ACCESS HMO®
Global Health Insurance
PHCS Sirius International

in association with VZP for Foreigners

Terms and Conditions

Global Health Insurance→

A. AGREEMENT - Access HMO's globally recognized underwriter, Sirius International Insurance Corporation (publ) offers the financial security and reputation demanded by international consumers. Rated A (excellent) by A.M. Best and A- by Standard & Poor's*, Sirius International shares Access HMO's vision of the international marketplace and offers the stability of a well-established insurance company. Sirius International Insurance Corporation (publ) (the Company) promises and agrees to provide the Insured Person with the benefits described in the Master Policy, as outlined here in and coverage for which is certified hereunder by the Company. The Company makes this promise and agreement in consideration of the Assured's Application, the accuracy and truthfulness of the Insured Person's Application and payment of Premium, and subject to all of the Terms of the Master Policy and as contained therein, including any Riders. The Master Policy is effective as of January 1, 2014, and shall remain in effect until terminated in accordance with the TERMINATION OF MASTER POLICY section. This Certificate shall be effective as of the Effective Date of Coverage shown on the Declaration, and shall remain in effect until terminated in accordance with the TERMINATION OF COVERAGE FOR INSURED PERSON section. This Certificate is not part of the insurance contract. The contract is the Master Policy, the Application, and any applicable Riders. This Certificate is merely a description of and evidence of the Insured Person's rights and benefits under the contract. The Declaration likewise is evidence of the coverage under the contract and a statement of the Effective Date of Coverage, subject always to the terms of coverage contained within the contract. The Company hereby recognizes AccessHMO®, Ltd., as the Company's authorized agent and representative, and as the Plan Administrator of the Master Policy and this Certificate. Subject to the provisions of the SERVICE OF SUIT; VENUE; CHOICE OF LAW; TRIAL BY COURT section, all comm unications, notices and payments to the Company that are required or permitted under the Master Policy and/or as described in this Certificate shall be transmitted through the Plan Administrator, and receipt of same by the Plan Administrator shall be considered receipt by the Company.

B. CONDITIONS AND GENERAL PROVISIONS - The following Terms are conditions precedent to the Company's liability under the insurance provided to the Insured Person pursuant to and in accordance with the Terms of the Master Policy, as represented by this Certificate (such insurance being sometimes referred to herein as "this insurance" or "the plan"):

(1) ENTIRE AGREEMENT - The Master Policy, including the Application, and any Riders, shall constitute the entire agreement among the Company, the Assured, and the Insured Person. This Certificate, including the Application, the Declaration, and any Riders, is an outline and evidence of the insurance provided by the Master Policy. This Certificate does not extend or change the coverage

provided by the Master Policy. The insurance evidenced by this Certificate is subject to all Terms of the Master Policy, including the Application, and any Riders.

(**2) PREMIUM -** Payment of required Premium shall be remitted to the Plan Administrator:

(a) on or before the Due Date(s) specified on the Declaration; and

(b) prior to any reinstatement under the REINSTATEMENT OF COVERAGE FOR INSURED PERSONS section; and

(c) on or before any renewal date as specified in the RENEWAL; AMENDMENTS section.
A grace period of ten (10) days (notwithstanding intervening Saturdays, Sundays or legal holidays) will be allowed for the payment of each instalment of Premium except the first. If any Premium is unpaid at the end of the grace period, all insurance coverage and benefits under this insurance shall lapse and terminate with effect from the initial Due Date of the unpaid Premium, and the Company shall have no liability to the Insured Person for any claims incurred on or after such date. Premium is considered paid on the date the payment is actually received by the Plan Administrator.

(3) PROOF OF CLAIM - When the Plan Administrator receives notice of a claim for benefits under this insurance from or on behalf of an Insured Person it will provide the Insured Person with Claimant's Statement and Authorization Forms ("Claim Forms") for filing Proof of Claim. The following items must be submitted by or on behalf of the Insured Person to be considered a complete Proof of Claim eligible for consideration of coverage under this insurance ("Proof of Claim"):
(a) a duly completed, timely submitted [within sixty (60) days], and signed Claim Form and authorization for release of information; and

(b) all original itemized bills and statements of services rendered from all Physicians, Hospitals and other healthcare or medical service providers involved with respect to the claim; and

(c) all original receipts for any costs, fees or expenses that have been incurred or paid by or on behalf of the Insured Person with respect to the claim, including without limitation all original receipts for any cash and/or credit card payments.
The Insured Person and/or Physician, Hospital and other healthcare and medical service providers and supplier shall have sixty (60) days from the date a medical expense is incurred to submit a complete Proof of Claim, and the Company at its option may pend resolution and adjudication of submitted claims and/or may deny coverage: for Proofs of Claim submitted thereafter; or for incomplete Proofs of Claim; and/or for failure to submit a Proof of Claim; provided, however, that the Company at its option may waive the requirements regarding submission of a new Claim Form for subsequent claims incurred by an Insured Person relating to a continuing Illness, Injury or other medical condition for which a properly completed and signed Claim Form has previously been submitted and received.

(4) APPEALING A CLAIM - In the event the Company denies all or part of a claim, the Insured Person shall have sixty (60) days from the date that the notice of denial was mailed to the Insured Person's last known residence or mailing address within which to appeal the determination, and shall have the opportunity to submit written comments, documents, records, and other information relating to the claim. The Company's review will take all into account without regard to whether such information was submitted or considered in the initial claim determination. Insured Persons must file two (2) appeals of a claim denial prior to bringing any legal action under the contract of insurance. Upon receipt of a written appeal, the Company shall have an opportunity for further reasonable investigation and/or review as set forth in the Explanation or Verification of Benefits section, and will respond in writing within ninety (90) days from receipt thereof.

