A. AGREEMENT

Sirius International Insurance Company (publ) (the Company) promises to provide the Insured Person with the benefits described in the Master Policy. The Company makes this promise in consideration of the Assured's Application, the Insured Person's Application and payment of Premium.

International Medical Group, Inc. is hereby recognized by the Company as the Plan Administrator. All communications, notices and payments required under this Agreement shall be transmitted through the Plan Administrator. Receipt by the Plan Administrator shall be considered receipt by the Company.

The Master Policy is effective as of January 1, 1998 and shall remain in effect until terminated in accordance with Section B. CONDITIONS AND GENERAL PROVISIONS, article 17. TERMINATION OF GROUP POLICY. This Certificate is effective as of the date shown on the Declaration of this Certificate and shall remain in effect until terminated in accordance with Section B. CONDITIONS AND GENERAL PROVISIONS, article 18. TERMINATION OF COVERAGE FOR INSURED PERSONS.

The Company's agreement is subject to all terms, conditions, provisions and exclusions of the Master Policy, including any Exhibits, Schedules, Endorsements, and/or Riders attached thereto.

B. CONDITIONS AND GENERAL PROVISIONS

The following are conditions precedent to the Company's liability under this insurance:

1. ENTIRE AGREEMENT - The Master Policy, including any Exhibits, Schedules, Endorsements, and/or Riders attached thereto, shall constitute the Entire Agreement between the Company and the Assured. This Certificate, including the Application, any Exhibits, Schedules, Endorsements, and/or Riders attached hereto, is an outline of the insurance provided by the Master Policy. This Certificate does not extend or change the coverage provided by the Master Policy. The insurance described in this Certificate is subject to all terms, conditions, provisions and exclusions of the Master Policy, including any Exhibits, Schedules, Endorsements, and/or Riders attached hereto.

2. PREMIUM

   a. Payment: Payment of required Premium shall be remitted to the Company on or before the Due Date(s) specified on the Declaration.

   b. Grace Period: A grace period of 10 days will be allowed for the payment of each Premium except the first.

   c. Non-Payment: If any Premium is unpaid at the end of a Grace Period, all insurance shall terminate and the Company's liability shall cease with effect from the Due Date of the unpaid Premium. Premium is considered to be paid on the date the payment instrument is received by the Company.

3. PROOF OF CLAIM - When the Company receives notice of claim it will provide the Insured Person with forms for filing Proof of Claim. The following is considered to be Proof of Claim:

   a. A completed and signed Claim Form; and

   b. Original itemized bills from Physicians, Hospitals and other medical providers; and

   c. Original receipts for any expenses which have already been paid by or on behalf of the Insured Person.

   The Insured Person shall have 90 days from the date the Eligible Medical Expenses are incurred to submit Proof of Claim.

4. TIME LIMIT FOR APPEALING A CLAIM - In the event that the Company denies all or part of a medical expense incurred under this Insurance, the Insured Person shall have 90 days from the date that the notice of denial was mailed to the Insured Person's last known address to file a written appeal with the Company.

5. ASSIGNMENT, CHANGE OR WAIVER - No Assignment of the Assured or any Insured Person's interest hereunder shall be binding on the Company. The terms of this Insurance shall not be waived or changed except by the express written agreement of the Company.

6. SERVICE OF SUIT - It is agreed that in the event of the failure of the Company to pay any amount claimed to be due hereunder, the Company, at the request of the Insured Person, will submit to the jurisdiction of a Court of

competent jurisdiction within the United States. Nothing in this clause constitutes or should be understood to constitute a waiver of the Company's rights to commence an action in any Court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another Court as permitted by the laws of the United States or of any state in the United States. In any suit instituted against the Company upon this agreement, the Company will abide by the final decision of such Court or of any Appellate Court in the event of an appeal.

Further, pursuant to any statute of any state, territory or district of the United States which makes provision therefore, the Company hereby designates the Superintendent, Commissioner or Director of Insurance or other officer specified for that purpose in the statute, or his successor or successors in office, as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the Insured Person hereunder arising out of this agreement of Insurance, and hereby designates Thomas Dawson of LeBoeuf, Lamb, Greene & MacRae at 125 West 55th Street, New York, New York 10019-5389, as the person to whom the said officer is authorized to mail such process or a true copy thereof.

7. MISREPRESENTATION - Any misstatement, concealment or fraud, either in the Application for the Master Policy or in any Insured Person's Application which forms a part of this Certificate or in relation to any statement or warranty made by the Assured or any Insured Person or their authorized representative, whether in writing or otherwise, to the Company or its representatives, or in connection with the making of any claim hereunder shall render this insurance null and void and all claims hereunder shall be forfeited.

