



NEW WORLD MEDICAL PLAN

Underwritten by Certain Underwriters
At Lloyd's, London through the
WORLDWIDE MEDICAL TRUST

SCHEDULE OF BENEFITS

Coverage	Worldwide – This policy will pay for covered Medical Expenses necessarily and reasonably incurred for claims arising out of bodily injury or sickness that manifest itself after the effective date of the policy. Subject to waiting period.
Eligibility	Acceptance: anyone under 69; students up to age 24 as dependents
Insured Amount	Up to a Maximum of US\$ 1,000,000 of incurred charges per Insured, per Benefit Period. At age 70, the Maximum per Insured, per Benefit Period 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	Co-Insurance: 20% of the first US\$ 5,000 per Insured if treatment rendered in the USA; Canada or Europe An increase in the Co-Insurance will apply to any Insured who is NOT admitted to a Super Special Network Hospital. The amount the Insured will be responsible for will be an additional 40% of covered charges after the Deductible and Co-Insurance have been applied. Co-Insurance will apply for accidents and emergencies that are treated outside Your Country of Residence and not in a Super Special Network Hospital and will be paid after Your Deductible at 80% of Usual, Reasonable and Customary charges. This benefit is limited up to a maximum of US\$ 50,000 and the Insured must be admitted to a Hospital.

Hospitalization Coverage: Covered Charges & Covered Services

Limits

Cost of private room and board (maximum 180 days per Certificate Year, not to exceed US\$ 700 per day)	US\$ 126,000* per Insured
Cost of private room and board (maximum 180 days per Certificate Year) NO DAILY LIMIT if admitted to a Super Special Hospital plus REDUCTION in Deductible and Co-Insurance.	NO DAILY LIMIT per Insured if in a Super Special Hospital 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 Hospital plus REDUCTION in Deductible and Co-Insurance.	NO DAILY LIMIT per Insured if in a Super Special Hospital 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 Hospital. This benefit will be Subject to the Deductible and Co-Insurance.	
Physician fees, diagnostic tests (laboratory, imagenology), treatment and supplies, administered while the Insured is registered as an Inpatient in a Hospital	100% Usual, Reasonable & Customary per Insured
Maternity and Health Newborn In Country of Residence: Out of Country of Residence: Cost of vaginal delivery, including pre-natal consultations, birth and post-natal care: Cesarean delivery is covered as an operation if medically necessary: Elective Cesarean is covered as a vaginal delivery: Mother and Father must be covered continuously on this certificate for at least 12 months to be eligible for this benefit. Cost of delivery due to artificial insemination Any medical complication related to the pregnancy for the mother only during pregnancy, labor, delivery and a maximum of six (6) weeks post partum: NO DEDUCTIBLE WILL BE APPLIED ON CERTIFICATES WITH DEDUCTIBLES UP TO \$1,000	100% Usual, Reasonable & Customary US\$ 4,000 Per Pregnancy US\$ 8,000 Per Pregnancy US\$ 6,000 Per Pregnancy US\$ 5,000 Per Pregnancy US\$ 20,000 Per Pregnancy
Newborn Coverage for Congenital Disorders or Illnesses, Hereditary Conditions and Premature Birth All cost of treatment relating to birth defects, Congenital Disorders or Illnesses, hereditary conditions and premature birth for the first six (6) months after birth if born under a covered Maternity. See provisions and Definitions for adding a newborn to this policy. The newborn is covered automatically for the first forty-five (45) days after birth if born under a covered Maternity. To continue coverage beyond forty-five (45) days the newborn must be added to the policy within forty-five (45) days after birth	US\$ 30,000 Maximum benefit All Inclusive
Congenital Disorders or Illnesses, Hereditary Conditions and Premature Birth (Coverage if newborn is added to this policy during the first forty-five (45) days and born under a covered Maternity) Coverage beyond forty-five (45) after birth, for the cost of treatment relating to birth defects, Congenital Disorders or Illnesses, hereditary conditions and premature birth. See Provisions and Definitions for adding a newborn to this policy.	US\$ 100,000 Lifetime Maximum All Inclusive
Congenital Disorders or Illnesses Coverage for Congenital Disorders, Illnesses or hereditary conditions are covered if first manifesting after any respective Insured's eighteenth (18) birthday and while said Insured is covered under this policy. Congenital Disorders or Illnesses or Hereditary Conditions will then be covered as any other illness. (Subject to waiting period)	Up to Benefit Period /Policy Maximum

Home Nursing and Hospice 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 Benefit Period
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Rehabilitation: Covered Charges & Covered Services.