(5) SERVICE OF SUIT; VENUE; CHOICE OF LAW; TRIAL BY COURT - No action at law or in equity can be brought by an Insured Person to recover on the contract of insurance prior to the later of (1) expiration of sixty (60) days after written Proof of Claim has been furnished in accordance with the contract of insurance or (2) exhaustion of two (2) appeals under the APPEALING A CLAIM provision above. No action at law or in equity can be brought after the expiration of three (3) years after the time written Proof of Claim is required to be furnished under the contract of insurance. The contract of

insurance between the Insured Person and the Company as represented by the Master Policy and evidenced by this Certificate shall be deemed issued, finalized and made in Kent County, Michigan. Sole and exclusive jurisdiction and venue for any court action or administrative proceeding relating to this insurance shall be in Kent County, Michigan, for which the Insured Person expressly consents. The subjects, risks and benefits of insurance covered by the Master Policy and evidenced by this Certificate are not intended or considered by the Insured Person or the Company (or the Plan Administrator) to be resident, located, or to be performed in any particular State of the United States. Michigan surplus lines law shall govern all rights and claims raised under this Certificate of Insurance. In the event of the failure of the Company to provide benefits or pay or reimburse any amount claimed to be due under this insurance, the Company, at the request of the Insured Person and upon receipt of lawful process or summons, will submit to the jurisdiction of a court of competent subject matter jurisdiction located in Kent County, Michigan. The Company and the Insured Person consent to the exclusive personal jurisdiction and exclusive venue in the Circuit and/or Superior Courts of Kent County, Michigan, and in the United States District Court (assuming that federal jurisdiction is otherwise appropriate and lawful). All trials regarding any dispute under this insurance shall be exclusively presented to and determined solely by the court as the trier of fact, without a jury. The Company reserves the right, acting by and through the Plan Administrator, to initiate and pursue actions for declaratory judgment and/or other appropriate relief with respect to the validity, binding effect, administration of and/or any dispute or controversy arising under this insurance. In any suit instituted by or against the Company or the Insured Person pursuant to the Terms of this section, the Company and the Insured Person will abide by the final decision of such Michigan court or of any appellate court in the event of an appeal.

Nothing in this section constitutes or should be deemed, considered or understood to constitute a waiver of the Company's or the Insured Person’s rights to: (i) oppose venue, procedural and/or substantive choice of law, personal jurisdiction, or subject matter jurisdiction in any forum other than the Circuit or Superior Courts of Kent County, Michigan, or the United States District Court (assuming that federal jurisdiction is otherwise appropriate and lawful), (ii) oppose commencement of an action in any court of competent jurisdiction in or outside of the United States, other than an action commenced in the Circuit or Superior Courts of Kent County, Michigan, or the United States District Court (assuming that federal jurisdiction is otherwise appropriate and lawful), (iii) remove an action to a United States District Court (assuming that federal jurisdiction is otherwise appropriate and lawful), or (iv) seek transfer of an action in any court of competent jurisdiction in or outside of the United States, other than an action commenced in the Circuit or Superior Courts of Kent County, Michigan, or the United States District Court (assuming that federal jurisdiction is otherwise appropriate and lawful).

Subject to and without limiting, expanding, superseding, modifying or waiving any of the foregoing Terms contained in this section pursuant to any statute of any State, territory or district of the United States which makes provision thereof, the Company hereby designates the Superintendent, Commissioner, or Director of Insurance (or such other officer specified for that purpose in the statute), or his successor or successors in office, as its true and lawful attorney, under a special power of attorney, upon whom may be served any lawful process issued in connection with the initiation of any action, suit or proceeding instituted by or on behalf of the Insured Person arising out of this insurance, including specifically the Commissioner of Insurance for the Indiana Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, IN 46204, and hereby designates and appoints John P. Dearie, Jr., Esq., Edwards Wildman, LLP, 750 Lexington Avenue, New York, New York 10022, as its attorney-in-fact and agent for service of process to whom said officer or Commissioner is authorized to mail or serve any such process or a true copy thereof.

(6) MISREPRESENTATION – The Insured Person’s Application as stated in full is incorporated herein by this reference. Any false representation incomplete information, misleading statement, misstatement, omission, concealment or fraud, whether or not innocently made, either in the Insured Person's Application which forms a part of the Master Policy and this Certificate, or in relation to any claim form, statement, certification or warranty made by the Insured Person or his/her representatives, agents or proxies, whether in writing or otherwise, to the Company or the Plan Administrator or their respective agents, employees or representatives, or in connection with the making of any claim under this insurance, shall render the Declaration and this Certificate null and void and all claims and benefits under this insurance shall be forfeited and waived.

(7) SUBROGATION CLAUSE - The Insured Person shall undertake to pursue in his/her own name and stead, and to fully cooperate with the Company in the pursuit and prosecution of, any and all valid claims that the Insured Person may have against any third party who may be liable or responsible for any loss or damage arising out of any act, omission or occurrence which results or may result in a loss payment, provision of benefits, or coverage of claim by the Company under this insurance, and to fully account to the Company for any amounts recovered or recoverable in connection therewith, on the basis that the Company shall be reimbursed and entitled to recover first in full for any sums paid or to be paid by it before the Insured Person shares in any amount so recovered. The Insured Person further agrees and understands that the Company requires the Insured Person to complete a subrogation questionnaire, sign an acknowledgment of the Company's Subrogation rights and sign an agreement before the Company considers paying, or continues to pay, any claims. Should the Insured Person fail to so cooperate, account, or to prosecute any valid claims against any such third party or parties, and the Company thereupon or otherwise becomes liable or otherwise obligated to make payment under the Terms of this insurance, then the Company shall be fully subrogated to all rights and interests of the Insured Person with respect thereto and may prosecute such claims in its own name as subrogee. The Insured Person's submission of Proof of Claim or acceptance of coverage or benefits under this insurance shall be deemed to constitute an authorization, consent and assignment of such subrogation rights by the Insured Person to the Company. The Insured Person agrees the Company has a secured proprietary interest in any settlement proceeds the Insured Person receives or may be entitled to receive. The Insured Person understands and agrees the Company is entitled to a constructive trust interest in the proceeds of any settlement or recovery. The Insured Person agrees to include the Company as a co-payee on any settlement check or check from any third party or insurer. The Insured Person agrees he/she will not release any party or their insured without prior written approval from the Company, and will take no action which prejudices the Company's rights. The Insured Person is obligated to inform their legal representative of the Company's rights and lien and to make no distributions from any settlement or judgment which will in any way result in the Company receiving less than the full amount of its lien without the written approval of the Company. Any amount recovered by the Company in accordance with the foregoing shall first be used to pay in full the costs and expenses of collection incurred by the Company, including reasonable attorneys' fees, and for reimbursement to the Company for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts recovered shall be paid to the Insured Person or other persons lawfully entitled thereto, as applicable. In the event that the Insured Person receives any form or type of settlement and either fails or refuses to abide by the terms of this insurance contract, in addition to any other remedies the Company may have, the Company retains a right of equitable offset against future claims.