8. INSOLVENCY - The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors or dissolution of the Assured or any Insured Person shall not impose upon the Company any liability other than that specifically included in this Insurance.

9. SUBROGATION CLAUSE - The Assured and Insured Person undertakes to cooperate with the Company in the prosecution of any and all valid claims that they may have against third parties arising out of any occurrence which results or may result in a loss payment by the Company and to account for any amounts recovered on the basis that the Company shall be entitled to recover first in full any sums paid by it before the Insured Person shares in any amount so recovered. Should the Assured or Insured Person fail to prosecute any valid claims against third parties and the Company thereupon becomes liable to make payment under the terms and conditions of this insurance then the Company shall be subrogated to all rights of the Assured or Insured Person. Any amount recovered by the Company shall be used to pay the expenses of collection and reimbursement of the Company for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts shall be paid to the Assured or Insured Person.

10. OTHER INSURANCE - The Company shall not pay any claim if there is other insurance which would, or would but for the existence of this insurance, pay such claim, except in respect of any excess beyond the amount payable under such other insurance had this insurance not been effected. The Company shall not pay any claim in respect to care, treatment or supplies furnished by any program or agency funded by any government.

11. CANCELLATION BY INSURED PERSON - The Insured Person may request Cancellation of this insurance by giving the Company not less than 60 days advance written request. Cancellation is at the option of the Company. If the Company grants Cancellation, coverage shall terminate with effect from the Cancellation Date specified by the Company. The Company shall calculate the Short Rate Earned Premium in accordance with the Short Rate Cancellation Table in effect as of the date of Cancellation. If the Insured Person has paid more than the Short Rate Earned Premium, the Company shall refund the difference between the amount actually paid and the Short Rate Earned Premium. If the Insured Person has paid less than the Short Rate Earned Premium, the Insured Person shall remit to the Company the difference between the Short Rate Earned Premium and the amount actually paid.

12. The monetary limits stated in the Master Policy and this Certificate and the Premium shall be in U.S. dollars.

13. The Insured Person and his/her Physician shall cooperate fully with the Company including granting full right of access to all related medical documentation, reports and evidence.

14. If the circumstances in which this insurance was entered into shall be materially altered without the written consent of the Company, this insurance shall be voidable.

15. If any claim under this insurance shall be in any respect fraudulent or if any fraudulent means or devices are used by the Assured or Insured Person or anyone acting on their behalf under this insurance, all benefits hereunder shall be forfeited.

16. If any dispute shall arise as to the amount to be paid under this insurance (liability being otherwise admitted), such

dispute shall be referred to arbitration in accordance with procedures of the American Arbitration Association. Where any dispute is by this provision referred to arbitration, the making of an award shall be a condition precedent to any right of action against the Company.

17. TERMINATION OF GROUP POLICY - Coverage under the Master Policy can be terminated at any time by either the Company or Assured by giving at least thirty (30) days written notice. Such termination will have no effect on Certificates issued to Insured Persons prior to the date of the termination or on payments to be made by or to the Company under such Certificates. No Certificates will be issued after the date the Master Policy is terminated.

18. TERMINATION OF COVERAGE FOR INSURED PERSONS - Coverage for Insured Persons terminates effective the earliest of the following dates:

    a. The end of the period for which Premium has been paid; or

    b. The Termination Date as shown on this Certificate; or

    c. The date the Insured Person no longer meets the Eligibility requirements set forth herein; or

    d. The 30th day after the Effective Date of this insurance if the Insured Person is a Citizen of the United States of America (USA) and located in the USA at the time of Application for this insurance and has not departed the USA; or

    e. The 30th day after the Effective Date of this insurance if the Insured Person is not a Citizen of the USA but is located in the USA at the time of Application for this insurance and has not departed the USA unless the Insured Person is not eligible for any other medical insurance plan which is available to individuals similarly located in the USA; or

    f. The date the Company, at it's sole option, elects to cancel all Insured Persons of the same sex, age, class or geographic location of the Insured Person, provided the Company gives no less than 30 days advance written notice by mail to the Insured Person's last known address.; or

    g. The Cancellation Date specified by the Company pursuant to Section B. CONDITIONS AND GENERAL PROVISIONS, article 11. CANCELLATION BY INSURED PERSON.

    h. Coverage for the insured person shall remain in full force and effect, unless terminated pursuant to Section B. CONDITIONS AND GENERAL PROVISIONS, article 18. TERMINATION OF COVERAGE FOR INSURED PERSONS sub-articles a. through g. Coverage shall be automatically renewed from year to year thereafter. The renewal is subject to termination upon thirty (30) days written notice to the other party prior to the expiration date of the then existing term.

