



AmFirst Insurance Company, Ltd.

The Pearman Building, 3rd Floor
3 Gorham Road
P. O. Box HM 3103
Hamilton HM NX, Bermuda
A STOCK COMPANY

INSURING AGREEMENT. The Company promises to pay You, the Insured, the benefits provided by this policy for covered Medical Expenses necessarily and reasonably incurred up to policy limits as stated in the Schedule of Benefits. All benefits are subject to the Policy Certificate of Coverage, Schedule of Benefits, Provisions, Definitions, Conditions, Exclusions, Organ Transplant Section (if any) and Amendments (if any).

CONSIDERATION. This policy is issued in consideration of the application (a copy is enclosed) and the receipt of the initial premium. Premiums must be paid in U.S. dollars.

COMMENCEMENT OF COVERAGE. Insurance coverage is provided after the application has been reviewed and accepted, the policy is issued and the premium has been received by the Company in accordance with the mode of payment specified on the Certificate of Coverage.

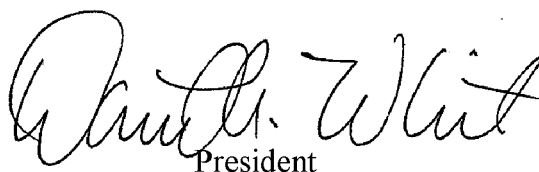
TEN DAY RIGHT TO RETURN POLICY. If for any reason You are not satisfied with this policy, You may return it to Us within 10 days after You receive it. You may return it to Us by mail or to the agent who sold it. Then We will refund any premium paid and the policy will be deemed void just as though no policy had been issued.

EFFECTIVE DATE. This policy begins at 12:01 a.m. Standard Time at Your residence on the Policy Effective Date shown in the Certificate of Coverage. It ends, subject to the grace period, at 12:01 a.m. on the date any renewal premium is due.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION. Please read the copy of the application, which is a part of this policy. Check to see if any medical history has been omitted. Write to Us within 10 days if any information shown is incorrect or incomplete. Notify the Company of any changes in Your health that had occurred between the date the application was completed and the origination date of the policy. This policy is issued on the basis that the answers to all questions are correct and complete. Any omissions or incorrect statements could cause an otherwise valid claim to be denied.

Signed for AmFirst Insurance Company Ltd., at its administrative office in Jackson, Mississippi.


Secretary


President

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PREFERRED MEDICAL PLAN

SCHEDULE OF BENEFITS

Coverage	Worldwide - based on Usual, Reasonable and Customary charges for the country where treatment occurred.
Eligibility	Acceptance up to age 74; students up to age 24 as dependents
Insured Amount	Up to a Maximum of US\$ 1,000,000 of incurred charges per Insured, per Certificate Year. At age 70, the Maximum per Insured, per Certificate Year maximum will reduce to US\$ 500,000.
Annual Deductible per Insured	Choice of: US\$ 500; US\$ 1,000; US\$ 2,000; US \$ 3,000; US \$5,000; US\$ 10,000, US \$25,000.
Co-Insurance	<p>Co-Insurance: 20% of the first US\$ 5,000 per Insured if treatment rendered in the USA; Canada or Europe</p> <p>An increase in the Co-Insurance will apply to any Insured who is NOT admitted to an Elite Network Hospital. The amount the Insured will be responsible for will be an additional 30% of covered charges after the Deductible and Co-Insurance have been applied.</p> <p>Co-Insurance will apply for accidents and emergencies that are treated outside Your Country of Residence and not in an Elite Network Hospital and will be paid after Your Deductible at 90% of Usual, Reasonable and Customary charges. This benefit is limited up to a maximum of US\$ 100,000 and the Insured must be admitted to a Hospital.</p>
Waiting Period	90 days; immediate coverage given for accidents and infectious diseases.
	10 months for maternity coverage. (This Waiting Period is not waived even if an international policy existed prior to this coverage.)
	90-day wait is waived if an international policy existed for a period of at least 12 months prior to this coverage and the international policy did not expire before a period of 30 days or more prior to the effective date of this insurance. Coverage for this waiver will be limited to the lesser of benefits provided by this certificate or the prior policy.

Hospitalization Coverage: Covered Charges & Covered Services

Limits

Cost of private room and board (maximum 180 days per Certificate Year, not to exceed US\$ 800 per day)	US\$ 144,000* per Insured
Cost of private room and board (maximum 180 days per Certificate Year) NO DAILY LIMIT if admitted to a Super Special Hospitals plus REDUCTION in Deductible and Co-Insurance.	NO DAILY LIMIT per Insured if in a Super Special Hospitals 100% of Usual, Reasonable & Customary
Cost of room and board at the Hospital for a parent accompanying an Insured child under 18 years of age. Maximum US\$ 300 per day	US\$ 54,000 Maximum per Year
Cost of intensive care (maximum 90 days per Certificate Year, not to exceed US\$ 2,000 per day)	US\$ 180,000* per Insured
Cost of intensive care (maximum 90 days per Certificate Year) NO DAILY LIMIT if admitted to a Super Special Hospitals plus REDUCTION in Deductible and Co-Insurance.	NO DAILY LIMIT per Insured if in a Super Special Hospitals 100% of Usual, Reasonable & Customary
Cost of room and board at the Hospital for a parent accompanying an Insured child under 18 years of age. Maximum US\$ 300 per day	US\$ 27,000 Maximum per Year
* These sums are the maximum benefit that will be paid if the Insured IS NOT admitted to a Super Special Hospitals. This benefit will be subject to the Deductible and Co-Insurance.	
Cost of surgery, Anesthesiologist Fees, dialysis, Laboratory tests, X-Rays, medication or supplies prescribed by Physician or specialist, administered while the Insured is registered as an Inpatient in a Hospital	100% Usual, Reasonable & Customary per Insured
Maternity In Country of Residence: Out of Country of Residence: Cost of normal delivery, including pre-natal consultations, birth and post-natal care: Caesarean delivery is covered as an operation if medically necessary: Elective Caesarean is covered as a normal delivery: Mother and Father must be covered continuously on this certificate for at least 10 months to be eligible for this benefit. Cost of delivery due to artificial insemination NO DEDUCTIBLE WILL BE APPLIED ON CERTIFICATES WITH DEDUCTIBLES UP TO US\$ 1,000.	100% Usual, Reasonable & Customary US\$ 6,000 Per Pregnancy US\$ 10,000 Per Pregnancy US\$ 6,000 Per Pregnancy US\$ 5,000 Per Pregnancy
Congenital Disorders or Illnesses (Coverage for the (31) first thirty-one days) Cost of treatment relating to birth defects, Congenital Disorders or Illnesses, hereditary conditions and premature birth for the first thirty-one (31) days after birth if born under a covered Maternity.	US\$ 30,000 Maximum per pregnancy
Congenital Disorders or Illnesses (Coverage if newborn is added to this policy) If the newborn, form a covered Maternity is added to this policy within thirty-one (31) days of the birth for birth defects, Congenital Disorders or Illnesses, hereditary conditions diagnosed and treated before age eighteen (18). See Provisions and Definitions for adding a newborn to this policy.	US\$ 250,000 per Insured Lifetime
Congenital Disorders or Illnesses Coverage for Congenital Disorders or illnesses are covered if first manifested after any respective Insured's eighteenth (18) birthday and while said Insured is covered under this policy. Congenital Disorders or Illnesses will then be covered as any other illness.	Up to Annual Maximum Policy Maximum

Home Nursing: Covered Charges & Covered Services

The cost of medically prescribed home nursing by a registered nurse. Home nursing must be approved by American Medical Services prior to any services received – US\$ 300 per day (Maximum 30 days per year)	US\$ 9,000 Maximum All Inclusive, per Insured
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Rehabilitation: Covered Charges & Covered Services.

The cost of medically prescribed rehabilitation at a center approved by American Medical Services prior to treatment being received following a covered Hospitalization – US\$ 400 per visit. All inclusive. (Maximum 30 days per year)	US\$ 12,000 Maximum All Inclusive, per Insured
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Hospital/Clinic Outpatient Benefits: Covered Charges & Covered Services.