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

(9) CANCELLATION BY INSURED PERSON - The Insured Person shall have up until the Effective Date of Coverage to review the benefits, conditions, limitations, exclusions and all other Terms of the Master Policy as evidenced and outlined by this Certificate. If not completely satisfied, the Insured Person may request cancellation of this insurance by sending a written request to the Plan Administrator by mail or email prior to the Effective Date of Coverage, thereby qualifying to receive a full refund of Premium paid. Upon effectuation of such cancellation and refund, neither the Company nor the Insured Person shall have any further rights, liabilities or obligations under this insurance.

If this coverage was not purchased for visa or residency permit purposes, the Insured Person may request cancellation of the Declaration and this Certificate by giving the Plan Administrator not less than sixty (60) days advance written request. Cancellation is at the sole option of the Company,

except as provided in the RENEWAL; AMENDMENTS section, and the Company may request and/or require the Insured Person to execute a release of claims as a condition to and/or in consideration of granting such cancellation. If the Company grants cancellation, coverage for the Insured Person under this insurance shall terminate with effect from the cancellation date specified by the Company.

(10) APPLICABLE CURRENCY - All benefit amounts, coverage, monetary limits and sub-limits, and other amounts stated in the Master Policy, the Application, the Declaration, this Certificate, and in any Riders, including Premium, are in the currency specified in the Application.

(11) COOPERATION - The Insured Person and his/her Physicians, Hospitals and other healthcare and medical service providers and suppliers shall undertake to cooperate fully with the Company and the Plan Administrator in reviewing, investigating, adjudicating, considering an appeal of, and/or administering any claim for benefits under this insurance, including granting full right of access to all relevant, pertinent or related records, medical documentation, medical histories, reports, lab or test results, x-rays, and all other available evidence relating to or affecting the review, investigation, adjudication or administration of the claim. The Company at its own expense shall have the right and opportunity to examine all evidence related to a claim when and as often as it may reasonably require during the pendency of a claim hereunder and to request an autopsy in case of death where it is not forbidden by law. The Company at its option may suspend or pend adjudication of a claim, and/or may deny benefits and/or coverage for a claim, when there has been: (i) a refusal to so cooperate, (ii) an unreasonable delay in such cooperation, and/or (iii) any other act or omission on the part of the Insured Person and/or his/her healthcare providers which hinders, delays, impairs, or otherwise prejudices the performance of the Company's obligations under this insurance.

(12) CLAIM SETTLEMENT - Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have previously been paid by or on behalf of the Insured Person at the time of the Company's favourable adjudication thereof will be reimbursed by the Company directly to the Insured Person, by check, at his/her last known residence or mailing address. While this insurance is in effect, in order to effectuate proper administration the Insured Person shall undertake to promptly notify the Company of any change in such addresses. Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have not been paid by or on behalf of the Insured Person at the time of adjudication will be paid by the Company by check or electronic funds transfer to the Insured Person at his/her last known residence or mailing address, or, at the sole option and discretion of the Company (but without obligation to do so), and as an accommodation to the Insured Person, directly to the provider(s), as applicable. All claim settlements, payments and reimbursements are subject to the applicable Deductible and Coinsurance, if any, and to the benefit limits and sub-limits and all other Terms of this insurance. No healthcare or medical service provider or supplier, or any other third-party, shall have any direct or indirect interest, claim or right of action against the Company under this Certificate, the Declaration or the Master Policy, whether by purported assignment of benefits, subrogation of interests or otherwise, unless first expressly agreed and consented to in writing by the Company, and notwithstanding the Company's exercise or failure to exercise any option or discretion under this section regarding the method of claim payment. No such provider, supplier or other third-party is intended to have or shall have any rights as a third-party beneficiary under this Certificate, the Declaration, or the Master Policy.

(13) FRAUDULENT CLAIMS - A person who knowingly and with intent to defraud the Company files a statement of claim containing any false, incomplete, or misleading information commits a felony. If any claim or request for benefits under this insurance shall be in any respect knowingly false, incomplete, misleading, concealing, fraudulent or deceitful, or if the Insured Person or anyone acting for or on his/her behalf under this insurance knowingly uses any false, incomplete, misleading, concealing, fraudulent or deceitful statements regarding the Insured Person, the insurance contract and all coverage thereunder may be cancelled, voided, rescinded and terminated by the Company in its sole and absolute discretion, and the Company shall have no obligation or liability for any such benefits, coverage or claims.

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

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

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

(a) The next day following the end of the coverage period for which Premium has been fully and timely
Paid; or

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

(c) The date the Master Policy is terminated pursuant to the TERMINATION OF MASTER POLICY section; or

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

(e) the date the Company, at its sole option, elects to cancel from the AccessHMO® plan (sometimes referred to herein as “this insurance plan” or “the plan”) all insured persons of the same sex, age, class or geographic location as the Insured Person, provided the Company gives no less than thirty (30) days advance written notice by mail to the Insured Person's last known residence or mailing address of its intent to exercise such option; or

(f) the cancellation date specified by the Company pursuant to the CANCELLATION BY INSURED PERSON section; or

(g) the cancellation date specified by the Insured Person pursuant to the RENEWAL; AMENDMENTS section; or

(h) the date specified by the Company in any notice of cancellation, forfeiture or rescission issued pursuant to or as a result of the circumstances described in the MISREPRESENTATION, FRAUDULENT CLAIMS and RIGHT OF RECOVERY sections, or as otherwise permitted by the Terms of this insurance.

Coverage for the Insured Person shall remain in full force and effect unless terminated pursuant to the provisions of this TERMINATION OF COVERAGE FOR INSURED PERSONS section, except as otherwise provided in the Master Policy, the Declaration, or this Certificate.