The cost of medically and prescribed home nursing or Hospice by a registered nurse. Home nursing or Hospice must be approved by the Administrator 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.
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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 (Inpatient or Outpatient) following a covered Surgery or Accident/Injury and within twelve (12) months of the covered Surgery or Accident/Injury occurrence.	US\$ 10,000 Lifetime per Insured
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Non-Hospital Outpatient Charges: Covered Charges & Covered Services – DEDUCTIBLES APPLY

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 - 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, Biopsy	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
Cancer treatment and related tests including 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 Benefit Period
Cancer treatment and related tests including 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 Subject to Benefit Period
Prescription drugs as prescribed by a Physician for an Insured.	US\$ 500 per Insured
Dialysis	100% of Usual , Reasonable & Customary - Per Benefit Period

Human Organ Transplant:

Incurred charges for covered organ transplant.	US\$ 250,000 Lifetime Maximum per Certificate
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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. *See page 7 of the Certificate for full details.*

US\$ 25,000 Maximum per Certificate

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 40% will be applied to covered charges in the USA, Canada or Europe and not in a Super Special 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 80% 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, 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, instructions.
- 2.- The treatment necessary is not available in the country where the event occurred.

POLICY ADMINISTRATION

All terms contained herein including the Provisions and Definitions, General Conditions, General Exclusions, Specific Exclusions, Schedule of Benefits, Application for Coverage, Organ Transplant Section (if any), and any Amendments or Endorsements attached to the contract constitute the Policy and 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 solely on behalf of the Insured and not the Company or the Administrator. Since such broker/agent is acting solely on behalf of the Insured, neither the Company nor the Administrator is responsible to the Insured if the broker/agent, who sold this Policy, fails now or in the future to transmit or communicate any documentation or funds to or from the Administrator, and the Insured.

NOTIFICATION OF MEDICAL CARE

- 1) The Insured must notify the Administrator at least fifteen (15) days in advance of receiving any Inpatient treatment as per the Pre-Certification requirements set forth in this Policy.
- 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, as per the Pre-Certification requirements set forth in this Policy.
- 3) The Insured must notify the Administrator within forty-eight hours (48) of admittance to a Hospital for emergency treatment, as per the Pre-Certification requirements set forth in this Policy.

If the Insured fails to notify the Administrator as required, the Insured will be responsible for forty (40%) 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 payments of all 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 eight (8) and number fourteen (14) of the of this Policy. Submission of a fraudulent claim will be grounds for denial of the claim and cancellation of the Policy by the Company.

PRECERTIFICATION OF HOSPITAL ADMISSION AND/OR HOSPITAL CONFINEMENT

Hospital Confinement/Admissions must be Pre-Certified

- a: In the case of a non-emergency hospital admission or confinement, the Insured or the admitting Physician must contact the Administrator a minimum of fifteen (15) days prior to Hospital admission to certify admission and provide all medical history and other relevant documents (such as, but not limited to, prior hospital admission records and medical records from other Physicians visited) requested by the Administrator. If the required medical history and other relevant documents required by the Administrator are not or cannot be provided to the Administrator a minimum of fifteen (15) days prior to the Hospital admission, then no pre-certification can be made and the claim, if payable, will be paid by reimbursement.
- 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 with these Precertification requirements will result in reduced benefits. (See Specific Exclusion number 36)

COORDINATION OF BENEFITS

The Insured person is not entitled to receive payment of benefits from this Policy in addition to those provided under any other insurance or benefit plan. If another Policy is in effect 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 secondary benefits, not to exceed 100% of the claim, and only 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 is made. The Company may change the administrative procedures by written notice.