19. REINSTATEMENT OF COVERAGE FOR INSURED PERSONS - In the event this Insurance is terminated in accordance with section B. CONDITIONS AND GENERAL PROVISIONS, article 2., PREMIUM, or article 18, TERMINATION OF COVERAGE FOR INSURED PERSONS, sub-section a., the Insured Person may apply to the Company for Reinstatement. Reinstatement is at the option of the Company. In order to be considered for Reinstatement, the Insured Person must submit all of the following to the Company:

    a. A written request for Reinstatement; and

    b. A completed Application; and

    c. A written statement giving full details, as requested by the Company, of any claims incurred by the Insured Person since the termination date; and

    d. Payment of all premiums due.

    If the Company grants Reinstatement, it will promptly inform the Insured Person, and Reinstatement shall be effective as of the termination date. If the Company does not grant Reinstatement, the Company's sole obligation shall be to return any balance due to the Insured Person.

20. PATIENT ADVOCACY - The Company may determine that a particular claim or diagnosis occurring under this insurance may be placed under the Patient Advocacy program to ensure that Medically Necessary services and supplies are provided in the most cost effective manner. In the event the Company determines that a claim or diagnosis meets the Patient Advocacy program requirements, the Company will notify the Insured Person, and a

Patient Advocate will be assigned to the Insured Person. Thereafter, the Patient Advocate may make recommendations of alternative treatment settings and/or procedures and/or supplies which may be more cost effective for the Company and/or the Insured Person. Such recommendations will be made with input from the Insured Person and the Insured Person's Physician and will be made only when it can be reasonably demonstrated that the Medically Necessary services and supplies can be provided in a more cost effective manner to the Company and/or the Insured Person. The Company will use its best efforts to evaluate and recommend alternative treatment settings and/or procedures and/or supplies which can reasonably be expected to result in the same or better care of the Insured Person. The Insured Person, in accepting the Company's recommendations, agrees to hold the Company harmless and the Company shall not be held liable or otherwise responsible for any treatment, service, supply, procedure or care provided to the Insured Person except for the payment of benefits under this Insurance. After the Insured Person has been notified that the claim or diagnosis meets the Patient Advocacy program requirements, the Company reserves the right to:

a. Make payment for services and supplies which are not covered under this insurance which would be beneficial to the Insured Person and cost effective to the Company; and

b. Deny payment for expenses which may be covered under this insurance which are over the amount the Company would have paid had the Insured Person followed the recommendations of the Patient Advocacy program.

21. RIGHT OF RECOVERY - In the event of overpayment of any claim hereunder because:

a. all or some of the expenses were not paid for by or on behalf of the Insured Person; or

b. any person in the Insured Person's family, whether or not that person is or was an Insured Person, is repaid for all or some of those expenses by a source other than the Company; or

c. all or some of the expenses were not Eligible Medical Expenses; or

d. all or some of the expenses were paid or reimbursed based on incorrect benefit application,

the Company has the right to recover the amount of overpayment from the Insured Person and/or the Hospital, Physician, or other provider of services or supplies. The amount of the recovery is the difference between:

i. the amount of expenses actually paid by the Company; and

ii. the amount of expenses which should have been paid by the Company (after deducting expenses listed in a. and b. above if applicable).

If the Insured Person or the Hospital, Physician or other provider of services or supplies does not promptly make any such refund to the Company, the Company may, in addition to any other rights available to it, either

a. reduce the amount of any future claim that is otherwise eligible for payment hereunder, to the full extent of the refund due to the Company; or

b. cancel this Certificate by giving thirty days advance written notice by mail to the Insured Person's last known address.

22. REINSTATEMENT OF MAXIMUM LIMIT - After each Period of Insurance, the Company will reinstate up to $5,000 of the Maximum Limit for the next Period of Insurance for the Insured Person. This does not apply to Mental or Nervous Disorders, Maternity and Newborn Care or Pre-existing Conditions limits. Reinstatement will not apply where coverage for the Insured Person terminates. In no event shall the Maximum Limit exceed $5,000,000 in all, any one Period of Insurance.

23. Every attempt will be made to help Insured Persons understand their benefits, however, any statement made by an employee of the Company or an employee of the Plan Administrator will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time a claim is submitted and all facts are presented in writing. All payments made are governed by the provisions of the Master Policy. If a definite answer to a specific question is required, the Insured Person can submit a written request, including all pertinent information and a statement from the attending Physician (if applicable), and a written reply will be sent and kept on file.