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

(a) a written request for Reinstatement; and

(b) a newly completed Reinstatement Application, which shall become a part of the Master Policy and any reinstated Certificate; and

(c) a written statement giving full details, as requested by the Company, of any claims incurred, diagnoses made, manifestations of symptoms or health conditions experienced, and/or Treatment or supplies received by the Insured Person since the Initial Effective Date under this insurance plan; and

(d) a written statement giving full details of the reason for the previous failure to pay Premium when due or to accept renewal terms in a timely manner; and

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

(18) PATIENT ADVOCACY - Neither the Company nor the Plan Administrator shall have any right, obligation, or authority of any kind to ultimately select Physicians, Hospitals, or other healthcare or health service providers for the Insured Person or to make any medical Treatment decisions for or on behalf of the Insured Person, and all such decisions shall be made solely and exclusively by the Insured Person and/or his/her guardians, family members and treating Physicians and other healthcare providers.

(19) RENEWAL; AMENDMENTS - Subject to the Terms of the TERMINATION OF MASTER POLICY, TERMINATION OF COVERAGE FOR INSURED PERSONS, and REINSTATEMENT OF COVERAGE FOR INSURED PERSONS sections, the Insured Person can request coverage under this insurance plan to be renewed from year to year in accordance with and subject to the Terms of the plan then in effect (including the Terms of the then applicable Master Policy) and so long as renewal Premium is paid when due and the Insured Person otherwise continues to meet the applicable eligibility requirements of the plan. A Notice of Amendment will be sent to the Insured Person's last known mailing address and shall include a complete description of the changes, additions and/or deletions to be made, the effective date thereof (the "Change Date"). Upon issuance of the Notice of Amendment, the Assured and/or the Insured Person shall have the right to request cancellation of this Certificate above, at any time prior to the Change Date. If the Insured Person does not elect to cancel this Certificate in accordance with the foregoing, the changes, additions and/or deletions as made by the Company and specified in said Notice of Amendment shall take effect as of the Change Date specified in the Company's Notice, and this insurance shall thereafter continue in effect in accordance with its Terms, as so amended and modified.
(20) EXPLANATION OR VERIFICATION OF BENEFITS - In the event of any verbal or telephone inquiry, every attempt will be made to help the Insured Person and his/her healthcare providers and suppliers understand the status, scope and extent of available benefits and coverage under this insurance; provided, however, that no statement made by any agent, employee or representative of the Company or the Plan Administrator will be deemed or construed as an actionable representation, promise, or an estoppel, or will create any liability against the Company or the Plan Administrator or be deemed or construed to bind the Company or to modify, replace, waive, extend or amend any of the Terms of the Master Policy or this Certificate, unless expressly set forth in writing and signed by an authorized agent or representative of the Company.

C. SCHEDULE OF BENEFITS/LIMITS - Subject to the Terms of this insurance, including without limitation the Deductible and Coinsurance (unless otherwise expressly set forth to the contrary), the Exclusions, and the various limits and sub-limits set forth below, the Company promises to provide the Insured Person the following benefits and coverage arising out of Injury or Illness incurred while this Certificate is in effect.

D. PRE-CERTIFICATION PROVISIONS/REQUIREMENTS - Pre-certification is a general determination of Medical Necessity, only, and all such determinations are made by the Company (acting through its authorized agents and representatives) in reliance and based upon the completeness and accuracy of the information provided by the Insured Person and/or his/her relatives, guardians and/or healthcare providers at the time of Pre-certification. The Company reserves the right to challenge, dispute and/or revoke a prior determination of Medical Necessity based upon subsequent information obtained. Pre-certification is not an assurance, authorization, preauthorization, or verification of Treatment or coverage, a verification of benefits, or a guarantee of

payment. The fact that Treatment or supplies are Pre-certified by the Company does not guarantee the payment of benefits, the availability of coverage, or the amount of or eligibility for benefits. The Company's consideration and determination of a Pre-certification request, as well as any subsequent review or adjudication of all medical claims submitted in connection therewith, shall remain subject to all of the Terms of the Master Policy and this Certificate.

(1) SPECIFIC REQUIREMENTS - The following Treatments and/or supplies must always be Precertified for Medical Necessity by the Company through the Plan Administrator. See your medical ID card for the proper contact information.

(2) LOSS OF COVERAGE/BENEFITS FOR NON-COMPLIANCE WITH PRECERTIFICATION REQUIREMENTS - If the Insured Person or his/her healthcare providers do not comply with the foregoing Pre-certification requirements, coverage for any and all Eligible Medical Expenses may be denied.

(3) EMERGENCY PRE-CERTIFICATION - In the event of an Emergency Hospital admission, Pre-certification must be completed within forty-eight (48) hours after the admission, or as soon as is reasonably possible.

(4) CONCURRENT REVIEW - For Inpatient Treatment of any kind, the Company will Pre-certify a limited number of days of confinement based upon the disclosed medical condition. Thereafter, Precertification must again be requested and approved if additional days of Inpatient Treatment are necessary.

(5) APPEAL PROCESS - If the Insured Person disagrees with a Pre-certification decision of the Company, the Insured Person may in writing ask the Company to reconsider the decision and may supply additional documentation to support the appeal. The Company may reconsider its decision based on review of the additional documentation and facts, if any. The Company will advise the Insured Person of its decision within a reasonable time frame following receipt of additional documentation and facts.

E. MANDATORY SECOND SURGICAL OPINION - Except in the case of an Emergency, if a Physician recommends one or more of the Surgeries listed below, the Company may require, as a condition to becoming eligible for benefits under this insurance, that the Insured Person consult with another independent Physician for a second opinion as to the Medical Necessity of the Surgery ("Second Surgical Opinion").

(1) The Company will notify the Insured Person if a Second Surgical Opinion is required as soon as is reasonably possible after the Insured Person Pre-certifies such Surgery in accordance with the PRECERTIFICATION PROVISIONS/ REQUIREMENTS set forth in this Certificate. Including, Cataract Removal, Cholecystectomy, Coronary Bypass, Haemorrhoidectomy, Herniorrhaphy, Hysterectomy, Knee Surgery, Laminectomy, Ligation and stripping of varicose veins, Lithotripsy, Submucous resection, Septo-rhinoplasty, Spinal Fusion, Tonsillectomy and/or adenoidectomy, and any Covered Transplant.