The cost of emergency room treatment due to an Accident or Sickness, per Insured: The cost of emergency dental treatment due to an Accident following a covered Hospitalization within 72 hours of such Accident, per Insured:	100% of Usual, Reasonable & Customary 100% of Usual, Reasonable & Customary
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Non-Hospital Outpatient Charges: Covered Charges & Covered Services

Reconstructive Surgery Cost of medically necessary Reconstructive Surgery on an Outpatient basis.	US\$ 15,000 Lifetime per Insured
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Non-Hospital Outpatient Charges: Covered Charges & Covered Services

Outpatient Surgery Cost of Outpatient surgery in a Hospital, Clinic or Physician’s office.	100% of Usual, Reasonable & Customary
Other Non-Hospital Outpatient Benefits: Cost of office visit to a Physician or Psychiatrist - US\$ 80 per visit (maximum 30 per Certificate Year)	US\$ 2,400 Maximum per Insured
Treatment costs of Chiropractors or Physiotherapists – US\$ 70 per treatment (maximum 30 per Certificate Year)	US\$ 2,100 Maximum per Insured
The cost of CAT scans, MRI scans and Echocardiogram	US\$ 700 per exam, per Insured
The cost of Endoscopy, i.e. Gastroscopy, Colonoscopy and Cystoscopy	US\$ 700 per exam, per Insured
The cost of one Mammogram per Certificate Year for female Insured’s (This benefit is not available until after the first annual anniversary)	US\$ 150 No Deductible
The cost of one PSA test per Certificate Year for male Insured’s (This benefit is not available until after the first annual anniversary)	US\$ 150 No Deductible
The cost of X-Rays	US\$ 400 per exam, per Insured
Laboratory tests	US\$ 400 per exam, per Insured
Radiation or Chemotherapy administered as an Inpatient or Outpatient if treatment is rendered at one of the Administrator’s Super Special dedicated facilities.	UP TO COVERAGE LIMITS per Insured
Radiation or Chemotherapy administered as an Inpatient or Outpatient if treatment is NOT rendered at one of the Administrator’s Super Special dedicated facilities.	US\$ 5,000 per month All Inclusive US\$ 60,000 Maximum per certificate, per year
The cost of one Health Check-up. This benefit is not available until the first annual anniversary of the Certificate and is applicable to the Main Insured and spouse only.	US\$ 200 per Insured, per year No deductible.
Prescription drugs as prescribed by a Physician for an Insured.	US\$ 500 per Insured
Dialysis for Kidney failure	100% of Usual , Reasonable & Customary

Human Organ Transplants: Covered Charges & Covered Services

Costs of procedures performed for Organ Transplant. Does not cover cost of maintenance or transport of the organ.	US\$ 500,000 Maximum per Insured All Inclusive
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Emergency Transportation:

Cost of emergency Ground Transportation incurred necessarily in connection with the events covered by this insurance in the country where the event occurs.	100%
Cost of emergency Air Transportation and related expenses (as below) for the transfer to the nearest center where adequate medical facilities exist. (Must be medically necessary). The Administrator retains the right to dictate the Hospital to which the Insured person shall be transported. <i>See Certificate Provisions and Definitions for full details.</i>	100%
Cost of transporting the body or ashes of a deceased Insured person to the usual Country of Residence or country of nationality.	100%

Temporary Emergency Coverage:

During the process of issuance of the certificate, all proposed Insureds will be covered for medical expenses incurred caused by accidental physical injury. This benefit is subject to the selected Deductible & Co-Insurance. <i>See page 7 of the Certificate for full details.</i>	US\$ 25,000 Maximum per Certificate
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Deductibles and Co-Insurance:

1. Deductible: The selected Deductible will apply per Insured per Certificate Year. Maximum of two deductibles if more than two Insureds on this Certificate.
2. Co-Insurance: Co-Insurance of 20% will be applied to the first US\$ 5,000 of any claims incurred in the USA, Canada or Europe. Co-Insurance of 30% will be applied to covered charges in the USA, Canada or Europe and not in an Elite Network Hospital after the Deductible and Co-Insurance have been applied.

Emergency Treatment incurred anywhere in the World except the USA, Latin America or the Caribbean will be paid, after the Deductible, at 90% of covered charges or Usual and Customary whichever is the lesser. Claims occurring in a Super Special Hospital will receive a REDUCTION of up to US\$ 1,000 from the Insured's Deductible and up to US\$ 1,000 from the Co-Insurance.

Additional Benefits

1. For care in a Super Special Hospital the following additional benefits are granted:
 - a) Reimbursement of airfare up to a maximum of US\$ 500 if care is received in a Super Special Hospital and the claim is payable according to the certificate benefits.
 - b) Discount of up to 50% for treatment of declared pre-existing conditions excluded in this insurance.
2. Specific medications or treatment used as an alternative to Inpatient care will be covered when approved in advance in writing by the Administrator. To be approved, a copy of the prescription or type of care must be submitted to the Administrator in advance. Original itemized receipts must accompany any claims.

Emergency Air Transportation

Daily lodging cost of one companion during treatment of the Insured US\$ 200 per day for a maximum of 5 days. Cost of economy airfare of one companion accompanying the Insured. Cost of return journey by economy airfare for the Insured only, if certified as being fully recovered. The Administrator, American Medical Services, or its designee, will retain the right to decide the place for the treatment.

This coverage is subject to:

- 1.- The Insured complies with the Administrator's, American Medical Services, or its designees' instructions.
- 2.- The treatment necessary is not available in the country where the event occurred.

Accidental Loss of Use Coverage:

If the main insured or spouse (if insured on this certificate) loses the Use of: 1) One Hand, or 2) One Foot, or 3) One Arm, 4) One Leg, or 5) Sight of Both Eyes due to an accident during the time that this certificate is in force. *See Certificate Provisions and Definitions for full details.*

US\$ 3,000 Maximum per Month for 36 months, then a lump sum of 30 times the monthly benefit

POLICY ADMINISTRATION

The policy, Policy Provisions and Definitions, General Conditions, General Exclusions, Specific Exclusions, Certificate of Coverage, Schedule of Benefits, Application for Coverage, Organ Transplant Section (if any), and any Amendments or Endorsements attached to the contract constitute the entire contract between the parties. The English version shall be the official version and the terms of the English language version shall control.

AUTHORITY

No agent, broker, or any other person has authority to change the policy or to waive any of its provisions. No change in the policy shall be valid unless approved in writing by an officer of the Company and such approval be endorsed on the policy or by amendment signed by a Company officer.

REPRESENTATION

The broker/agent that sold this policy is the representative of and is acting on behalf of the Insured and not the Company or Morgan-White Administrators International Inc. Neither the Company nor Morgan-White Administrators International Inc., can be held liable for any circumstance if the broker/agent, who sold this policy, fails now or in the future to transmit or communicate any documentation or funds from Morgan-White Administrators International Inc., to the Insured and/or any documentation or funds from the Insured to Morgan-White Administrators International Inc.

NOTIFICATION OF MEDICAL CARE

- 1) The Insured must notify the Administrator at least fifteen (15) days in advance of receiving any Inpatient treatment, all as per the Pre-Certification process on page four (4) of this insurance document.
- 2) The Insured must notify the Administrator at least seventy-two (72) hours in advance of receiving any Outpatient surgical procedure that is medically necessary.
- 3) The Insured must notify the Administrator within forty-eight hours (48) of admittance to a Hospital for emergency treatment, all as per the Pre-Certification process on page four (4) of this insurance document.

If the Insured fails to notify the Administrator as stated herein, the Insured will be responsible for thirty (30%) percent of all covered medical and Hospital charges related to the claim in addition to the Deductible and Co-Insurance, if applicable.

PAYMENT OF CLAIMS

The Company will make all payments of claims directly to the Insured. If the Insured has assigned the benefits of this policy to any provider of services, the payment will be made directly to that provider. All such payments to be made in accordance with the Covered Charges Provision on page seven (7) paragraph ten (10) of this policy.

Submission of a fraudulent claim will be grounds for cancellation of the policy by the Company.

PRECERTIFICATION OF HOSPITAL ADMISSION AND/OR HOSPITAL CONFINEMENT

Hospital Admissions must be Pre-Certified

- a: In the case of a non-emergency hospital confinement, the Insured or the admitting Physician must contact the Administrator a minimum of fifteen (15) days prior to Hospital admission to certify admission, based upon proven medical necessity.
- b: In the case of an emergency admission, the Hospital in which the Insured individual is confined must contact the Administrator within forty eight (48) hours of the admission and/or confinement regardless of whether or not said individual has been discharged.

Failure to comply will result in reduced benefits. (See Specific Exclusion number 35)

COORDINATION OF BENEFITS

The Insured person is not entitled to receive duplicate payment of benefits from this policy in addition to those provided under any other insurance or benefit plan. Where another policy is in existence which provides benefits also covered by this policy, all claims must be made in the first instance against the other policy. This policy shall only then provide benefits, not to exceed 100% of the claim, when such benefits payable under the other policy have been exhausted.

PROOF OF CLAIM

Written proof of loss must be furnished to **Morgan-White Administrators International, Inc., 3191 Coral Way, Suite 704 Miami, Florida, 33145, U.S.A.** or to a claims office in Your local area appointed by the Company, within ninety (90) days after the date of such loss. Failure to submit proof of a claim within ninety (90) days of its occurrence shall serve to invalidate the claim. Original itemized receipts must be submitted with the Company's claim form. Photocopies of receipts are not acceptable. Exchange rates for payments not in U. S. dollars will be in accordance with the actual exchange rate at the time the fully documented claim occurred. The Company may change the administrative procedures by written notice.