C. SCHEDULE OF BENEFITS/LIMITS

Benefit	Limit
Deductible	$500, $1,000, $2,500 or $5,000 per Insured Person per Period of Insurance, as indicated on the Declaration. The deductible will be reduced by 50% to the extent satisfied with Eligible Medical Expenses incurred within the Preferred Provider Network. An additional deductible of $250 per Hospital Admission will be applied for each admission to a Hospital that is not within the Preferred Provider Network. This applies only to US Hospital admissions.
Coinsurance	For the Period of Insurance, the Company will pay 80% of the next $5,000 of Eligible Medical Expenses after the Deductible; then 100% of Eligible Medical Expenses up to the applicable limit. The coinsurance will be waived if satisfied with Eligible Medical Expenses incurred within the Preferred Provider Network.
Maximum Limit	$5,000,000 Lifetime
Mental or Nervous Disorders	$10,000 per Period of Insurance (after 12 months of continuous coverage) $20,000 lifetime maximum, provided the condition is not Pre-existing.
Maternity and Newborn Care	$25,000 lifetime maximum (after 12 months of continuous coverage)
Pre-Existing Conditions	$25,000 lifetime maximum (after 24 months of continuous coverage)
Local Ambulance Expense	Subject to the Deductible and Coinsurance, $2,500.00 per occurence
Hospital Room & Board	The average semi-private room rate, including nursing service
Intensive Care Unit	3 times the average semi-private room rate
Physical Therapy	$50 Maximum per visit
Eligible Medical Expenses	Usual, Reasonable and Customary
Emergency Medical Evacuation	$25,000 lifetime maximum (only when approved in advance and coordinated by the Company)
Pre-Certification	
Maternity and Newborn Care	50% Reduction if Pre-Certification Requirements are not met within the first 90 days of the Insured Person's Pregnancy
All Other	50% reduction of Eligible Medical Expenses if Pre-Certification Requirements are not met.
Wellness	$100 per Period of Insurance (after 24 months of continuous coverage) for Females over the age of 35 and Males over the age of 40. NOT SUBJECT TO DEDUCTIBLE.
Transplant Expense	$500,000 Lifetime Maximum for Covered Transplants, subject to Special Transplant Pre-certification Requirements, and only when treatment is provided within the Managed Transplant System Network. Covered Transplants are: Heart, Heart/Lung, Lung, Kidney, Kidney/Pancreas, Liver and Allogenic and Autologous Bone Marrow.
Second Surgical Opinion	Subject to the Deductible and Coinsurance unless requested by the Company or required under the Mandatory Second Surgical Opinion provision of this Certificate. (Note, 50% penalty for failure to obtain a Second Surgical Opinion when required by the Company.)

D. ELIGIBILITY :

In order to be eligible for coverage, a person must:

1. Complete and sign an Application with all questions answered truthfully; and

2. Pay the required Premium on or before the Due Dates; and

3. Receive written acceptance of Application or Renewal from the Company; and

4. Be at least 31 days old but not yet 75 years old; and

5. If a United States citizen, must be located outside of the USA at time of Application or renewal or plan to reside outside of the USA continuously for at least 6 months with departure from the USA not more than 30 days after the initial Effective Date or renewal Effective Date; or

6. If not a United States citizen, must be located outside the USA at time of Application or renewal or plan to reside outside of the USA continuously for at least 6 months with departure from the USA not more than 30 days after the initial Effective Date or renewal Effective Date ; or

7. If not a United States citizen but located inside the USA at time of Application or renewal , must not be eligible for any other medical insurance plan which is available to individuals similarly located in the USA; and:

8. Not be Pregnant, hospitalized or Disabled on the initial Effective Date; and

9. Not be HIV+ on the initial Effective Date.

E. PRE-CERTIFICATION PROVISIONS/REQUIREMENTS

1. General Requirements: To comply with the Pre-certification requirements, the Insured Person must:

    a. Contact the Company at the telephone numbers contained on the Insured Persons ID card as soon as possible before the expense is to be incurred (see Maternity Pre-Certification Requirements); and

    b. Comply with the instructions of the Company and submit any information or documents required by the Company; and

    c. Notify all Physicians, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company.

    If the Insured Person complies with the Pre-certification requirements, and the expenses are Pre-certified, the Company will pay Eligible Medical Expenses subject to all terms, conditions, provisions and exclusions herein.

    If the Insured Person does not comply with the Pre-certification requirements, or if the expenses are not Pre-certified:

    a. Eligible Medical Expense claims will be reduced by 50%; and

    b. The Deductible will be subtracted from the remaining amount; and

    c. The Coinsurance will be applied.