(2) The Physician providing the second opinion must:
Second Surgical Opinion 50% reduction of Eligible Medical Expenses for failure to obtain a Second Surgical Opinion when required by the Company.

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

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

(c) provide the Company with a written opinion and any and all documents and records reasonably requested by the Company in support of such opinion. If the second opinion is required by the Company, the Company will reimburse the Insured Person for Eligible Medical Expenses incurred for the consultation, including any required diagnostic tests or procedures which were not carried out by the first recommending Physician, without application of any Deductible or Coinsurance.
If the second opinion concurs with the recommending Physician, then the Company will reimburse the Insured Person for Eligible Medical Expenses in accordance with the Terms of this insurance. If the second opinion differs from the recommending Physician, the Insured Person may be required to

consult with another Physician for a third opinion as to the Medical Necessity of the Surgery. The third Physician must also meet the requirements of subparagraphs 1 through 3 immediately above.
If the third opinion is required by the Company, the Company will reimburse the Insured Person for Eligible Medical Expenses incurred for the consultation, including any required diagnostic tests or procedures which were not carried out by the first or second Physicians, without application of any Deductible or Coinsurance. The Insured Person must notify the Company immediately in the event any one or more of the Surgeries listed above is recommended by a Physician. The Company will promptly advise the Insured Person whether or not it will require a second opinion. Upon receipt of a second opinion that differs from the recommending Physician, the Company will promptly advise the Insured Person whether or not it will require a third opinion.

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

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

F. ELIGIBLE MEDICAL EXPENSES - Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and the various limits and sub-limits set forth in the Schedule of Benefits/Limits, and the EXCLUSIONS, below, the Company will reimburse the Insured Person for any expense incurred for Treatment that is deemed Medically Necessary by a licensed Physician.

G. WELLNESS EXPENSES - Provided the Insured Person has been continuously insured under this insurance plan for not less than twelve (12) months and subject to the Terms of this insurance, the Company will reimburse the Insured Person for the following expenses incurred while this Certificate is in effect:

(1) For Males thirty (30) years of age and older: one Routine Physical Exam, limited to € 200. per Period of Coverage, provided at least twelve (12) months have elapsed since the Insured Person's most recent Routine Physical Exam; and

(2) for Females thirty (30) years of age and older: one Routine Physical Exam, limited to € 200. per Period of Coverage, including expenses for mammography exams and pap smears, provided at least twelve (12) months have elapsed since the Insured Person's most recent Routine Physical Exam; and

(3) for a Child, limited to € 150. per Period of Coverage:

(a) One Routine Physical Exam per Period of Coverage, provided at least twelve (12) months have Elapsed since the Child's most recent Routine Physical Exam; and

(b) routine inoculations and vaccinations commonly administered to children less than eighteen (18) years of age in accordance with standard medical practice.
H. EXCLUSIONS - All charges, costs, expenses and/or claims (collectively "Charges") incurred by the Insured Person and directly or indirectly relating to or arising or resulting from or in connection with any of the following acts, omissions, events, conditions, charges, consequences, claims, Treatment (including diagnoses, consultations, tests, examinations and evaluations related thereto), services and/or supplies are expressly excluded from coverage under this insurance, and the Company shall provide no benefits or reimbursements and shall have no liability or obligation for any coverage thereof or therefore:

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

(a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war;

(b) mutiny, riot, strike, military or popular uprising, insurrection, rebellion, revolution, military or Usurped power.

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

(2) Terrorism - The Company shall not be liable for and will not provide coverage or benefits for any claim or charges, Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with any act of Terrorism.

(3) Pre-existing Conditions - (i) For medical conditions existing at the time of Application which are fully disclosed on the Application and are not excluded or restricted through a Rider attached to this Certificate and for medical conditions which existed but that were unknown at the time of Application, charges resulting directly or indirectly from or relating to any such Pre-existing Condition are excluded from coverage under this insurance until the Insured Person has maintained coverage under this insurance plan continuously for at least twenty-four (24) months, and thereafter such Charges are limited in coverage as provided in the SCHEDULE OF BENEFITS/LIMITS section; and (ii) Any expenses incurred, obtained, or received by an Insured Person for any Non-Disclosed conditions will be excluded under this insurance; and

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

(5) Maternity and Newborn Care - Charges for pre-natal care, delivery, post-natal care, and care of Newborns, are excluded from coverage under this insurance, unless selected on the Application as an optional benefit for an additional premium; and

(6) Wellness - Preventive care is covered in the second policy year; and4

(7) Charges for any Treatment or supplies that are:
(a) not incurred, obtained or received by an Insured Person during the Period of Coverage; and/or
(b) not presented to the Company for payment by way of a complete Proof of Claim within sixty (60) days of the date such Charges are incurred; and/or

(c) not administered or ordered by a Physician; and/or

(d) not Medically Necessary; and/or

(e) provided at no cost to the Insured Person or for which the Insured Person is not otherwise liable; and/or

(f) in excess of Usual, Reasonable, and Customary; and/or

(g) incurred by an Insured Person who was HIV + on or before the Effective Date of this insurance relating to or arising or resulting directly or indirectly from HIV, AIDS virus, AIDS related Illness, ARC Syndrome, AIDS and/or any other Illness arising or resulting from any complications or consequences of any of the foregoing conditions; whether or not the Insured Person had knowledge of his/her HIV status prior to the Effective Date, and whether or not the Charges are incurred in relation to or as a result of said status; and/or

(h) provided by or at the direction or recommendation of a chiropractor, unless ordered in advance by a Physician; and/or

(i) performed or provided by a Relative of the Insured Person; and/or

(j) provided by a person who resides or has resided with the Insured Person or in the Insured Person's home; and/or

(k) 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

(l) for Congenital Disorders and conditions arising out of or resulting there from; and

(8) Charges incurred for telephone consultations except Telemedicine consultations through an established Telemedicine protocol system will be considered individually based on medical necessity and appropriateness as determined by the Company under the plan; and

(9) Charges incurred due to a failure to keep a scheduled appointment; and

(10) Charges incurred for Surgeries or Treatment or supplies which are:

(a) Investigational, Experimental, or for research purposes, and/or

(b) Related to genetic medicine, genetic testing, surveillance testing and/or wellness screening including, but not limited to amniocentesis, genetic screening, risk assessment, preventive and prophylactic surgeries recommended by genetic testing, and/or any procedures used to determine genetic pre-disposition, provide genetic counselling, or administration of gene therapy; and

(11) Charges incurred while confined primarily to receive Custodial Care, Educational or Rehabilitative Care; and

(12) Charges incurred for any Surgery, Treatment or supplies relating to, arising from or in connection with, for, or as a result of:

(a) weight modification or any Inpatient, Outpatient, Surgical or other Treatment of obesity (including without limitation morbid obesity), including without limitation wiring of the teeth and all forms or procedures of bariatric Surgery by whatever name called, or reversal thereof, including without limitation intestinal bypass, gastric bypass, gastric banding, vertical banded gastroplasty, biliopancreatic diversion, duodenal switch, or stomach reduction or stapling; and/or
(b) Modification of the physical body in order to change or improve or attempt to change or improve the physical appearance or psychological, mental or emotional well-being of the Insured Person (such as but not limited to sex-change Surgery or Surgery relating to sexual performance or enhancement thereof); and/or

(c) Elective Surgery or Treatment of any kind; and/or

(d) Cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is medically

Necessary and is directly related to and follows a Surgery which was covered under this insurance; and/or

(e) 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

(f) Any Illness or Injury sustained while participating in any activity where such activity is undertaken in disregard of or against the recommendations, Treatment programs, or medical advice of a Physician or other healthcare provider; and/or

(g) Any Injury or Illness sustained as a result of being under the influence of or due wholly or partly to the effects of alcohol, liquor, intoxicating substance, narcotics or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician but not for the Treatment of Substance Abuse; and/or

(h) any Injury or Illness sustained while operating a moving vehicle after consumption of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician. For purposes of this exclusion, “vehicle” shall include motorized devices regardless of whether or not a driver or operator license is required (including watercraft and aircraft) and no motorized bicycles and scooters for which no permit or license is required; and/or

(i) Any wilfully Self-inflicted Injury or Illness; and/or

(j) Any sexually transmitted or venereal disease; and/or

(k) Any testing for the following: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS; and/or

(l) Any Illness or Injury resulting from or occurring during the commission of a violation of law by the Insured Person, including, without limitation, the engaging in an illegal occupation or act, but Excluding minor traffic violations; and/or

(m) Any Substance Abuse; and/or

(n) Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy; and/or

(o) Orthotics, visual therapy or visual eye training; and/or

(p) Any Illness or Treatment of the feet, including without limitation: orthopaedic shoes; orthopaedic prescription devices to be attached to or placed in shoes; Treatment of weak, strained, flat, unstable or unbalanced feet; metatarsalgia, bone spurs, hammer toes or bunions; and any Treatment or supplies for corns, calluses or toenails; 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:

(i) An Injury to the foot arising from an Accident covered hereunder; or

(ii) An Illness for which foot Surgery is Medically Necessary and determined to be the only appropriate method of Treatment; and/or

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

(r) Any sleep disorder, including without limitation sleep apnea; and/or

(s) Any exercise program, whether or not prescribed or recommended by a Physician; and/or

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

(u) 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

(v) Any artificial or mechanical devices designed to replace human organs temporarily or permanently; and/or

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

(x) Any transplant expenses incurred outside the Company's approved independent Managed Transplant System Network; and/or

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

(z) any Illness or Injury resulting from or sustained as a result of epidemics, pandemics, communicable diseases, global infections, public health emergencies, dangerous and emerging pathogen outbreaks, disease outbreaks, natural disasters, or other disease outbreak conditions that may affect a person's health and about which the World Health Organization, Centers for Disease Control & Prevention, or similar governmental agency of the Insured Person's Home Country had previously published, communicated or issued a restriction, notice, warning, alert, or watch informing the public about such health issues.

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

(14) 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

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

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

(17) Charges incurred for eye Surgery, such as but not limited to radial keratotomy, when the primary purpose is to correct or attempt to correct near-sightedness, farsightedness, or astigmatism; and

(18) Charges incurred for Treatment of the temporomandibular joint; and

(19) Charges incurred by the Insured Person for the Treatment of his/her Newborns (or for supplies related thereto); and

(20) Charges incurred for any immunizations and/or routine physical exams except for the eligible benefits and covered expenses provided for under the WELLNESS EXPENSES section, or as otherwise expressly provided for hereunder; and

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

(22) Any taxes, involuntary or forced contributions, assessments, charges, fees or surcharges imposed by any governmental agency or authority:

(a) arising out of or as a result of any Treatment or supplies received by the Insured Person, or

(b) based upon the Company's election hereunder, if any, to pay benefits directly to providers as an accommodation to the Insured Person, or
(c) for any other reason; and

(23) Unless otherwise expressly included under the Complementary Medicine Benefit section, Charges or expenses incurred for any medication, tablet, or remedy other than those prescribed by a licensed Physician and purchased from a licensed pharmacy.

I. EMERGENCY MEDICAL EVACUATION BENEFIT - Subject to the applicable Maximum Limit set forth in the SCHEDULE OF BENEFITS/LIMITS section, and the other Terms of this insurance, including the EXCLUSIONS and the Conditions and Restrictions set forth below, the Company will reimburse the Insured Person for the following transportation costs, when the Company or Plan Administrator arranges such transportation, and expenses incurred by the Insured Person arising out of or in connection with an Emergency Medical Evacuation occurring while this Certificate is in effect and during the Period of Coverage:

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

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

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

(a) Medically Necessary Treatment cannot be provided locally; and

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

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

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

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

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

(i) occurred suddenly, Unexpectedly, and spontaneously, and without: (1) advance warning, (2) advance Treatment, diagnosis or recommendation for Treatment by a Physician, or (3) prior manifestation of symptoms or conditions which would have caused a reasonably prudent person to seek medical attention prior to the onset of the Emergency; and (ii) was not a Pre-existing Condition; and