REFUSAL TO REPATRIATE

The Company and the Administrator 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 the Administrator of any liability and the coverage will cease.

INSURED AMOUNT

The maximum benefit allowable under this Policy for any one Policy Year is set forth under Insured Amount 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.

SUBROGATION

In the event You incur medical expenses as a result of negligence, wrongdoing or other liability of a third party, the Company has the 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 also has the right to proceed at its own expense, with full right of subrogation, in the name of the Insured person, against any 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.

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 pertinent medical reports and records, and when requested, shall sign all authorization forms necessary to give the Company full and complete medical records. 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 Insured, Company and Administrator 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 Miami, Florida, U.S.A. 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 is jurisdictional and 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. The prevailing party in any such arbitration (or litigation, if applicable) shall also be entitled to receive an award from the losing party of reasonable attorney's fees and costs incurred in the arbitration/litigation.

ELIGIBILITY

Persons who are less than seventy (70) years old and their Dependent(s) and who(s): 1) have been diagnosed or treated for the following conditions: Down's Syndrome, Autism, Epilepsy, Seizure, Paralysis of any kind, Alzheimer's Disease, Dementia, any degenerative neurological disorder, Multiple Sclerosis, Cerebral Palsy, Lou Gehrig's disease, Sickle Cell Anemia, Cystic Fibrosis, Parkinson's disease, Crohn's Disease, Hemophilia, HIV Infection or AIDS, Lupus, Chronic Renal Insufficiency or failure, Schizophrenia, Rheumatoid Arthritis, Chronic Obstructive Pulmonary Disease (COPD), hereditary and congenital disorders or Sickneses are **not** eligible for this insurance coverage and will not be covered by this Policy. 2) weight and height is within the Company's 2010 Height/Weight Chart. 3) are not Permanent Residents of the United States of the America.

GOVERNING LAW

Any matters relating to this Policy, including but not limited to, interpretation of Policy provisions, claims and representations of the insured in connection with the application for or issuance of this Policy, shall be subject to the contract laws of Bermuda. This policy has not been filed with or approved by any insurance regulatory authority in the United States of America.

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 AND WAITING PERIODS

Covered benefits for the costs of any medical condition, resulting from Accident or Contagious Diseases become payable on the Effective Date of the Policy. No benefits will be payable for the costs of any other medical condition which manifests itself within one hundred and fifty (150) days after the Effective Date of the Policy. Maternity is not covered until the Mother and Father are both covered continuously on this Policy for at least twelve (12) months.

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, and
- (2) the premium coming due prior to the expiration has been received by the Company, and
- (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 the Administrator. at www.morganwhite.com Renewal of this Policy on-line is deemed to have been completed in Bermuda.

Such offer to renew may be accepted by payment of the renewal premium by conventional means within thirty (30) days of the renewal date or ten (10) days if paid on-line. Upon payment and acceptance of 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.

TEMPORARY EMERGENCY COVERAGE

From the time 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.

Underwritten by Certain Underwriters at Lloyd's, London

Juan de Rodriguez

Specimen

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. **ADMINISTRATOR:** Means Morgan-White Administrators International, Inc., 3191 Coral Way, Miami, Florida 33145.
3. **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.
4. **APPLICANT:** Means the individual who executed the application for coverage.
5. **ANESTHESIOLOGIST FEES:** Means the charges made by an anesthesiologist in the performance of a surgical procedure or for medically necessary pain control.
6. **ANNIVERSARY DATE:** means the renewal date of the Policy.
7. **BENEFIT PERIOD:** Means the allowable time period You have from the date of Accident, Injury or the onset of Sickness to receive treatment for an Accident, Injury or Sickness which is covered by this Policy. If Your Policy terminates during Your Benefit Period, all benefits and payments for Covered Services that occurred after the termination of your Policy will cease. The Benefit Period of this Policy is three (3) years. If during the Benefit Period, Your treatment for the Accident, Injury, or Sickness ceases and you remain Treatment Free for a one (1) year, then that Accident, Injury, or Sickness is deemed to have ended. If treatment, hospital charges, or Physician charges are incurred for that same Accident, Injury, or Sickness is required after You have been Treatment Free for one (1) year, then a new three (3) year Benefit Period will be deemed to have begun. If the Benefit Period ends while your Policy is still active, You will have coverage under the Extended Benefits provision of this Policy. (See definition of Extended Benefits)
8. **CLASS:** Means characterizations of all policies of the same type, including but not limited to: Deductibles, Policy origination date, age, group, geographical area, plans or a combination of the above.
9. **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.
10. **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.
11. **COMPANY or THE COMPANY:** Means Certain Underwriters at Lloyd's, London.
12. **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.
13. **CONTAGIOUS DISEASE:** Means common communicable diseases caused by parasites, bacteria, protozoa, fungi or viruses. Do not include sexual transmitted disease.
14. **COVERED CHARGES:** Means charges in the Policy contract which, in the Company's judgment, are not excessive, for the treatment and supplies provided. 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;
 - (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.