REFUSAL TO REPATRIATE

The Company and American Medical Services reserve the right to repatriate an Insured to His De Facto Country of Residence in consultation with the treating Physician. Refusal to comply with the transfer request will absolve the Company and American Medical Services of any liability and the coverage will cease.

INSURED AMOUNT

The maximum benefit allowable under this policy for any one Policy Year is as stated on the Schedule of Benefits. Under no circumstance can any combination of benefits payable under this policy exceed the Insured Amount as stated on the Schedule of Benefits in any one Policy Year nor can this policy pay more than \$1,000,000 for the lifetime of any one insured.

SUBROGATION

In the event You incur medical expenses as a result of negligence, wrongdoing or other liability of a third party, the Company has a right to recover and be reimbursed for any claim payments it has made on Your behalf, to the extent that You have received partial or full recovery from any liable third party for such medical expenses. This right is known as subrogation. The Company has the right to proceed at its own expense in the name of the Insured person, against third parties who may be responsible for causing a claim under this policy, or who may be responsible for providing indemnity or benefits similar to this insurance. The Company has full rights of subrogation.

PHYSICAL EXAMINATIONS

The Company, at its own expense, shall have the right and opportunity to have a licensed medical practitioner examine any Insured whose Injury or Sickness is the basis of claim when and as often as it may be reasonably required while a claim is pending. The Company shall have the right and opportunity to require an autopsy in the case of death, when not forbidden by law or religious practices. The Insured shall make available to the Company all medical reports and records, and when required, shall sign all authorization forms necessary to give the Company a full and complete medical history. The refusal of Your doctor or Hospital to make all medical reports and records available to the Company could cause an otherwise valid claim to be denied or the claim to be closed due to no or insufficient reply from the Insured's medical providers.

DISPUTES AND LEGAL ACTIONS

The parties hereon agree that any and all disputes, claims, or controversies arising out of or relating to this policy, or its alleged breach, that are not resolved by the parties hereon, shall be submitted to final and binding arbitration. Such arbitration shall be conducted in the City of Hamilton, Bermuda in accordance with Commercial Arbitration Rules of the American Arbitration Association, and judgement on any award rendered in such arbitration may be entered in any state or federal court in such City. Such arbitration shall be the sole remedy for any disputes, claims or controversies on this policy. Notices in connection with such arbitration and process in any judicial proceeding in connection herewith may be served by personal delivery or registered mail or via courier to the Company at its home office, and to the Insured at the most current address appearing on the records of the Company, with the same

effect as if personally served, sent by registered mail or via courier in such City. The Insured must file the request for arbitration to the Company within one hundred and eighty (180) days of the event which brought about the dispute, claim or controversy between the parties hereon. **Failure of the Insured to give such notice to the Company within the one hundred and eighty (180) day period will relieve the Company of any and all liability for the dispute, claim or controversy.** The Company's liability in any such arbitration shall be limited to such amounts that are specified under this policy, with such interest thereon and such costs of the arbitration proceeding, if any, as the arbitrators may direct. In no event shall the Company be liable for any extra-contractual damages, whether characterized, without limitation, as consequential, exemplary, punitive or tort damages, for any disputes, claims or controversies arising out of or relating to this policy.

ELIGIBILITY

Persons and their Dependent(s) who are less than seventy-four (74) years old are eligible for this insurance. This policy is not available to any permanent resident of the United States of the America who has been assigned a social security number. This policy has not been filed with or approved by any insurance regulatory authority in the United States of America.

GOVERNING LAW

Any matters relating to interpretation of this policy including any matters relating to the representations of the Insured in connection with the application for or issuance of this policy shall be resolved in accordance with the contract laws of Bermuda.

SEVERABILITY

If any provision of this policy is found to be unenforceable, such provision shall be considered severed from the remaining provisions of this policy and such remaining provisions shall be and remain in full force and effect.

COMMENCEMENT OF BENEFITS

Covered benefits become payable on the Effective Date of the policy for the costs of any medical condition resulting from Accident or Infectious Diseases. No benefits will be payable for the costs of any other medical condition which manifests itself within one hundred and twenty (120) days of the Effective Date of the policy. The Company may elect to waive this provision if an international medical insurance policy was in force with another company for the Insured person for one continuous year with a termination date of no more than thirty (30) days immediately prior to the Effective Date of this policy. This is subject to receipt of the original prior policy and written verification of the termination date of the prior policy from the previous company. Benefits payable under this policy provision will be limited to the lesser of benefits provided by this policy or the prior policy.

RENEWAL CONDITIONS

This policy is an annual contract which, until terminated, may be renewed on the anniversary date as provided below:

- (1) If no notice of cancellation has been given by either party at least one month prior to renewal,
- (2) the premium coming due prior to the expiration has been received by the Company,
- (3) no condition of this policy has been breached by the Insured.

The Company through the broker who is representing You in Your Country of Residence, shall offer to renew this policy at rates and on the terms prevailing at the time for the class of the Insured. Alternatively, You can renew this policy on-line by visiting the website of MorganWhite Administrators International Inc. at www.morganwhite.com. Renewal of this policy on-line is deemed to have been completed in Bermuda.

Such offer may be accepted by payment of the renewal premium within thirty-days (30) or ten-days (10) if paid on-line, of the renewal date. Upon payment for each renewal a new Certificate of Coverage will be issued as evidence that insurance is in force.

The Company agrees that no individual Insured person shall be independently penalized by cancellation of the policy or rate increase due to a poor claims record. Any policy cancellations or rate increases will only be made by Class of Insured not by individual Insured.

PAYMENT OF LOSS OF USE BENEFITS

Accidental Loss of Use Monthly Benefits will be paid as follows:

Monthly Loss of Use Benefits will be paid by the Company to an Insured Person when the Insured Person has satisfied the Waiting Period and the Elimination Period of ninety (90) days. Monthly Loss of Use Benefits will not exceed the maximum Monthly Loss of Use Benefits shown in the Schedule of Benefits and such payments will not exceed the Maximum Benefit Period of thirty six (36) months if the Accidental Injury caused an Insured Person to experience any of the following within three hundred and sixty-five (365) days after the Accident:

Loss of Use of:

- 1) One Hand, or 2) One Foot, or 3) One Arm, 4) One Leg, or 5) Sight of Both Eyes.

TEMPORARY EMERGENCY COVERAGE

From the time of the application and total premium for this policy is received by the Company, through the date the policy is issued or, thirty (30) days from the date the application is received, whichever date comes first, the Company agrees to insure all proposed Insureds for the covered medical expenses resulting from Accidental bodily Injury up to a maximum benefit of US\$25,000 per policy. This temporary Accident coverage is subject to and governed by the respective policy terms, provisions and exclusions which would have been applicable, had the policy been in effect on the date of the Accident of the proposed Insured. This benefit is subject to the Deductible and Co-Insurance for the plan chosen by the proposed Insured.

This benefit does not apply if the application is declined for any reason. The injuries sustained in an Accident while the application is being evaluated cannot be the sole reason to decline an application.

POLICY PROVISIONS AND DEFINITIONS

The following provisions and definitions apply to this policy :