    The following expenses must always be Pre-certified:

    1. Maternity (see Maternity Pre-certification Requirements); and

    2. Inpatient care; and

    3. any Surgery or Surgical Procedure; and

    4. care in an Extended Care Facility; and

    5. Home Nursing Care generally; and

6. Durable Medical Equipment; and

7. artificial limbs; and

8. Computerized Tomography (CAT Scan); and

9. Magnetic Resonance Imaging (MRI); and

10. Transplants (see Transplant Pre-certification Requirements).

2. Maternity Pre-certification Requirements - To comply with the Maternity Pre-certification requirements, the Insured Person must:

   a. Contact the Company at the telephone number contained on the Insured Persons ID card as soon as possible but always within the first 90 days of Pregnancy; and

   b. Comply with the instructions of the Company and submit any information or documents required by the Company; and

   c. Notify all Physicians, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company; and

   d. The Insured Person must Pre-certify Hospitalization for Delivery. This is in addition to the Pre-certification required within the first 90 days of Pregnancy.

   If the Insured Person complies with the Maternity Pre-certification requirements and has satisfied the waiting period of 12 months, and the expenses are Pre-certified, the Company will pay Maternity and Newborn Care benefits, subject to all terms, conditions, provisions and exclusions herein. If the Insured Person does not comply with the Maternity Pre-certification requirements, or if the expenses are not Pre-certified, Maternity and Newborn Care benefits are Reduced. If for any reason, after initial Maternity Pre-certification, the Insured Person shall become aware of complications during Pregnancy, the Insured Person must Pre-certify again, in accordance with the General Requirements for Pre-certification.

3. Transplant Pre-certification Requirements - To comply with the Transplant Pre-certification requirements, the Insured Person must:

   a. Contact the Company at the telephone number contained on the Insured Persons ID card as soon as possible but always within 72 hours of becoming a candidate for a Covered Transplant; and

   b. Comply with the instructions of the Company and submit any information or documents required by the Company; and

   c. Notify all Physicians, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company.

   If the Insured Person complies with the Transplant Pre-certification requirements and the expenses are Pre-certified, the Company will pay Transplant benefits, subject to all terms, conditions, provisions and exclusions herein. If the Insured Person does not comply with the Transplant Pre-certification requirements, or if the expenses are not Pre-certified, all Transplant Benefits are Forfeited.

4. Emergency Pre-certification - In the event of an Emergency Hospital admission, Pre-Certification must be made within 48 hours after the admission, or as soon as is reasonably possible.

5. Pre-certification Does Not Guarantee Benefits - The fact that expenses are Pre-certified by the Company does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of benefits are subject to all the terms, conditions, provisions and exclusions of this insurance.

6. Concurrent Review - For Inpatient stays of any kind, the Company will Pre-certify a limited number of days of confinement. Additional days of Inpatient confinement may later be Pre-certified if an Insured Person receives prior approval.

7. Appeal Process - If an Insured Person disagrees with a decision of the Company, that Person may ask the Company to reconsider the decision and may supply additional documentation to support the appeal. The

Company may reconsider it's decision based on review of the additional documentation and facts, if any. The Company will advise the Insured Person of it's decision.

F. UNITED STATES PREFERRED PROVIDER ORGANIZATION (PPO) REQUIREMENTS

To comply with the United States Preferred Provider Organization requirements, the Insured Person must receive medical treatment from PPO providers while in the United States. If the Insured person complies with the PPO requirements and the expenses are incurred with a PPO provider, the Company will reduce any part of the Deductible applicable to such expenses by 50%, and the Company will waive any and all of any Coinsurance applicable to such expenses.

If the Insured Person is admitted to a Hospital within the United States that is not a PPO Provider, as Inpatient, a Deductible of $250 shall apply, in addition to the Deductible selected by the Insured person as show on their Declaration page card, and in addition to any applicable Coinsurance. This Deductible shall be waived only in the event that a PPO Hospital is not located within a 50 mile radius of the location of the Hospital where the Insured person is admitted.

An Insured Person can contact the Company and request a PPO Directory for the area where the Insured person will be receiving treatment.

To comply with the Managed Transplant System Network requirements, the Insured Person must receive all Transplant treatment and services from a Managed Transplant System network provider. If the Insured Person receives Transplant treatment and services from a provider that is not a member of the Managed Transplant System Network, all Transplant Benefits are forfeited.

G. MANDATORY SECOND SURGICAL OPINION

If a Physician recommends one or more of the Surgeries listed below, except in the case of Emergency, the Company may require that the Insured Person consult with another Physician for a second opinion as to the Medical Necessity of the Surgery. The Company will notify the Insured Person if a Second Surgical Opinion is mandatory as soon as is reasonably possible after the Insured Person Pre-certifies such Surgery in accordance with the PRE-CERTIFICATION PROVISIONS/REQUIREMENTS of this Certificate.