15. **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.
16. **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. The Company reserves the right to make the final determination as to whether the surgical procedure is considered reconstructive or cosmetic.
17. **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.
18. **CURRENCY:** Means payments related to this Policy are in U.S. Dollars, unless otherwise stated.
19. **CUSTODIAL CARE:** Means care, which is not skilled care.
20. **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 Deductible will double and Co-Insurance of fifty percent (50.00%) will apply to all covered medical expenses.
21. **DEPENDENT(S):** Means persons listed on the Certificate of Coverage of the Policy and who meet the following qualifications:
- 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 (24) 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. 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.
22. **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 MRI, Cat Scans, Pet Scans;
 - b. Laboratory and pathology; and EKG's and EEG's.
23. **DEDUCTIBLE PER PERSON:** Means a specific amount selected by the applicant which constitutes the initial responsibility of the Insured at the moment the loss occurs. The selected Deductible will be applied per person per Policy Year in accordance with the Schedule of Benefits.
24. **EFFECTIVE DATE OR EFFECTIVE DATE OF COVERAGE:** Means the first date the Policy is in effect after the Company approves the application and payment is received or upon renewal of the Policy.
25. **EMERGENCY DENTAL TREATMENT:** Means the cost of dental procedures necessary to restore or replace sound natural teeth lost or damaged in an Accident.

26. **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. 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. No air transportation will be paid unless approved in advance of the transportation and coordinated by the Administrator.
- (2) Medically necessary means the treatment cannot be provided locally and transportation by any other method would result in loss of life.
- (3) The Administrator and the Company are held harmless for delays or restrictions on flights by weather, 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 Administrator or the Company 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.
27. **EMERGENCY TREATMENT:** Means any sudden and unforeseen event occurring during a Policy Year resulting in the Insured seeking treatment as an Inpatient in a Hospital.
28. **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 proposed 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.
29. **EXTENDED BENEFIT PERIOD:** Means a period of 24 months after the end of the Benefit Period during which up to USD \$10,000 per month will be paid for Covered Services for treatment rendered for an Accident or Illness for which the Benefit Period has ended or terminated. The Policy must not be Lapsed or Terminated for the Extended Benefits Period payments to be made.
30. **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 (30) day Grace Period for annually and semi-annually paid premiums and ten (10) days for monthly paid premiums.

31. **GROUND TRANSPORTATION:** Means emergency transportation to a hospital by Ground Ambulance.
32. **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, para-gliding, 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.
33. **HOSPITAL:** Means a facility which is a short-term acute care general Hospital and which:
1. Is a duly licensed facility; and
 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; and
 3. Has organized departments of medicine and major surgery; and
 4. Provides 24-hour nursing service by or under the supervision of registered nurses; and
 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.
34. **HOSPITAL CONFINEMENT:** Means an admission or admissions of an Insured for at least twenty four (24) hours as Inpatient in a Hospital or Hospitals for treatment (do not include Emergency Room, Recovery Room or Observation Room). 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.
35. **HOSPITAL SERVICES:** Means medically necessary treatments ordered by a Physician and provided to the Insured while admitted as a registered Inpatient to a Hospital.
36. **INJURY:** Means bodily Injury which is not self inflicted, is caused by an Accident and which occurs while the Policy is in force.
37. **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, Recovery Room or Observation Room.
38. **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 whose names are listed on the Certificate of Coverage, for whom commencement of coverage has been confirmed by the Company, who have been issued a Policy and for whom the premium has been paid.
39. **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.
40. **LAPSED:** Means the Policy has expired due to non-payment of premium, but can be reinstated within 90 days of the expiration of the Policy by submitting a reinstatement application which application is approved by the Company and paying the premiums due.
41. **MANIFESTED OR MANIFEST ITSELF:** Means the demonstration of the presence of a sign, symptom, or alteration associated with a Sickness or disease(s) process.
42. **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.