1. **ACCIDENT:** means any sudden and unforeseen event occurring during the policy period resulting in bodily Injury independent of disease or bodily infirmity, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control.
2. **ALL INCLUSIVE:** means that this benefit does not relate to any other benefits on the Schedule of Benefits. The maximum benefit specified is all that will apply to that benefit and all expenses incurred will accrue towards the maximum for the stated benefit.
3. **APPLICANT:** means the individual who executed the application for coverage.
4. **ANESTHESIOLOGIST FEES:** means the charges made by an anesthesiologist in the performance of a surgical procedure or for medically necessary pain control.
5. **ANNIVERSARY DATE:** means the renewal date of the policy.
6. **CLASS:** means characterizations of all policies of the same type, including but not limited to: Deductible's, policy origination date, age, group, geographical area, plans, or a combination of the above.
7. **CHEMOTHERAPY:** means the treatment of disease by chemical agents, first applied to the use of chemicals that affect the causative organism unfavorably, but do not harm the patient.
8. **CO-INSURANCE:** means the portion of the medical bills an Insured must pay per Policy Year. The percent of Co-Insurance is specified on the Schedule of Benefits.
9. **CONGENITAL DISORDERS OR ILLNESSES:** means any disorder or illness existing at, or before birth regardless of its cause, whether or not manifested or diagnosed at birth, after birth or years later.
10. **COVERED CHARGES:** means in the Company's judgment, the charges that are not excessive, for Covered Services. Judgment will be based on one or a combination of the following:
 - (1) a negotiated rate based on services provided;
 - (2) a fixed rate per day; or
 - (3) the Reasonable and Customary (R&C) allowance for similar providers who perform like Covered Services.
- (4) for claims incurred in a Network Hospital that are paid directly to the Hospital by the Insured will be reimbursed at the Network Hospital negotiated rates, but reimbursement will never exceed the amount actually paid by the Insured.
11. **COVERED SERVICES:** means services for which benefits will be paid when provided by a provider acting within the scope of their license. In order to be considered a Covered Service, charges must be incurred while Your coverage is in force.
12. **COSMETIC SURGERY:** means surgery which is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.
13. **COUNTRY of RESIDENCE:** means the De Facto Country of Residence of the Insured. The Country of Residence must be declared on the application form. If the Insured changes His Country of Residence, He must immediately notify the Company about His new Country of Residence. Failure to do so may result in the invalidation or termination of coverage.
14. **CURRENCY:** means payments related to this policy are in U.S. Dollars unless otherwise stated.
15. **CUSTODIAL CARE:** means care which is not skilled care.
16. **DE FACTO COUNTRY of RESIDENCE:** means the country stated in the application, but if an Insured is present in another country for one hundred and eighty (180) or more days, consecutively, the most recent such country shall become His or Her De facto Country of Residence. If the De facto Country of Residence should become the United States of America then treatment for any covered medical expenses shall be rendered only at the Company's Super Special Hospitals. If a consultation is needed with a general Physician then reimbursement will only be made if the Physician is part of the Company's Network of Doctors. If, for any reason, treatment is not delivered at a Super Special Hospital or by a Network Doctor during the time Your Country of Residence is the United States of America, then Your Out of Country Deductible will double and Co-Insurance of fifty percent (50.00%) will apply to all covered medical expenses.
17. **DEPENDENT(S):** means following persons are provided coverage while the contract is in effect:
 - a. The primary Insured's spouse.
 - b. Any of the following who qualify as the primary Insured's Dependent(s) until they reach the age of eighteen (18) unless they are full time students in an accredited college or university and then until they are twenty five (25) years of age.
 1. unmarried children

2. unmarried stepchildren;
3. unmarried adopted children of the primary Insured or the primary Insured's spouse, from the earlier of:
 - (a) the date of placement for the purpose of adoption; or
 - (b) the date of entry of a court order granting the adoptive parent custody of the child for adoption;
4. or unmarried children for whom the primary Insured or the primary Insured's spouse has legal guardianship.

Coverage for a newly adopted child will continue for thirty (30) days unless the placement is disrupted prior to legal adoption and the child is removed from placement. For coverage beyond the first thirty (30) days, You must apply to the Company to add the adopted child to the policy. This requires an application to be completed and may also require additional premium. You must apply to the Company within the thirty (30) day period after placement or entry of a court order.

18. **DIAGNOSTIC SERVICES:** means the following procedures are covered when ordered by a provider because of specific symptoms in order to determine a definite condition or disease:
 - a. radiology, ultrasound, and nuclear medicine;
 - b. Laboratory and pathology; and
 - c. EKG's, EEG's, and other electronic diagnostic medical procedures.
19. **DEDUCTIBLE PER POLICY:** means a specific amount selected by the applicant which constitutes the initial responsibility of the Insured at the moment a loss occurs. The selected Deductible will be applied once per Policy Year according to the Schedule of Benefits.
20. **ELIMINATION PERIOD:** means a period of consecutive days that an Insured Person is continuously Disabled before any Monthly Loss of Use Benefit is payable. No Monthly Loss of Use Benefit is payable during the Elimination Period. The duration of the Elimination Period is shown on the Schedule of Benefits. The Elimination Period begins on the first day of Disability occurring after the Effective Date of this policy and if the Waiting Period has been satisfied if applicable.
21. **EMERGENCY DENTAL TREATMENT:** means the cost of Emergency Dental Treatment and dental procedures necessary to restore or replace sound natural teeth lost or damaged in an Accident.
22. **EMERGENCY TRANSPORT:** means the imperative evacuation of an Insured to the nearest medical institution for immediate medical care by a ground or air ambulance.

(a) **Ground Transportation/Ground Ambulance:** Transportation and related expenses to the nearest center where adequate medical facilities are available by ground emergency vehicle. Must take place within the country where the related medical event occurred.

(b) **Air Transportation/Air Ambulance:** Transportation and related expenses to the nearest center where adequate medical facilities are available. American Medical Services or the Administrator and the Company retain the right to dictate the place the Insured person shall be transported. The following provisions apply:
 (1) Emergency air transportation must be considered medically necessary and approved by the Administrator or American Medical Services. No air transportation will be paid unless approved in advance of the transportation and coordinated by American Medical Services.

(2) Medically necessary means the treatment cannot be provided locally and transportation by any other method would result in loss of life.

(3) American Medical Services, the Administrator and the Company are held harmless for delays or restrictions on flights by weather, by mechanical problems, by government officials, or by the pilot, due to operational conditions. The contract organization providing the service shall use diligence in selecting persons and equipment to provide the required service. If outside contractors are used, the organizations listed above shall not be liable for any negligence or tortious acts resulting from such service. Should treatment be available locally, but the Insured person chooses to be treated elsewhere, transportation costs shall be the responsibility of the Insured person.

23. **EXPERIMENTAL/INVESTIGATIONAL:** means all services or supplies associated with:
 1. Treatment or diagnostic evaluation which is not generally and widely accepted in the practice of medicine in the United States of America or which does not have evidence of effectiveness documented by peer review in medical journals published in the United States of America. For the treatment or diagnostic evaluation to be considered effective, such journals should indicate that it is more effective than others available; or if less effective than other available treatments or diagnostic evaluations, is safer or less costly;
 2. A drug which does not have United States Food and Drug Administration (FDA) marketing approval; or
 3. A medical device which:
 - a. Does not have FDA marketing approval; or
 - b. Has FDA approval under 21 CFR 807.81, but does not have evidence of effectiveness for the pro-

posed use documented in peer review articles in medical journals published in the United States of America.

For the device to be considered effective, such articles should indicate that it is more effective than other available devices for the purposed use; or if less effective than other available devices, is safer or less costly.

The Company will make a final determination as to whether a service or supply is Experimental/Investigational.

24. **EMERGENCY TREATMENT:** means any sudden and unforeseen event occurring during a Policy Year resulting in the Insured seeking Emergency Treatment as an Inpatient in a Hospital. There is no coverage for Emergency Treatment if treatment sought was as a result of an undeclared Pre-Existing Condition, nor for treatment which the Insured had sought medical advice during the last twelve (12) months pre-ceding the Emergency Treatment or, in the opinion of the Company, the Emergency Treatment is deemed unnecessary.
25. **GRACE PERIOD:** means that period of time after the policy has lapsed due to non-payment of premium during which time the Insured may continue coverage upon receipt by the Administrator of payment in full of the premium due. The Company will allow a thirty-day (30) Grace Period for annually and semi-annually paid premiums and ten (10) days for monthly paid premiums.
26. **GROUND TRANSPORTATION:** means emergency transportation to a hospital by Ground Ambulance.
27. **HAZARDOUS ACTIVITIES OR HAZARDOUS SPORTS:** means any activity or sport requiring skill or physical prowess, often of a competitive nature, that exposes the participant to any unavoidable danger or risk with the lack of predictability, even though the danger or risk is often foreseeable. Examples of hazardous activities or sports include but are not limited to: sky diving, mountain climbing, rock climbing, rodeo, bullfighting, any type of aviation sport, caving and pot-holing, rafting or canoeing involving white water rapids in excess of grade 5, parachuting, paragliding, hang-gliding, para-sending, test of velocity, motorcycle racing, motor sports or competition, scuba diving at a depth of more than thirty (30) meters, boxing, jockeying, bungee jumping, polo, participation in any extreme sport or participation in any sport for compensation or as a professional.
28. **HOSPITAL:** means a facility which is a short-term acute care general Hospital and which:
 1. is a duly licensed facility;
 2. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or

under the supervision of Physicians, for compensation from its patients;

3. has organized departments of medicine and major surgery; and
4. provides 24-hour nursing service by or under the supervision of registered nurses.
5. is under the constant supervision of a Physician.

A Hospital is not a spa, hydro-clinic, sanatorium, rehabilitation institution/facility, nursing home, or home for the aged.