1. Cataract Removal; and
2. Cholecystectomy; and
3. Coronary Bypass; and
4. Hemorrhoidectomy; and
5. Herniorrhaphy; and
6. Hysterectomy; and
7. Knee Surgery; and
8. Laminectomy; and
9. Ligation and stripping of varicose veins; and
10. Lithotripsy; and
11. Submucous resection
12. Septo-rhinoplasty; and
13. Spinal Fusion; and
14. Tonsillectomy and/or adenoidectomy; and
15. Transplant.

The Physician providing the Second Opinion must:

1. Not be a Relative of the Insured Person or the first Recommending Physician; and
2. Not be financially or professionally or in any other way associated with the first recommending Physician; and
3. Provide the Company with a written opinion and any and all documents and records reasonably requested by the Company in support of such opinion.

If the second opinion is required by the Company, the Company will pay Eligible Medical Expenses incurred for the consultation, including any required diagnostic tests or procedures which were not carried out by the first recommending Physician, without application of any Deductible or Coinsurance. If the second opinion concurs with the recommending Physician, then the Company will pay Eligible Medical Expenses in accordance with the terms, conditions, provisions and exclusions of the Master Policy.

If the second opinion differs from the recommending Physician, the Insured Person may be required to consult with another Physician for a third opinion as to the Medical Necessity of the Surgery. The third Physician must also be in compliance with 1 through 3 above.

If the third opinion is required by the Company, the Company will pay Eligible Medical Expenses incurred for the consultation, including any required diagnostic tests or procedures which were not carried out by the first or second Physicians, without application of any Deductible or Coinsurance.

The Insured Person must notify the Company immediately in the event any one or more of the Surgeries listed above are recommended by a Physician. The Company will promptly advise the Insured Person whether or not it will require a second opinion. Upon receipt of a second opinion that differs from the recommending Physician, the Company will promptly advise the Insured Person whether or not it will require a third opinion.

If a second opinion is not required by the Company, the Company will pay Eligible Medical Expenses in accordance with all terms, conditions, provisions and exclusions of the Master Policy.

If the Insured Person is required to obtain a second opinion and does not, benefits payable for Eligible Medical Expenses which are directly or indirectly related to or consequence of the Surgery, shall be reduced by 50%.

If the Insured Person is required to obtain a third opinion and does not, benefits payable for Eligible Medical Expenses which are directly or indirectly related to or consequence of the Surgery, shall be reduced by 50%.

If the Insured Person obtains three opinions, the Company will pay Eligible Medical Benefits in accordance with all terms, conditions, provisions and exclusions of the Master Policy based on the recommendations of two of the three Physicians opinions. If the Insured Person elects not to follow the recommendations of the two concurring Physicians, all benefits payable for Eligible Medical Expenses which are directly or indirectly related to or consequence of the Surgery, or the Insured Person's refusal to undergo the recommended Surgery, shall be reduced by 50%.

H. ELIGIBLE MEDICAL EXPENSES

Subject to the Deductible, Coinsurance and limits set forth in the Schedule of Benefits/Limits, the Company will pay the following Eligible Medical Expenses arising out of Injury or Illness incurred while this insurance is in effect:

1. Charges made by a Hospital for:
   a. Daily room and board and nursing services not to exceed the average semi-private room rate; and
   b. Daily room and board and nursing services in Intensive Care Unit; and
   c. Use of operating, treatment or recovery room; and
   d. Services and supplies which are routinely provided by the Hospital to persons for use while Inpatients; and
   e. Emergency treatment of an Injury, even if Hospital confinement is not required; and
   f. Emergency treatment of an Illness; however charges for use of the emergency room itself will not be covered unless the Insured Person is directly admitted to the Hospital as Inpatient for further treatment of that Illness; and
2. For Surgery at an Outpatient surgical facility, including services and supplies; and
3. Charges made by a Physician for professional services, including Surgery. Charges for an assistant surgeon are covered up to 20% of the Usual, Reasonable and Customary charge of the primary surgeon, but standby availability will not be deemed to be a professional service; and
4. For dressings, sutures, casts or other supplies which are Medically Necessary; and
5. For diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, behavioral and educational testing are not included); and
6. For artificial limbs, eyes or larynx, breast prosthesis or basic functional artificial limbs, but not the replacement or repair thereof; and
7. For reconstructive Surgery when the Surgery is directly related to Surgery which was covered hereunder; and
8. For radiation therapy or treatment and chemotherapy; and

9. For hemodialysis and the charges by the Hospital for processing and administration of blood or blood components, but not the cost of the actual blood or blood components; and

10. For oxygen and other gasses and their administration; and

11. For anesthetics and their administration by a Physician; and

12. For drugs which require prescription by a Physician for treatment of Injury or Illness, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, and for a maximum supply of 90 days any one prescription; and

