axis Series family of Insurance plans and maintains continuous unbroken coverage thereafter, this date is indicated on the Participating Members ID Card.

Eligible Medical Expenses: Expenses for Injuries, Illnesses and cost incurred by a Participating Member in which all Terms, Conditions and Limits of the Evidence of Insurance have been met in full. Eligible Medical Expenses will not be determined until the Scheme Administrator has received and reviewed the Complete Proof of Claim. Eligible Medical Expenses are subject the Limits, Deductibles and Coinsurance set forth on the Participating Members Declaration Page, Schedule of Benefits and Evidence of Insurance.

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: US 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 coverage 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 Care Facility by the state or country in which it operates; is regularly engaged in providing twenty-four (24)-hour skilled nursing care under the regular supervision of a Physician and the direct supervision of a Registered Nurse; 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 (see definition of Spouse) who is covered as a Participating Member under this insurance plan and his/her Dependent Child or Children (see definition of Dependent Child; Children) who are under the age of eighteen (18) or less than twenty-six (26) 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.

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 Care: 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 one hundred (180) days.

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 twenty-four (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, any other medical, physical or health condition. Illness does not include learning disabilities, attitudinal, or disciplinary problems.

Injury: Bodily Injury resulting from an Accident.

Inpatient: A person who is an overnight patient of a Hospital, using & 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.

Medical Research: Research conducted to aid and supports the body of knowledge in the field of medicine.

Medical Research can be divided into two general categories: the evaluation of new treatments for both safety and efficacy in what are termed clinical trials, and all other research that contributes to the development of new treatments. The latter is termed preclinical research if its goal is specifically to elaborate knowledge for the development of new therapeutic strategies.

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.

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: All participants enrolled in the Beacon/Axis Series Group Insurance Trust (Anguilla); under the Meridian Series Plan.

Participating Organization: A business, society or association that purchase medical coverage for a group of individuals.

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 services must be within the scope of that license.

Pre-notification; Pre-notify: 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-notification is not an assurance, authorization, or verification of coverage, a verification of benefits, or a guarantee of payment. See **Section 23** 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 Effective Date of Coverage, whether or not previously manifested or symptomatic, diagnosed, treated or disclosed on the Application or on any Claim Form or otherwise, which would include 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.

Pregnant/Pregnancy: 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.

Professional Athletics/Professional Sports: A sport activity, which would include 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.

Rare Conditions/Defect: Conditions/defect which affects a small number of people compared to the general population and, because they are rare, can present challenges with regards to diagnosis, Treatment, and prevention. A condition/defect is considered to be rare when it affects 1 person in 2,000 or fewer.

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.

Rehabilitation 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.

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.

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.

Spouse: Wife/husband or domestic partner living at the same address and sharing financial responsibilities but not including business partners or associates.

Sub-Limits: Extra limitations in an insurance policy's coverage of certain losses. They are part of the original limit. That is, they do not provide extra coverage, but set a maximum to cover a specific loss. Sub-Limits may be expressed as a dollar amount or a percentage of the coverage available.

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

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

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

Act of Terrorism: An act, which would include, 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, which would include the intention to influence any government and/or to put the public, or any section of the public, in fear.

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, which would include 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.

US: 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.