29. **HOSPITAL CONFINEMENT:** means an admission or admissions of an Insured as an overnight Inpatient in a Hospital or Hospitals for treatment. Readmission to a Hospital within ninety (90) days of discharge from a Hospital for the same or related condition shall be determined to be continuous and to constitute a single confinement.
30. **HOSPITAL SERVICES:** means medically necessary treatments ordered by a Physician and provided to the Insured who is admitted as a registered Inpatient to a Hospital.
31. **INFECTIOUS DISEASE:** means common communicable contagious diseases caused by parasites, bacteria, protozoa, fungi or viruses.
32. **INJURY:** means bodily Injury which is not self inflicted, is caused by an Accident and which occurs after the policy is in force.
33. **INPATIENT:** means a patient who has been admitted upon orders of a Physician primarily for treatment as a bed-patient in a Hospital for at least twenty four (24) continuous hours, not in an emergency room.
34. **INSURED(S):** means the individual for whom an application has been completed or in the case of Dependent(s), those individuals whose names have been declared on the application form, and for whom commencement of coverage has been confirmed by the Company on the Certificate of Coverage and who have been issued a policy and for whom the premium has been paid.
35. **LABORATORY and X-RAY SERVICES:** means medically necessary Laboratory testing procedures and radiographic and nuclear medicine procedures used to diagnose and treat medical conditions. Laboratory and X-Ray Services must be ordered by a licensed Physician.
36. **LOSS OF USE:** means the total and irrecoverable Loss of Use of a Hand, Foot, Arm or Leg of an Insured person and such loss is considered to be permanent and due to an Accidental Injury. With reference to the Eyes means the irrecoverable loss of an Insured person's sight in both Eyes and such loss is considered to be permanent due to an Accidental Injury.

37. **MATERNITY:** means prenatal, childbirth and postnatal treatment for the mother **ONLY**. Benefits will only apply if maternity is covered on the Schedule of Benefits and only for pregnancies where the actual date of birth of the child/children is at least twelve (12) months after the policy Effective Date. The father and mother of the child must both be covered continuously on this policy for twelve (12) months prior to delivery.

38. **NEWBORN COVERAGE:** a) The newborn will be covered automatically for the first thirty-one (31) days after birth, if born under a covered pregnancy. b) If any newborn, from a covered Maternity, is added to this policy beyond thirty-one (31) days, the Company require an application and birth certificate and the appropriate premium to be paid. If the application and additional premium is not received within thirty-one (31) days of the covered birth, the coverage for that child is automatically terminated.

39. **OUTPATIENT SERVICES:** means medically necessary treatments provided for the Insured when the Insured is not a registered Inpatient overnight in a Hospital, or in any other facility for medical care. Outpatient Services include services performed in an Outpatient surgical center or emergency room.

40. **PAYMENT DUE DATE:** means the day the policy's payment is due, as stated on the Certificate of Coverage.

41. **PHARMACY:** means any licensed facility which operates to compound or dispense drugs. If facilities are located outside of the United States of America, the facility must be approved by the relevant authority in that country.

42. **PHYSICIANS or DOCTORS:** means a person who is licensed to practice medicine and surgery as a Doctor of medicine while acting within the scope of their practice and to the extent that benefits are provided.

Assisting Physicians or surgeons are Doctors/Physicians assisting in the performance of the surgical operation but only when an assisting surgeon is medically necessary for that operation and limited to the lesser of :

- (a) 20% of the Reasonable and Customary fee for the surgeon, or
- (b) 20% of the fee charged for the surgical procedure, or
- (c) special rates established for an area or country and approved by the Company.

The Company will only pay for a maximum of one (1) assistant physician or surgeon.

Anesthesiologist's Fees are limited to the lesser of the same charges listed for the assistant surgeon.

43. **POLICY YEAR:** means a period of twelve (12) consecutive months beginning on the policy Effective Date.

44. **PRE-EXISTING CONDITIONS:** means any condition or consequence related to a medical condition, which (1) manifests itself prior to the Effective Date of the policy or its Reinstatement, which was diagnosed by a Physician, or (2) for which medical advice or treatment was recommended by or received from a Physician prior to the Effective Date of the policy; or (3) any obvious symptom which, if presented to a Physician would have resulted in a diagnosis.

There are two types of Pre-Existing Conditions:

(a) **DISCLOSED AT THE TIME OF THE APPLICATION:** Means any medical condition, which manifests itself prior to the Effective Date on the Policy of Insurance or its Reinstatement. If a pre-existing condition is fully and accurately disclosed on the application, and the condition is not excluded or restricted by an exclusionary rider, your pre-existing condition will be covered after you have been continuously insured by this policy for twelve (12) months. This is called the pre-existing condition waiting period.

Pre-existing conditions are any Injury or Illness that meets the following criteria: 1) A condition that would have caused a person to seek medical advice, diagnosis, care or treatment prior to the Effective Date of coverage under this Policy; 2) A condition for which manifestation, medical advice, diagnosis, care or treatment (including medication) was recommended or received prior to the Effective Date of coverage under this Policy; 3) Expenses for Pregnancy within twelve (12) months of the Effective Date of coverage under this Policy.

The following illnesses which exist, manifest themselves or are treated or have treatment recommended prior to or during the first 180 one hundred eighty days of coverage under this Policy beginning on the initial Effective Date are considered pre-existing conditions and are subject to the pre-existing condition waiting period and other limitations of coverage described above: any condition of the breasts, any condition of the prostate, disorders of the reproductive system, or conditions of the back or spine. Note: coverage for such illnesses or surgeries may be further limited under the pre-existing condition limitations or exclusions and definitions of the Policy. Disclosed Pre-Existing Conditions, unless specifically excluded by endorsement or an amendment to the policy are covered after 12 months of continuous coverage under this policy or the period of time declared on the Schedule of Benefits page of this policy, whichever is longer.

(b) **UN-DISCLOSED AT THE TIME OF APPLICATION:** The Company reserves the right to insure persons considered to be in good health and good moral risk. Un-disclosed Pre-Existing Conditions prevent the Company from making the proper evaluation of the risk. Consequently, Un-disclosed Pre-Existing Conditions are not covered and could result in the

denial of a medical claim and/or the cancellation or rescinding of this policy. (See Exclusion 32 & Exclusion 43).

45. **PRESCRIPTION DRUGS:** means medications whose sale and use are legally restricted to the order of a Physician and do not include items that may be purchased without a Physician's prescription.
46. **PROTECTION AGAINST UNNECESSARY MEDICAL CHARGES:** means when the Company acts upon the Company's review organization's recommendations not to pay for the care and services that the Company's Physician consultants have decided were not medically necessary, it is likely that the provider (the Hospital, the Doctor, or both) will try to collect the unpaid portions of claims from the Insured. When this happens, the Company will hold the Insured harmless. Holding the Insured harmless means that, if it is determined in a court of law that the Company's review organization's decisions were incorrect, the Company will assume the Insured's liability for payment of the disputed medical care, less Deductible's or Co-Insurance and charges not covered by this policy.
47. **REINSTATEMENT:** means after the Grace Period has expired, the Company will consider its Reinstatement only after receiving an application for Reinstatement and payment of premium back to the date of the termination. The reinstated policy shall cover only losses resulting from Injury that are sustained after the date of Reinstatement and those losses due to Sickness that manifests itself not less than ten (10) days after the date of Reinstatement. No Reinstatement application will be accepted if received by the Company ninety (90) days or more after the date the policy lapsed due to non-payment of premium. The Company reserves the right to request medical information and/or issue any amendment/endorsement deemed necessary.
48. **REQUIRED SECOND SURGICAL OPINION:** means if a qualified surgeon has recommended that an Insured person undergo a non-emergency surgical procedure, the Insured must notify the Administrator at least seventy two (72) hours prior to the scheduled procedure. The Company reserves the right to require the Insured person to obtain a Second Surgical Opinion for which the Company will pay one hundred (100%) percent of the cost. Arrangements for such Second Surgical Opinion will be made by the Administrator on behalf of the Company. In the event the second surgical opinion is not in the affirmative, the Company will also pay for a third opinion. If the second or third opinion confirm the need for the proposed surgery, benefits for the surgery will be paid according to the Schedule of Benefits, provided that the surgery is performed by the original surgeon.

If the Company requires a Second Surgical Opinion and the surgery for a non-emergency and elective procedure is performed without first obtaining a confirming opinion, covered benefits for all charges related to the surgery will be reduced by a minimum of thirty (30%) percent or may be completely denied.