(g) The Company will cover reimbursement for the above-described costs and expenses and will arrange Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary Treatment to prevent the Insured Person's loss of life or limb. The Insured Person may select a different Hospital in his/her Home Country at his/her option, but in such event the Insured Person shall be solely responsible for all costs and expenses in excess of the amounts that

would have been incurred had the Insured Person used the nearest qualified Hospital. If a Hospital other than the nearest qualified Hospital is selected by the Insured Person, then the attending physician, Insured Person, or a relative of the Insured Person shall certify to the Company the Insured Person's understanding and acknowledgement of such responsibility for excess costs and expenses in addition to the matters set forth in the Conditions and Restrictions, above. In all cases the Company will make the necessary arrangements for the Emergency Medical Evacuation, and will use its best efforts to arrange with independent, third-party contractors any Emergency Medical Evacuation within the least amount of time reasonably possible. By acceptance of this Certificate and request for Emergency Medical Evacuation benefits hereunder, the Insured Person understands, acknowledges and agrees that the timeliness, duration, occurrences during, and outcome of an Emergency Medical Evacuation can be directly and indirectly affected by events and/or circumstances which are not within the supervision or control of the Company, including but not limited to: the availability, limitations, physical condition, reliability, maintenance and training schedules and procedures, and performance or non-performance of competent transportation equipment, supplies and/or staff of such third-party contractors; delays or restrictions on flights or other modes or means of transportation caused by mechanical problems, government officials, telecommunications problems, non-availability of routes, and/or other travel, geographical or weather conditions; and other acts of God and unforeseeable and/or uncontrollable occurrences. The Insured Person agrees to release and to hold the Company, the Plan Administrator and their agents and representatives harmless from, and agrees that the Company, the Plan Administrator and their agents and representatives shall not be held liable or responsible for, any delays, losses, damages, further injuries or illnesses, or any other claims that arise from or are caused in whole or in part by the acts or omissions of such independent third-party contractors or their agents, employees or representatives, or that arise from or are caused in whole or in part by any acts, omissions, events or circumstances that are not within the direct and immediate supervision and control of the Company, the Plan Administrator and/or their authorized agents and representatives, including without limitation the events and circumstances set forth above. The Insured Person further agrees that upon seeking an Emergency Medical Evacuation, he or she will cooperate fully as required by the COOPERATION section. Failure to so cooperate and/or failure to use or accept Emergency Medical Evacuation once it has been arranged by the Company or Plan Administrator will require the Insured Person to reimburse the Company for costs incurred for any Emergency Medical Evacuation that was arranged, but not used, by the Insured Person. Furthermore, the Insured Person may be required to arrange for payment of any subsequent Emergency Medical Evacuation and seek reimbursement thereafter for eligible costs associated with that subsequent Emergency Medical Evacuation.

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

K. SUPPLEMENTAL ACCIDENT BENEFIT - In the event of an Accident which gives rise to benefits covered under the Terms of this insurance, as a supplemental benefit the Company will also reimburse the Insured Person for the first € 250. of Eligible Medical Expenses related to the Treatment of an Injury resulting from such Accident, before applying any Deductible.

L. RECREATIONAL UNDERWATER ACTIVITIES - Subject to the Terms of this insurance, including without limitation the Deductible, Coinsurance, and limits and sub-limits set forth in the SCHEDULE OF BENEFITS/LIMITS, the EXCLUSIONS, and the Special Exclusions and Limitations below, the Company will reimburse the Insured Person for Eligible Medical Expenses incurred by the Insured Person with respect to an Illness or Injury suffered or sustained by the Insured Person while engaged in Sports Diving during the Period of Coverage, so long as the same is carried out in strict

accordance with the guidelines, codes of good practice, and recommendations for safe diving practices as laid down by an Authoritative Diving Body.

Special Exclusions and Limitations: In addition to the EXCLUSIONS section, this insurance does not cover any charges, costs, expenses and/or claims incurred by the Insured Person relating to, arising from, as a consequence of, or in connection with, directly or indirectly, any of the following acts, omissions, events, occurrences or conditions:

(1) Diving by the Insured Person without holding a recognized certificate issued by an Authoritative Diving Body for the type of diving being undertaken, or not under professional instruction;
(2) Diving without proper and well-maintained equipment in good working order and/or contrary to the guidelines, codes of good practice and/or recommendations as laid down by the Authoritative Diving Body under which the Insured Person has been certified;
(3) Diving to depths greater than thirty (30) meters, or diving requiring decompression stops;
(4) Solo diving;
(5) Any form of cave diving;
(6) Flying within twenty-four (24) hours of the last dive or diving within ten (10) hours of flying;
(7) Diving for hire, reward, or treasure;
(8) Diving while suffering from a cold, influenza or any other condition, Illness or Injury causing an obstruction of the sinuses or ears, or diving while otherwise medically unfit to dive;
(9) Diving by an Insured Person under twelve (12) years of age or over sixty-five (65) years of age;
(10) Willfully self-inflicted Injury or Illness, the effects of alcohol or drugs (other than as prescribed by a licensed Physician in full awareness of the Insured Person's sub-aqua activities) and any self exposure to needless peril (unless in an attempt to save human life);
SAGH15 18
(11) Any condition for which the Insured Person was undergoing, recovering from or awaiting Treatment immediately prior to the sub-aqua activities;
(12) Diving with artificial or other underwater breathing apparatus containing any gas other than compressed air. It is a condition precedent to the Company's liability under this insurance that any prospective diver applying for coverage under this insurance is medically fit to dive. If in any doubt, the Insured Person should refrain from participating in S.C.U.B.A. diving until medical advice and approval has been obtained from a qualified Physician.

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

Accident: An Unexpected occurrence directly caused by external, visible means and no other cause, which directly, without any intervening cause, results in physical Injury to the Insured Person.

Affidavit of Eligibility: The properly completed form provided to the Company 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.

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

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

Assured: The Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN.

Certificate: This document, including any Riders, as issued to the Insured Person, which describes and provides an outline and evidence of eligible insurance coverage and benefits payable to or for the benefit of the Insured Person under the Master Policy. The Application is incorporated herein by this reference and made a part hereof.

CET: Central European Time

Child; Children: An Insured Person who is at least fourteen (14) days old but less than eighteen (18) years of age.