43. **MEDICALLY NECESSARY or MEDICAL NECESSITY:** Means services, treatment(s) or supplies received by the Insured Person(s) that are determined by the Company to be: 1.) Appropriate and necessary for the symptoms, diagnosis, or direct care and Treatment(s) of the Insured Person(s)'s medical conditions; 2.) Within the standards the organized medical community deems good medical practice for the Insured Person(s)'s condition; 3.) Not provided solely for educational purposes or primarily for the convenience of the Insured Person(s), the Insured Person(s)'s Physician(s) or another Service Provider or person; 4.) Not Experimental / Investigational and/or for Research; and 5.) Not excessive in scope, duration, or intensity to provide safe and adequate, and appropriate treatment(s).

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kinds of services the Insured Person(s) is receiving or the severity of the Insured Person(s)'s condition, in that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The fact that any particular Physician(s) may prescribe, order, recommend, or approve a service, treatment(s), supply or level of care, does not of itself, make such treatment(s) Medically Necessary or make the charge a Covered Service under this Policy.

44. **MEDICINE OR MEDICATIONS:** Means the drugs and/or anesthetics prescribed by a Physician(s) and dispensed to the Insured Person(s) by a licensed pharmacist, as a result of a Sickness or Accident). Medicine or Medication shall mean the generic equivalent of a drug, or if the generic equivalent is not available, the brand name drug. Medicine or Medication shall mean only prescription drugs.
45. **NEWBORN COVERAGE:** Means; a) The newborn will be covered automatically for the first forty -five (45) days after birth, if born under a covered pregnancy. b) If any newborn, from a covered Maternity, is added to this Policy beyond forty-five (45) days, the Company requires an application be made and the appropriate premium to be paid. If the application and additional premium is not received within forty-five (45) days of the covered birth, the coverage for that child is automatically Terminated.
46. **OUTPATIENT SERVICES:** Means medically necessary treatments provided for the Insured when the Insured is not a registered Inpatient in a Hospital for more than twenty four (24) hours, or in any other facility for medical care. Outpatient Services include services performed in an Outpatient surgical center or emergency room.
47. **ORGAN TRANSPLANTS:** Means transplant of human to human procedures only for heart, heart/lung, lung, liver, pancreas, simultaneous kidney/pancreas and kidney.
48. **PAYMENT DUE DATE:** Means the day the Policy's payment is due, as stated on the Certificate of Coverage.
49. **PERMANENT RESIDENT:** Means a person whose resides over six months of each year in a country and who lists that country as his residence on his government documents. (passport, driver's license, etc.)
50. **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.
51. **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.

52. **POLICY YEAR:** Means a period of twelve (12) consecutive months beginning on the Policy Effective Date.
53. **PRE-EXISTING CONDITIONS:** Means any condition or consequence related to a medical condition, Sickness or Accident for which medical advice, consultation, diagnosis, care or treatment was received, or

medications prescribed or taken, within the seven (7) years prior to the Effective Date of this Policy or its Reinstatement or; or (2) a condition that would have caused a prudent person to seek medical advice, consultation, diagnosis, care or treatment prior to the Individual Effective Date of this Policy; or 3) a condition for which medical advice, consultation, diagnosis, care or treatment or any obvious symptom thereof which, if presented to a Physician would have resulted in an attempt to diagnose the condition producing the symptoms prior to the Effective Date of this Policy; or 4) any Covered Charges or Covered Services for Pregnancy within twelve (12) months after the Effective Date of Coverage under this Policy.