49. **RECONSTRUCTIVE SURGERY:** means surgery which is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.
50. **REASONABLE AND CUSTOMARY (R&C):** means:
1. **Reasonable:** a charge that meets the **Customary** criteria and, that in the judgment of the Company, is not an excessive amount for similar services or supplies; or, a charge that merits special consideration due to complexity of treatment in the opinion of a review committee or consultant.
 2. **Customary:** the amount charged by a majority of providers in the same geographic area for similar services or supplies and is relative to the value and worth of similar services;
- If a provider accepts as full payment, in the absence of insurance, an amount less than R&C, the lesser amount will be the maximum R&C. The Company will pay the lesser of the actual billed charge or the R&C.
51. **SICKNESS:** Sickness means illness or disease the symptoms of which first manifests itself while the policy is in force.
52. **THE COMPANY:** means AmFirst Insurance Company Ltd.
53. **WAITING PERIOD FOR LOSS OF USE:** Means the time beginning at the policy Effective Date and ending ninety (90) days thereafter. No claim will be paid for Illnesses, which first manifests itself and causes Disablement of an Insured during this time.
54. **WE, OUR OR US:** means AmFirst Insurance Company Ltd.
55. **HE, HIS, HER, YOU, YOUR OR FAMILY:** means the main Insured and/or any Dependent(s) included in this policy.

General Conditions

1. This policy, Policy Provisions and Definitions, General Conditions, General Exclusions, Specific Exclusions, Certificate of Coverage, Schedule of Benefits, Organ Transplant Section (if any), Amendments or Endorsements, and the written Application for Coverage make up the entire contract and shall be read together as one contract. Any word or expression to which a specific meaning has been attached in any part of this policy shall bear such specific meaning, wherever it may appear.
2. The Insured, including any person to whom this insurance applies, shall at all times take reasonable precautions to prevent Accidents, loss or Injury.
3. If the circumstances in which the insurance was entered into shall be materially changed, this policy shall be voidable.
4. The due observance and fulfillment of the terms, conditions and limitations of this policy insofar as they relate to anything to be done or complied with by the Insured, and the truth of the statements and answers in the said application, shall be conditions precedent to any liability of the Company to make any payment under this policy.
5. If any claim under this policy shall be in any respect fraudulent or if any fraudulent means or devices are used by the Insured or anyone acting on behalf of the Insured under this policy, all benefits thereunder shall be forfeited. If any past or present provider of medical services or medications refuses, is unwilling, is unable, cannot locate or trace an Insured's past medical records, after being presented the Insured's authorization to inspect those records, all benefits under this policy shall be forfeited and the policy shall be voidable. The Company reserves the right to determine whether it has enough information on which it bases the validation of any claim submitted and the burden of providing all medical records to the Company shall be upon the Insured.
6. It is a condition of this policy that the Insured must sign and date the Company's medical release form when submitting a claim to the Company for consideration. The medical release form will authorize the Company to obtain medical records from any provider. Failure to do so will result in a forfeiture of all benefits otherwise due under a claim submitted by an Insured.
7. The policy will become null and void unless the Company is notified of any change in the De Facto Country of Residence of the Insured within thirty (30) days of the change. All terms and conditions are subject to revision upon a change in the De Facto Country of Residence.
8. Neither the Company, American Medical Services, the Administrator nor any of their agents shall be responsible for the availability, result, or quality of any medical care, treatment, or transportation, nor for the failure of the Insured to receive medical treatment.
9. The legal representative of an Insured shall have the right to act for an Insured who is incapacitated or deceased.
10. In the event the Company cancels or otherwise invalidates this policy due to the Insured's failure to disclose past medical history or Pre-Existing Conditions, the Company reserves the right to recover from the Insured all costs and fees incurred in reasonably investigating those matters not fully disclosed. Recovery may be accomplished in any lawful manner including deduction of those costs and fees from any unearned premiums otherwise due the Insured.
11. If an Insured or the Company cancels the policy after it has been issued, the Company will refund the unearned portion of the premium, less policy fees and any policy expenses paid. The unearned portion of the premium is based on the number of months corresponding to the payment mode. Policy expenses include commissions, claims handling and administrative fees.
12. Benefits payable pursuant to the terms and conditions of this policy shall cease upon the death of the insured, which, for the purposes of this policy, shall be defined as the time at which irreversible cessation of that person's brain function occurs.

General Exclusions

The Company shall not be liable for any consequence whether directly or indirectly, proximately or remotely, occasioned by, contributed to, by or traceable to, or arising in connection with:

- (I) War, invasion, act of foreign enemy, hostilities or warlike operations (whether war is declared or not) or civil war.
- (II) Mutiny, riot, strike, military or popular uprising, insurrection, rebellion, revolution, military or usurped power.
- (III) Any act of any person acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the government de jure or de facto or to the influencing of it by terrorism or violence.
- (IV) Martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege (hereinafter for the purposes of this Exclusion called the "Occurrence").
- (V) Committing or attempting to commit a criminal offense, or provoking an assault.
- (VI) Any act of terrorism.
- (VII) Any radioactive contamination.
- (VIII) Nuclear/Chemical/Biological Terrorism in any way caused or contributed to by an act of war or terrorism involving the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent.

The Company and the Insured agrees that regardless of any contributory cause(s) this insurance does not cover any claim(s) in any way caused or contributed to by an act of war or terrorism involving the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent.

For the purpose of this exclusion an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purpose or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

Any consequent happening or arising during the existence of abnormal conditions (whether physical or otherwise) whether directly or indirectly, proximately or remotely, occasioned by or contributed to, traceable to or arising in connection with any of the said Occurrences shall be deemed to be a consequence for which the Company shall not be liable under this policy except to the extent that the Insured shall prove that such consequence happened independently of the existence of such abnormal conditions.

In any action, suit or other proceeding where the Company alleged that by reason of this exclusion any consequence is not covered by the policy, the burden of proving that such consequence is covered shall be upon the Insured.

Specific Exclusions

Any treatment or medication or the consequences thereof, or charges related to the following are not covered under this policy unless specifically included or changed on the Schedule of Benefits:

1. Emergency transportation or repatriation expenses which are incurred without the prior approval of American Medical Services or the Administrator.
2. The amount of the selected Deductible and Co-Insurance when applicable per Policy Year.
3. Treatment of mental illnesses, dementia, Alzheimer's disease, psychiatric, psychological or behavioral disorders and maintenance in a mental facility.
4. Cosmetic surgery and associated treatment.
5. Any operation or treatment pending at the time of inception of the coverage.
6. All hazardous activities and hazardous sports. This does not include normal vacation sports such as skiing or snorkeling. However, based on the "Prudent Man Rule", the Company will deny claims when it is determined that risk or negligence was a factor. Other sports will also be excluded where they involve a higher risk due to inexperience, lack of care, or knowledge of overly dangerous conditions.
7. Bodily Injury sustained while under the influence of or disablement due wholly or partly to the effects of intoxicating liquor or drugs (other than taken in accordance with treatment prescribed by a Physician, but not for treatment of drug addiction), or with a blood alcohol level of 100mg percent or You are above the legal level of alcohol consumption within the country or jurisdiction where the event occurs.
8. Claims or treatment related to a willfully self-inflicted Injury .
9. Any claims for dental treatment or care or orthodontic treatment except in case of Accidental Injury to sound teeth. Such Accident treatment must take place within thirty (30) days of the Accident.
10. Routine physical exam's, check-ups, examinations and related diagnostic tests. This includes vaccinations and prophylactic mammograms.
11. Any claim arising directly or indirectly from any death, Injury, illness, expense or other liability attributable to Human Immunodeficiency Virus (HIV) and/or HIV illness including Acquired Immune Deficiency Syndrome (AIDS) and/or any mutant derivative or variations thereof, however caused.
12. Treatment for Chronic Fatigue Syndrome or related conditions including, but not limited to diagnostic workups.
13. Treatment that is considered experimental or research oriented or is not scientifically or medically recognized by United States standards, including, but not limited to, acupuncture and homeopathic medicine.
14. Claims and costs of medical treatment incurred after the expiration date of the policy, resulting from Accidents or illnesses which occurred during the policy period.
15. Any charges arising from the Insured's treatment of any bodily Injury or Sickness for which the person for whom the claim is being presented is not under the regular care of a qualified Physician or which are not authorized or prescribed by a qualified Physician.
16. Treatment in any governmental facility or any expense if the individual would be entitled to care at no expense to the Insured.
17. Any portion of any charge which is in excess of the Reasonable and Customary charge for the particular service or supply in the area where it is incurred.
18. Any expense for male or female sterilization, reversal of sterilization, sex change or implantation, or treatment for sexual transformation, sexual dysfunction or inadequacies.
19. Cost of any unwed pregnancy or any type of abortion (and its consequences) unless imminent material demise exists.
20. Artificial insemination or test and treatments of or related to treatment of infertility.
21. Any expense, service or treatment for any form of food supplement or augmentation (unless necessary to sustain life in a critically ill person), or for any program for weight control, including any program of exercise activities, whether for obesity or any diagnosis and whether by diet, injection of any fluid, or use of any medications or surgery of any kind.
22. Chiropractic or podiatric care including foot care in connection with corns, calluses, flat feet, weak arches, weak feet, or symptomatic complaints of the feet, and shoe inserts of any type.
23. Any charges arising from any treatment, service or supply which are not medically necessary.
24. Treatment by a family member.
25. Sickness which manifests itself during the first one hundred and twenty (120) days after the inception of the Insured person into this insurance are not covered for the life of the policy.
26. Any claims or treatment related to sexually transmitted or venereal disease.
27. Routine eye and ear examinations, eye refraction, eye glasses, contact lenses, radial keratotomy, or hearing aids.