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

14. Home Nursing Care in bed by a qualified licensed professional, provided by a Home Health Care Agency upon direct transfer from an acute care Hospital; and

15. Emergency Local Ambulance transport necessarily incurred in connection with Injury or Illness resulting in Hospitalization; and

16. For Emergency Dental Treatment and dental Surgery necessary to restore or replace sound natural teeth lost or damaged in an Accident which was covered under this insurance; and

17. For routine and Medically Necessary care of Newborns during the first 31 days of life, if the delivery of the Newborn is covered under this insurance; and

18. For pre-natal care, delivery of Newborn, and post-natal care, including complications thereof, provided the Insured Person has been continuously insured hereunder for not less than 12 continuous months immediately preceding treatment; and

19. For treatment of Mental and Nervous conditions, provided the Insured Person has been continuously insured hereunder for not less than 12 months immediately preceding treatment; and

20. For charges for physical therapy performed by a professional physical therapist prescribed by a Physician necessarily incurred to continue recovery from a covered Injury or covered Illness; and

21. For Medically Necessary rental of Durable Medical Equipment, (consisting of the following items: a standard basic hospital bed; and/or a standard basic wheel chair), up to the purchase price.

I. WELLNESS EXPENSES

The Company will pay up to $100 for the following Wellness expenses incurred while this insurance is in effect:

1. For Males over the age of 40, one Routine Physical Exam per Period of Insurance provided the Insured Person has been continuously insured hereunder for not less than 24 months, and provided at least 12 months has elapsed since the Insured Persons most recent Routine Physical Exam.

2. For Females over the age of 35, one Routine Physical Exam, including expenses for mammography exams and pap smears, per Period of Insurance provided the Insured Person has been continuously insured hereunder for not less than 24 months and provided at least 12 months has elapsed since the Insured Persons most recent Routine Physical Exam.

J. TRANSPLANT EXPENSES

The Company will pay the following Transplant expenses for Covered Transplants incurred while this Insurance is in effect:

1. Eligible Medical Expenses incurred by a live donor will be treated as if they were the expenses of the Insured Person receiving a Covered Transplant if the Insured Person received an organ or tissue of the live donor; and

2. Organ procurement and harvesting costs, excluding acquisition or purchase of the actual organ or tissue, up to a Lifetime Maximum of $10,000; and

3. Pre-transplant evaluation, the Transplant procedure, re-transplantation if during initial Transplant hospitalization, and post-Transplant care.

4. Reasonable travel and lodging expenses of the Insured Person if travel of more than 50 miles is necessary to receive Transplant treatment and services from a Managed Transplant System Network Provider, up to a Lifetime Maximum of $5,000.

K. EXCLUSIONS

War - 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, warlike operations (whether war be 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 "Occurrences").

Any consequence 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 by, traceable to, or arising in connection with, any of the said Occurrences shall be deemed to be consequences for which the Company shall not be liable under this Certificate except to the extent that the Insured Person shall prove that such consequence happened independently of the existence of such abnormal conditions.

Charges for the following services and/or supplies and/or treatments and/or conditions are excluded from coverage hereunder:

1. Pre-existing Conditions - Charges resulting directly or indirectly from any Pre-existing Condition, as herein defined, are excluded from this insurance until the Insured Person has maintained coverage hereunder continuously for 24 months; and

2. Charges for treatment of the following Illnesses which manifest themselves and/or procedures which take place and/or are recommended during the first 180 days of coverage hereunder beginning on the initial Effective Date: any condition of the breast, any condition of the prostate, tonsillectomy, adenoidectomy, hemorrhoids or hemorrhoidectomy, disorders of the reproductive system, hysterectomy, hernia, gall stones or kidney stones. Note, coverage for these Illnesses may be further limited under the Pre-existing Conditions exclusion and definition contained herein.

3. Maternity and Newborn Care - Charges for pre-natal care, delivery, post-natal care, and care of Newborns, are excluded from this insurance until the Insured Person has maintained coverage hereunder continuously for 12 months; and

4. Mental and Nervous - Charges for treatment of Mental or Nervous Disorders are excluded from this insurance until the Insured Person has maintained coverage hereunder continuously for 12 months; and

5. Wellness - Charges for Routine Physical Exams are excluded from this insurance until the Insured Person has maintained coverage hereunder continuously for 24 months, and if Female, has reached the age of 35, and if Male, has reached the age of 40. In no event will the Company pay for more than one Routine Physical Exam during any 12 month period.