54. **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.
55. **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 Policy Deductibles, Co-Insurance and charges not covered by this Policy.
56. **REINSTATEMENT:** Means after the Grace Period has expired, the Company will consider Policy 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.
57. **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 confirms 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.

58. **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. The Company reserves the right to make the final determination as to whether the surgical procedure is considered reconstructive or cosmetic.
59. **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.
60. **SICKNESS:** Sickness means illness or disease the symptoms of which first manifests itself while the Policy is in force.

61. **SUPER SPECIAL HOSPITALS:** Means those hospitals listed as Super Special Hospitals by the Administrator where an insured is entitled to special benefits. The list of Super Special Hospitals changes from time to time, so it is important that an insured contact the Administrator to determine if a hospital is on the Super Special Hospital list prior to making any arrangements for a non emergency hospitalization.
62. **TERMINATED or TERMINATION:** Means the Policy contract has expired or is no longer of force or effect.
63. **TREATMENT FREE:** Means the Insured's covered under the Policy have not received any treatment, seen a doctor or taken any prescription drugs for a sickness, accident or injury during the Treatment Free period of time.
64. **WE, OUR OR US:** Means Certain Underwriters at Lloyd's, London.
65. **HE, HIS, HER, YOU, YOUR OR FAMILY:** Means the main insured and/or any Dependent(s) listed on the Certificate of Coverage of this Policy.

General Conditions

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.

General Exclusions

The Company and the Insured agree 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 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 or Reconstructive Surgery or associated treatment, unless medically necessary and prescribed by a Doctor following a covered surgery or Accident/Injury and within 12 months of the covered surgery or Accident/Injury occurrence. This policy does not covers surgery to correct Nasal Septum Deviation, deformities and related pathologies, unless caused by a traumatic accident and is traumatic in nature and radiological evidence of the trauma showing trace of the fracture is provided at the moment of the injury. The Company reserves the right to make the final determination as to whether the surgical procedure is considered reconstructive or cosmetic.
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 physicals exams, check-ups, examinations and related diagnostic tests. This includes vaccinations, Screening Mammogram and Screening PSA.
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 related 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, birth control, sex change or implantation, or any treatment related to 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 obesity or morbid obesity including 1) any form of food supplement or augmentation or 2) for any program for weight control, including any program of exercise activities; or 3) any treatment 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 unless caused by a traumatic accident and is traumatic in nature and radiological evidence of the trauma showing trace of the fracture is provided at the moment of the injury. The Company reserves the right to make the final determination as to whether the surgical procedure is considered reconstructive or cosmetic.
23. Any charges arising from any treatment, service or supply which are not medically necessary. Including prophylactic treatments.

24. Treatment by a family member.
25. Sickness which manifests itself during the first one hundred and fifty (150) 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, including any disorder related to the Human Papiloma Virus.
27. Routine eye and ear examinations, eye refraction, eye glasses, contact lenses, radial keratotomy, or any procedure to correct eye refraction disorders, hearing aids or ear implants.
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 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 unless caused by a traumatic accident and is traumatic in nature and radiological evidence of the trauma showing trace of the fracture is provided at the moment of the injury. The Company reserves the right to make the final determination as to whether the surgical procedure is considered reconstructive or cosmetic.
35. Illnesses and disease as a result of alcoholism, drug abuse or addiction to any substance, however caused and consequences or variations thereof.
36. Any benefits otherwise payable in excess of sixty (60%) percent of Reasonable and Customary expenses if Hospital admission was not pre-certified by the Administrator.
37. Any treatment or medical care related to any Injury, 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 is related to the procedure known as bone marrow 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 related to pregnancy or for maternity for any Dependent other than the spouse of an Insured.