28. Services or treatment in any long term care facility, spa, hydro-clinic, weight loss clinics, rehabilitation institutions, sanatorium institutions for rest or custodial care, nursing home or home for the aged that is not a Hospital as defined in this policy.
29. Any claim or treatment related to human Organ Transplants in excess of the amount shown on the Schedule of Benefits.
30. Any claims related to non-human Organ Transplants or mechanical/artificial organs.
31. Any claims related to the purchase or rental of durable medical equipment outside of a Hospital including but not limited to: wheelchairs, crutches, oxygen tanks and walkers.
32. All treatments relating to Un-disclosed Pre-Existing Conditions are not covered for the life of this policy.
33. Treatment for any condition secondary to a condition which is excluded by the policy.
34. Treatment or charges related to any condition of the jaw or jaw joints including but not limited to jaw anomalies, and a condition known as TMJ or temporomandibular syndrome.
35. Any covered treatment which exceeds sixty (60%) percent of Reasonable and Customary expenses if Hospital admission was not pre-certified by the Administrator.
36. Illnesses and disease as a result of alcoholism, drug abuse or addiction to any substance, however caused and consequences or variations thereof.
37. Any treatment or medical care related to any Injury, illness or Accident that occurs while flying an airplane except while flying as a registered passenger on a regular commercial airline, operated by a professional commercial licensed pilot on regular scheduled flights between airports.
38. Any charges arising from any treatment, service, or supply which are related to the procedure known as organ transplant.
39. Any claims reimbursed by any Employer's Liability, Worker's Compensation or any Occupational Accident coverage.
40. All costs or treatment related to birth defects, including hereditary conditions and Congenital Disorders or Illnesses after thirty-one (31) days following birth unless included on this policy by endorsement.
41. Any claim arising where the Insured or any provider fails to provide medical records pertinent to the investigation of any claim submitted hereunder.
42. Any claim for maternity for any Dependent other than the spouse of an Insured.
43. Any declared Pre-Existing Condition, physical defect, infirmity, medical condition, or chronic or recurring illness which existed at the date of entry of an Insured into this insurance. This exclusion will remain in effect until the Insured has been continuously insured under this plan for one (1) year, if the Pre-Existing Condition has been declared on the application for coverage and not excluded from coverage.
44. Any claim for benefits (either Monthly Loss of Use Benefits or Lump Sum Benefits), after the anniversary date of the policy following the Insured's seventieth (70) birthday.

Assistance for emergencies and the following services are provided by:

American Medical Services

- 1. Pre-Trip Medical Referral Information:** American Medical Services will provide pre-trip referral information to primary Insured on countries and regions to be visited, including local multilingual doctors and/or addresses and phone numbers for Hospitals.
- 2. 24-Hour Worldwide Medical Information and Assistance:** The availability of any American Medical Services Worldwide Emergency Medical Center with multilingual medical staff on duty twenty four (24) hours a day who may be contacted for evaluation and referral. Calls may be made to any of the numbers listed to obtain the names of doctors or specialists in any area served by American Medical Services.
- 3. Emergency Evacuation:** When adequate medical facilities are not available locally, Morgan-White Administrators International Inc., or American Medical Services will arrange emergency evacuation under constant medical supervision by whatever means necessary to a facility capable of providing required care.
- 4. Medically Supervised Repatriation:** When medically advisable to hospitalize a primary insured nearer home, American Medical Services will make suitable arrangements for repatriation under medical supervision.
- 5. Repatriation of Mortal Remains:** In the event of a primary Insured's demise, American Medical Services will render every assistance possible to obtain clearances and arrange for return of mortal remains.
- 6. Embassy & Consular Information: American Medical Services** will provide primary Insureds with contact information for embassies and consulates worldwide.
- 7. Lost Document Assistance: American Medical Services** will assist with obtaining replacements if a primary Insured loses important documents while traveling - e.g. passport, credit cards.
- 8. Legal Access:** primary Insureds may call any American Medical Services Control Center for access to qualified attorneys available during regular working hours. Assistance will also be provided in obtaining Bail Bonds in those areas where such bonds are customarily issued. The primary Insured is responsible for contracted fees.
- 9. Claims Assistance: American Medical Services** will assist primary Insureds in coordinating overseas claims procedures with their insurance program.
- 10. Emergency Family Travel Arrangements: American Medical Services** will coordinate emergency travel arrangements for the family of the primary Insured who need to join a hospitalized primary Insured.
- 11. Return of Minor Children:** If Dependent children are left unattended as the result of a primary Insured's Accident, illness or death, American Medical Services will arrange one way economy air fare for them to their place of residence. Qualified attendants will also be arranged when required.

Notification of Claims

In the event of an Insured person becoming Hospitalized due to an Accident, notification must be given to the Morgan-White Administrators International Inc., office within forty-eight (48) hours or, as soon as is reasonably possible thereafter. Any other event which is likely to result in a hospital stay must be Pre-Certified by Morgan-White Administrators International Inc., in order to be able to receive full policy benefits.

TO PRE-CERTIFY A HOSPITAL STAY, VERIFY COVERAGE, REPORT AN ACCIDENT, RECEIVE INFORMATION ON NETWORK DOCTORS & HOSPITALS OR FOR CLAIMS INFORMATION: Write, call, fax or email

Morgan-White Administrators International, Inc.
3191 Coral Way, Suite 704
Miami, Fl. 33145

Telephone: (305) 442-0899
Fax: (305) 442-0961
Email: intlclaims@morganwhite.com

EMERGENCY TELEPHONE NUMBERS FOR WEEKENDS, HOLIDAYS OR IF OUT OF U.S.A. CALL:

American Medical Services

Monday-Friday 8:30 a.m. to 5:00 p.m Eastern U.S.Time

Telephone: (305) 442-0899
Toll Free in the U.S.A. 1 800 995-5335

For After Hours and on Weekends Call:

Telephone: (305) 476-0022
Fax (305) 442-0961

Organ Transplant Section

Schedule of Benefits

This policy will pay 100% of Covered Charges for benefits covered under the Organ Transplant Section necessarily and reasonably incurred up to the Maximum Lifetime Amount Assured of US\$500,000 per person for claims arising from a Covered Transplant Procedure less any Deductible and Co-Insurance, if applicable, for the following Covered Transplant Services:

Covered Transplant Procedures:

Any of the following medically necessary human organ and tissue transplants:

- | | |
|---------------|--------------------|
| 1. heart | 5. pancreas |
| 2. heart/lung | 6. kidney/pancreas |
| 3. lung | 7. kidney |
| 4. liver | |

Covered Transplant Services:

- Inpatient and Outpatient Hospital services.
- Services of a Physician for diagnosis, treatment, and surgery for a Covered Transplant Procedure.
- Diagnostic Services.
- Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue; Covered Services are limited to the actual procurement expenses, and benefits are subject to the amounts shown in the Maximum Benefit Section.
- Reasonable and necessary transportation costs for travel related to a Covered Transplant Procedure for the transplant recipient and one companion during a Benefit Period. Benefits for transportation are subject to the amounts shown in the Maximum Benefit Section.

If the recipient is a minor, transportation costs for two companions may be covered. Benefits for transportation are subject to the amounts shown in the Maximum Benefit Section.

Reasonable and necessary lodging and meal expenses incurred by the recipient and the recipient's companion(s), related to a Covered Transplant Procedure, during the Benefit Period. Benefits for lodging and meals are subject to the amounts shown in the Maximum Benefit Section.

Itemized receipts in a form satisfactory to the Company shall be submitted by the Insured when claims are filed.

- Rental of durable medical equipment for use outside the Hospital. Covered Charges are limited to the purchase price of the same equipment.
- Prescription drugs, including immunosuppressive drugs.
- Oxygen.

- Speech Therapy, Occupational Therapy, Physical Therapy, and Chemotherapy.
- Surgical dressings and supplies.
- Services and supplies for and related to High Dose Chemotherapy when provided as part of a treatment plan which includes High Dose Chemotherapy.

Benefits are paid as follows:

At a Participating Transplant Facility

100% of Covered Charges for Covered Transplant Services provided through a Participating Transplant Facility with respect to the type of Covered Transplant Procedure performed. However, in no event will the limits covered under this Organ Transplant Section and the benefits paid exceed the Organ Transplant Section Maximum Benefit Section.