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

Company: The "Company," as referred to in the Master Policy and this Certificate, is Sirius International Insurance Corporation (publ), headquartered in Stockholm, Sweden. This insurance and its risks are underwritten by the Company as the insurer and carrier, and the Company is solely obligated and liable for the coverage and benefits provided by this insurance.

Congenital Disorder: Physical abnormality that is present at birth.

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

Deductible: The dollar/euro amount of ELIGIBLE MEDICAL EXPENSES, as selected on the Application and specified in the Declaration, that the Insured Person must pay per Period of Coverage prior to receiving benefits or coverage under this insurance, and exclusive of Coinsurance.

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.
Effective Date; Effective Date of Coverage: The date coverage for the Insured Person begins under the Terms of the Master Policy as evidenced by this Certificate, as indicated on the Declaration.
Emergency: A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within twenty-four (24) hours, based upon a reasonable medical certainty.
Emergency Medical Evacuation: Emergency transportation from the Hospital or medical facility where the Insured Person is located to a non-local Hospital or medical facility, recommended by the attending Physician who certifies, to a reasonable medical certainty, that the Insured Person has experienced:

- a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within twenty-four (24) hours; and
- where Medically Necessary Treatment cannot be provided locally, either in the facility of the attending Physician or another local facility.

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

Family: An Insured Person and his/her spouse who is covered as an Insured Person under this

insurance plan and his/her Child or Children who are covered as Insured Persons under this insurance plan.

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

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

Hospital: An institution which operates as a hospital pursuant to law; and is licensed by the state or country in which it operates; and operates primarily for the reception, care, and Treatment of sick or injured persons as Inpatients; and provides 24-hour nursing service by Registered Nurses on duty or call; and has a staff of one or more Physicians available at all times; and 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 or abusers, 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, malady, morbidity, affliction, disability, defect, handicap, deformity, birth defect, congenital defect, symptomatology, syndrome, malaise, infection, infirmity, ailment, disease of any kind, or any other medical, physical or health condition. Provided, however, that Illness does not include learning disabilities, or attitudinal or disciplinary problems. All Illnesses that exist simultaneously or which arise subsequent to a prior Illness and which directly or indirectly relate to or result or arise from the same or related causes or as a consequence thereof or from one another are considered to be one Illness. Further, if a subsequent Illness results or arises from causes or consequences that are the same as or related to the causes or consequences of a prior Illness, the subsequent Illness will be deemed to be a continuation of the prior Illness and not a separate Illness.

Initial Effective Date: The date (most recent, if more than one) the Insured Person first obtains coverage under the AccessHMO® plan and maintains continuous unbroken coverage thereafter.

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

Inpatient: A person who has been admitted to and charged by a Hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if billed by the Hospital for Charges as an inpatient, and formally admitted as an inpatient with the expectation he will occupy a bed and (1) remain at least overnight or (2) is expected to need hospital care for 24 hours or more.

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

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

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

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

Maximum Limit: The cumulative total dollar amount of benefit payments and/or reimbursements

available to an Insured Person under this insurance during the Insured Person's lifetime. When the Maximum Limit is reached, no further benefits, reimbursements or payments will be available under this insurance.

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

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

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

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

Period of Coverage: The period beginning on the Effective Date of Coverage of this Certificate and ending on the earliest of the following dates: (a) the termination date specified in the Declaration, or (b) the termination date as determined in accordance with the TERMINATION OF COVERAGE FOR INSURED PERSONS section. The Period of Coverage can be no more than twelve (12) consecutive months.

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

Plan Administrator: The Plan Administrator for this insurance is AccessHMO Health®, 2885 Sanford Avenue SW, #27044, Grandville, MI 49418-1342, USA, Telephone Number 616/965-7996, Website: http://www.accessglobalhealth.com, Email: accessglobal67@gmail.com. As the Plan Administrator, AccessHMO Health® acts solely as the disclosed and authorized agent and representative for and on behalf of the Company, and does not have, and shall not be deemed, considered or alleged to have any, direct, indirect, joint, several, separate, individual, or independent liability, responsibility or obligation of any kind under the Master Policy, the Declaration, or this Certificate to the Insured Person or to any other person or entity, including without limitation to any Physician, Hospital, Extended Care Facility, Home Health Care Agency, or any other health care or medical service provider or supplier.

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

Pre-existing Condition: Any Illness, Injury, sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment that, with reasonable medical certainty, existed at the time of Application or at any time prior to the Effective Date of this insurance, whether or not previously manifested, symptomatic or known, diagnosed, Treated, or disclosed to the Company prior to the Effective Date, and including any and all chronic, subsequent or recurring complications or consequences related thereto or resulting or arising therefrom.

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

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

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

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

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

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

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

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

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

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

Travel Warning: Published statement or web-site document issued by the United States Department of State, Bureau of Consular Affairs or similar government agency of the Insured Person's Home Country, warning that travel to specific identified countries, regions, or locations is hazardous and is not advised.

Treated; Treatment; Treatments: Any and all undertakings, services and/or procedures rendered or employed with respect to the management and/or care of an Insured Person for the purpose of identifying, testing for, analyzing, diagnosing, treating, curing, resolving, preventing, monitoring, attending to, caring for, controlling and/or combating any Illness or Injury or the symptoms or manifestations thereof, including without limitation: verbal or written advice, consultation, examination, discussion, diagnostic or laboratory testing or evaluation of any kind, pharmacotherapy or other medication, and/or Surgery.

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

Usual, Reasonable and Customary: A typical and reasonable amount of reimbursement for similar services, medicines, or supplies within the area in which the charge is incurred. In determining the typical and reasonable amount of reimbursement, the Company may, in its reasonable discretion, consider one or more of the following factors, without limitation: the amount charged by the provider; the amount charged by similar providers or providers in the same or similar locality; the amount

reimbursed by other payers for the same or comparable services, medicines or supplies in the same or similar locality; the amount reimbursed by other payers for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or service as compared to the length of time required to perform other similar services; the length of time required to perform the procedure or service as compared to national standards and/or benchmarks; the severity or nature of the Illness or Injury being treated; and such other factors as the Company, in the reasonable exercise of its discretion, determines are appropriate.