MERIDIAN CLEAR SCHEDULE OF BENEFITS

Benefits	The Meridian Clear Plan is a schedule benefit plan with Limits as follows: all Limits are per Coverage Period unless otherwise noted	
Maximum Limit	$2,000,000 Maximum Limit	
Deductibles	$500; $1,000; $2,500; 5,000; 10,000 per Member per Coverage Period	
Coverage Area	Area 1: Worldwide Including US/ Canada	Area 2: Worldwide Excluding US/Canada
Coinsurance- Claims incurred in US or Canada	After the Deductible the Plan will pay 80% of the next $5,000 of Eligible Expenses, then 100% to the Overall Maximum Limit. The Coinsurance will be waived if expenses are incurred within the PPO.	
Coinsurance- Claims incurred outside US or Canada	After the Deductible the Plan will pay 100% of Eligible Expenses to the Overall Maximum Limit.	
Pre-certification Penalty	50%	
Pre-existing Condition	After 24 months of continuous coverage, with a $50,000 Maximum Limit. $5,000 Per Coverage Period.	
Sudden Onset of Pre-existing Conditions	Same as any other Injury or Illness (subject to Schedule) $1,000 1st Coverage Period and $2,500 thereafter.	
Maternity: Normal or Complicated Delivery/Newborn Care	$10,000 Maximum Limit after 24 months of continuous coverage. Covered Maternity expenses include pre-natal, Delivery, and post-natal care, and Newborn Care for the first 31 days.	
Human Organ/Tissue Transplants	$250,000 Maximum Limit for covered Transplant.	
Hospital Room and Board	Semi-Private room rate, subject to the set benefits limits.	
Intensive Care Unit	Usual, Reasonable, and Customary, subject to the set benefits limits.	
Prescription Drug Coverage	In-Patient prescription drugs covered only if Hospitalized. Out-Patient is URC. NO COVERAGE FOR MAINTENANCE MEDICATIONS	
Mental and Nervous Disorders	$25,000 Maximum Limit after 24 months of continuous coverage, subject to the set benefits limits.	
Wellness (Adult)	$250 for Males age 30 and over, Females 30 years of age and older per Member per Coverage Period (after 24 months continuous coverage)	
Wellness (Child)	$150 for Members 18 and under per Member per Coverage Period (after 12 months continuous coverage)	
Emergency Room Accident/Illness	Usual, Reasonable and Customary (subject to additional $250 Deductible if not admitted)	
Local Ambulance	Usual, Reasonable, and Customary	
All Other Eligible Expenses	Usual, Reasonable, and Customary	
Emergency Medical Evacuation	$30,000 Maximum Limit	
Emergency Reunion	$7,500 Maximum Limit	
Return of Mortal Remains	$30,000 Maximum Limit	

Meridian Clear Set Benefit Limits:	
Benefits:	**Limits:**
WELLNESS BENEFITS (Not Subject to Deductible or Coinsurance)	
Wellness (Adult)	$250 per Member per Coverage Period including Office Visit (after 24 months continuous coverage)
Wellness (Child)	$50 per visit for a maximum of 3 visits per Coverage Period (after 12 months continuous coverage)
INPATIENT BENEFITS (ALL Subject to Deductible and Coinsurance)	
Hospital Room and Board (Coverage Area 1)	$300 per day, maximum 240 days per Hospitalization (including ICU days)
Hospital Room and Board (Coverage Area 2)	$400 per day, maximum 240 days per Hospitalization (including ICU days)
Intensive Care Unit (Coverage Area 1)	$800 per day, maximum 240 days per Hospitalization (including non-ICU days)
Intensive Care Unit (Coverage Area 2)	$1,000 per day, maximum 240 days per Hospitalization (including non-ICU days)
OUTPATIENT BENEFITS (ALL Subject to Deductible and Coinsurance)	
Office Visit (including Physician, Specialist Physician, Psychiatrist, Chiropractor, Surgical Consultant, Physical or Occupational Therapist)	Limited to 15 visits per Member per Coverage Period.
Physician	$70 per visit
Physician Specialist	$70 per visit
Psychiatrist	$50 per visit (after 12 months continuous coverage)
Chiropractor	$50 per visit (must be prescribed by a non Chiropractor Physician)
Surgical Consultant	$350 per consultation prior to Surgery
Physical or Occupational Therapist	$50 per visit (must be prescribed by a Physician who is not affiliated with the Physical Therapy practice)
Emergency Room	Usual, Reasonable and Customary (subject to additional $250 Deductible if not admitted).
Laboratory	$250 per exam (includes Ultrasounds, Sonograms and diagnostic Mammograms)
Local Ambulance	$1,500 per covered event, per Member, per Coverage Period
X-rays	$250 per exam (includes all procedures carried out on one specimen)
INPATIENT OR OUTPATIENT BENEFITS (ALL Subject to Deductible and Coinsurance)	
Anesthesiologist	20% of Surgeon benefit
Assistant Surgeon	20% of Surgeon benefit
Surgery	Usual, Reasonable, and Customary
Midwife Services	$350 per covered Pregnancy
Prescription Drug Coverage	In-Patient prescription drugs covered only if Hospitalized. Out-Patient is URC. NO COVERAGE FOR MAINTENANCE MEDICATIONS
MRI, CAT Scan, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cystoscopy	$500 per exam
Chemotherapy and Radiation	Usual, Reasonable, and Customary
OTHER BENEFITS (ALL Subject to Deductible and Coinsurance)	
Durable Medical Equipment	Usual, Reasonable, and Customary charges for Wheelchair, Hospital Bed, and or Toilet
Emergency Medical Evacuation	$30,000 Maximum Limit
Emergency Reunion	$7,500 Maximum Limit
Return of Mortal Remains	$30,000 Maximum Limit

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