Non-participating Transplant Facility

The lesser of 80% of the billed charges or 80% of the amounts stated on the schedule below for Covered Transplant Services provided through a Non-participating Transplant Facility with respect to the type of Covered Transplant Procedure performed. However, in no event will the limits covered under this policy exceed the Organ Transplant Section and the benefits paid exceed the Organ Transplant Section Maximum Benefit Section.

Names of Participating Transplant Facilities are available from:

Morgan-White Administrators International, Inc.
3191 Coral Way Suite 704
Miami, FL 33145 USA

(305) 442-0899

Human Organ Transplant Schedule for Non-participating Transplant Facilities

Benefits paid are the lesser of 80% of the billed charges or 80% of the amount stated below:

Procedure	Maximum Amounts	
	Non-USA	USA
Heart	\$50,000	\$100,000
Heart/Lung	\$50,000	\$100,000
Lung	\$50,000	\$100,000
Liver	\$50,000	\$100,000
Pancreas	\$50,000	\$100,000
Simultaneous Kidney/Pancreas	\$50,000	\$100,000
Kidney	\$30,000	\$ 30,000

MAXIMUM BENEFIT SECTION

1. Transportation/Lodging/Meals

A maximum of US\$200.00 per day for lodging and meals, per Covered Transplant Procedure. US\$10,000 for all transportation, lodging, and meals per Covered Transplant Procedure. Itemized receipts in a form satisfactory to the Company shall be submitted by the Insured when claims are filed.

2. Procurement

The Company's payments for Procurement expenses for a donor organ or tissue will not exceed the following maximum, per Covered Transplant Procedure:

Heart	US\$17,500
Heart/Lung	US\$17,500
Lung	US\$17,500
Liver	US\$22,500
Pancreas	US\$25,000
Kidney/Pancreas	US\$25,000
Kidney	US\$10,000

3. Maximum for all Covered Transplant Services

The total dollar amount the Company will pay is US\$500,000 per Insured for all Covered Transplant Services including the Covered Transplant Procedure, under this policy or any preceding or succeeding Human Organ and Tissue Transplant contract or policy of the Company. The maximum shown for Transportation/Lodging/Meals/Procurement are included in and accrue toward this maximum for all Covered Transplant Services. The maximum payable will only be applicable after the Deductible and any Co-Insurance have been exhausted.

Limit:

If a Covered Transplant Procedure is not performed as scheduled due to the intended recipients medical condition or death, benefits will be paid for Covered Transplant Services until the earlier of:

1. the recipients death, or
2. the date the decision is made by the recipients Physician not to perform the transplant.

Multiple Transplants:

If a recipient requires more than one Covered Transplant Procedure, the Company will consider reimbursement for Covered Transplant Services during each Benefit Period as follows:

1. If each transplant is due to unrelated causes, each is considered as a separate Benefit Period.
2. If each transplant is due to related causes, each is considered as a separate Benefit Period if the transplants are separated by at least 90 days.
3. If the transplants are due to related causes, they are considered as one Benefit Period when not separated as shown in item 2 above.

Case Management

The Company or the Administrator may access the Insured's continuing care needs and discuss with the Insured's Physician less costly alternative means of care. Coverage will be provided for less costly alternatives even if such care is not specifically stated as covered under this policy. The Deductible, Co-Insurance and maximums contained in this policy will apply to the alternative care.

There is no penalty if the Insured or the Physician do not accept the proposed alternative care.

ADDITIONAL POLICY PROVISIONS AND DEFINITIONS FOR ORGAN TRANSPLANTS

1. **BENEFIT PERIOD:** The period of time:
 - a. beginning on the date the Insured first receives services directly related to evaluation as a candidate for a Covered Transplant Procedure; and
 - b. ending on the earlier of:
 1. the date 12 months after the Covered Transplant Procedure is performed; or
 2. the date this policy is canceled.

If this policy is renewed or replaced with a similar policy issued by the Company, any remaining days not used of such 12 month period shall continue until completed under the new policy.

2. **COVERED TRANSPLANT PROCEDURE(S):** Any of the following medically necessary human organ and tissue transplants: (1) heart; (2) heart/lung; (3) lung; (4) liver; (5) pancreas; (6) kidney/pancreas; and (7) kidney.
3. **PROVIDER:** The facilities and individuals listed below:

Provider Facilities:

Clinical Laboratory: A Laboratory that performs clinical procedures and is not affiliated or associated with a Hospital Physician, or other provider.

Hospital means a facility which is a short-term acute care general Hospital and which:

1. is a duly licensed facility;
2. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians, for compensation from its patients;
3. has organized departments of medicine and major surgery; and
4. provides 24-hour nursing service by or under the supervision of registered nurses.

Non-participating Transplant Facility: Any Hospital which has not contracted with the Company or the Administrator through an applicable transplant network, to provide Covered Transplant Procedures. A Hospital may be a Non-Participating Transplant Facility with respect to:

- (1) certain Covered Transplant Procedures; or
- (2) all Covered Transplant Procedures.

Participating Transplant Facility: Any Hospital contracting with the Company or the Administrator through an applicable transplant network, to provide Covered Transplant Procedures. A Hospital may be a Participating Transplant Facility with respect to:

- (1) certain Covered Transplant Procedures; or
- (2) all Covered Transplant Procedures.

Provider Individuals:

Occupational Therapist: A person who is licensed as such by the state in which they practice. If that state does not issue such licenses, an Occupational Therapist is a person certified as such by an appropriate professional body.

Physical Therapist: A person who is licensed as such by the state in which they practice. If that state does not issue such licenses, a Physical Therapist is a person certified as such by an appropriate professional body.

Respiratory/Inhalation Therapist: A person who is licensed as such by the state in which they practice. If that state does not issue such licenses, a Respiratory/Inhalation Therapist is a person certified as such by an appropriate professional body.

Speech Pathologist and Speech Therapist: A person so licensed by the state in which they practice. If that state does not issue such licenses, a Speech Pathologist or Speech Therapist is a person certified as such by an appropriate professional body.

SPECIFIC EXCLUSIONS for Organ Transplants

Any treatment or medication or the consequences thereof, or charges related to the following are not covered under this policy unless specifically included or changed on the Maximum Benefit Section:

1. Any costs or treatment for an Organ Transplant which is deemed by the Company to be the result of a Pre-Existing Condition or condition of which You were aware prior to the inception of this policy.
2. Any costs related to home health care.
3. Services and supplies for immunizations.
4. Animal organ or artificial Organ Transplants.
5. Stand-by charges of a Physician.
6. Services, supplies, or Hospital care which, in the judgment of the Company's medical consultants, are not medically necessary for the treatment of illness, Injury, diseased condition, or impairment, except as specifically stated as covered.
7. Custodial care or rehabilitation care and therapy.
8. Charges for any Experimental/Investigational treatment, procedure, facility, equipment, drug, device, or supply, except as specifically stated in the Maximum Benefit Section of this policy.
9. Charges paid or payable under Worker's Compensation.
10. Preventive or routine care, including physical's, premarital examinations, and any other routine or periodic examinations, except as specifically stated as covered.
11. Research studies or screening examinations.
12. Services or supplies to the extent You are not legally obligated to pay for them.
13. Expenses incurred before Your coverage begins or after it ends, except as stated as covered.
14. Rest cures or sanitarium care.
15. Services or supplies furnished by any person or institution acting beyond the scope of their license.
16. Services or supplies received from a dental or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust, or similar person or group.
17. Services provided by any governmental agency to the extent that You are not charged for them, except when this exclusion conflicts with state and federal law.
18. Services or supplies not specifically stated as covered.
19. Telephone consultations, charges for failure to keep a schedule visit, or charges for completing a claim form.
20. Recreation or diversional therapy.
21. Materials used in occupational therapy.
22. Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if a Physician prescribes such items.
23. Hospitalization for environmental change and all related charges.
24. Services and supplies of any provider located outside the United States of America that are in excess of the amounts as stated in the policy Maximum Benefit Section detailed in this policy.
25. Services and supplies which are eligible to be repaid under any private or public research fund whether or not such funding was applied for or received.
26. Services and supplies for treatment of complications unless such complications are determined by the Company to be the immediate and direct result of a Covered Transplant Procedure.
27. Services and supplies provided in connection with a Covered Transplant Procedure which was not performed within a Benefit Period.
28. Bone Marrow Transplants in any form whatsoever.
29. Imunosuppressive drugs for the treatment or prevention of a rejected heart, heart/lung, lung, liver, pancreas, kidney or kidney/pancreas following the end of the Benefit Period. This policy will no longer pay benefits following the end of the Benefit Period.