Assistance for emergencies and the following services are provided by the Company:

1. **Pre-Trip Medical Referral Information:** The Company 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 the Company's 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 the Company.
3. **Emergency Evacuation:** When adequate medical facilities are not available locally, **Morgan-White Administrators International Inc.**, 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, the Company will make suitable arrangements for repatriation under medical supervision.
5. **Repatriation of Mortal Remains:** In the event of primary Insured's demise, the Company will render the assistance possible to obtain clearances and arrange for return of mortal remains.
6. **Embassy & Consular Information:** The Company will provide primary Insureds with contact information for embassies and consulates worldwide.
7. **Lost Document Assistance:** The Company 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 the Company 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:** The Company will assist primary Insureds in coordinating overseas claims procedures with their insurance program.
10. **Emergency Family Travel Arrangements:** The Company 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; the Company 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 certificate will pay 100% of Covered Charges for benefits covered under this Organ Transplant Section necessarily and reasonably incurred up to the Maximum Lifetime Amount Assured of US\$250,000 per Insured 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
2. heart/lung
3. lung
4. liver
5. pancreas
6. kidney/pancreas
7. kidney

Covered Transplant Services:

1. Inpatient and outpatient Hospital services.
2. Services of a Physician for diagnosis, treatment, and surgery for a covered Transplant Procedure.
3. Diagnostic Services.
4. 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.
5. 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 recipients 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 Underwriters shall be submitted by the Assured when claims are filed.

6. Rental of durable medical equipment for use outside the Hospital. Covered charges are limited to the purchase price of the same equipment.
7. Prescription drugs, including immunosuppressive drugs.
8. Oxygen.
9. Speech Therapy, Occupational Therapy, Physical Therapy, and Chemotherapy.
10. Surgical dressings and supplies.
11. Services and supplies for and related to High Dose Chemotherapy and bone marrow tissue transplantation when provided as part of a treatment plan which includes bone marrow transplantation and 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 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 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 U.S.A.
(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-U.S.A.	U.S.A.
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 BENEFITS 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 Underwriters shall be submitted by the Assured 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 Underwriters will pay is US\$250,000 per Insured for all Covered Transplant Services including the Covered Transplant Procedure, under this Contract or any preceding or succeeding Human Organ and Tissue Transplant contract or certificate 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 Benefit Section limit will only be applicable after all Deductible, Co-Insurance have been exhausted.

Limit:

If a Covered Transplant Procedure is not performed as scheduled due to the intended recipient's 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 Underwriters 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 certificate. The Co-Insurance and maximums contained in this certificate 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 certificate is canceled.

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

2. **COVERED TRANSPLANT PROCEDURE:** 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. **HIGH DOSE CHEMOTHERAPY:** The use of a chemotherapeutic agent or agents for treating or for preventing recurrence of, cancer or cancer-like illness, with or without irradiation, in doses which exceed the FDA approved or commonly recognized dosage range for the drug or drugs employed, and which is expected to result in effects upon the bone marrow which would likely be lethal if treated.
4. **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 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 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 he or she practices. 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 he or she practices. 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 he or she practices. 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 he or she practices. 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.

ADDITIONAL SPECIFIC EXCLUSIONS for Organ Transplants

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

1. Any costs or treatment for an organ transplant which is deemed by the Underwriters to be the result of a Pre-Existing Condition or condition of which You were aware prior to the inception of this certificate.
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 Underwriters 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 Benefits Section of this certificate.
9. Charges paid or payable under Worker's Compensation.
10. Preventive or routine care, including physicals, 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 his/her/its 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 certificate Maximum Benefits Section detailed in this certificate.
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. Services and supplies connected with or incidental to any treatment which includes bone marrow transplantation and High Dose Chemotherapy as a part of the overall treatment plan unless the Assured receives the treatment as a participant in a National Cancer Institute (NCI) phase III or IV clinical trial or the treatment is provided for individuals with the same condition as the Assured in any current NCI phase III clinical trial, and no alternative conventional treatment can be expected to result in an equal or better benefit or outcome.
29. Immunosuppressive drugs for the treatment or prevention of a rejected heart, heart/lung, lung, liver, pancreas, kidney or kidney/pancreas transplant following the end of the Benefit Period. This Contract will no longer pay benefits following the end of the Benefit Period.

Specimen