6. Treatment which is not incurred by an Insured Person during the Period of Insurance; and

7. Treatment of Injury or Illness which are not presented to the Company for payment within 90 Days of the date incurred; and

8. Treatment which is not administered or ordered by a Physician; and

9. Treatment, services or supplies which are not Medically Necessary; and

10. Treatment provided at no cost to the Insured Person; and

11. Charges which exceed Usual, Reasonable, and Customary; and

12 Telephone consultations or failure to keep a scheduled appointment; and

13. Surgeries or treatments which are Investigational, Experimental, or for Research purposes; and

14. While confined primarily to receive Custodial Care, Educational or Rehabilitative Care; and

15. Weight modification, or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass Surgery; and

16. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the person such as sex-change Surgery; and

17. Treatment or surgery for cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is directly related to or follows a Surgery which was covered hereunder; and

18. Treatment which is incurred by Insured Persons who were HIV + at the Effective Date of this insurance; whether or not the Insured Person had knowledge of his/her HIV status; and

19. Any drug, treatment or procedure that either promotes or prevents conception; including but not limited to: artificial insemination; treatment for infertility or impotency; sterilization or reversal of sterilization; and

20. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction; and

21. Dental Treatment, except for Emergency Dental Treatment necessary to replace sound natural teeth lost or damaged in an Accident covered hereunder; and

22. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, or for any examination or fitting related to these devices; and

23. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism; and

24. Treatment of the temporomandibular joint; and

25. Care or treatment of Newborns after the first 31 days; and

26. Injury sustained while taking part in mountaineering where ropes or guides are normally used, Amateur or professional athletics, aviation (except when traveling solely as a passenger in a commercial aircraft) hang gliding and parachuting, snow skiing except for recreational downhill and/or cross country snow skiing (no cover provided whilst skiing away from prepared and marked in-bound territories and/or against the advice of the local ski school or local authoritative body), racing by horse, motor or motorcycle, spelunking, and subaqua pursuits involving underwater breathing apparatus; and

27. Injury sustained while under the influence of or due wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with treatment prescribed and directed by a Physician but not for the treatment of Substance Abuse; and

28. Willfully self-inflicted Injury or Illness; and

29. Venereal disease; and

30. Testing for the following: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS; and

31. Immunizations and routine physical exams except for Newborns under the age of 31 days and except for the expenses provided for under I. WELLNESS EXPENSES; and

32. Treatment by a chiropractor, unless ordered in advance by a Physician; and

33. Charges resulting from or occurring during the commission of a violation of law by the Insured Person, including, without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations; and

34. Treatment for Substance Abuse.

35. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy; and

36. Any services or supplies performed or provided by a Relative of the Insured Person; and

37. Orthoptics and visual eye training; and

38. Services or supplies which are not included as Eligible Medical Expenses as described herein; and

39. Services or supplies which are provided by a person who ordinarily resides in the Insured Person's home; and

40. The following care, treatment or supplies for the feet: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; and treatment of corns, calluses or toenails; and

41. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician; and

42. Treatment of sleep disorders; and

43. Exercise programs, whether or not prescribed or recommended by a Physician; and

44. Treatment required as a result of complications or consequences of a treatment or condition not covered hereunder; and

45. Charges for travel or accommodations, except for Local Ambulance Expense resulting in Hospitalization, Emergency Medical Evacuation, and Transplant benefit, as provided herein.

46. Treatment incurred as a result of exposure to non-medical nuclear radiation, and/or radioactive material(s).

47. Organ or Tissue Transplants or related services, except for Covered Transplants as defined herein; and

48. Artificial or mechanical devices designed to replace human organs temporarily or permanently; and

49. Expenses to keep a donor alive for a transplant procedure, whether or not the transplant procedure is a Covered Transplant; and

50. Expenses incurred outside the Managed Transplant System Network; and

51. Transplant benefits for more than one Covered Transplant during any twelve (12) month period, except re-transplantation if during initial transplant hospitalization.

L. EMERGENCY MEDICAL EVACUATION BENEFIT

Subject to the limit set forth in the Schedule of Benefits/Limits, and the Conditions and Restrictions contained herein, the Company will pay the following Expenses arising out of Emergency Medical Evacuation incurred while this insurance is in effect:

1. Emergency air transportation to a suitable airport nearest to the Hospital where the Insured Person will receive treatment; and

2. Emergency ground transportation necessarily preceding emergency air transportation; and from the destination airport to the Hospital where the Insured Person will receive treatment.

Conditions and Restrictions

1. The Insured Person must be in compliance with all conditions and provisions of this Certificate.

2. The Company will provide Emergency Medical Evacuation Benefits only when the condition giving rise to the Emergency Medical Evacuation is covered under this Certificate.

3. The Company will provide Emergency Medical Evacuation Benefits only when all of the following

conditions are met:

a. Medically Necessary treatment cannot be provided locally; and

b. Transportation by any other method would result in loss of Insured Person's life; and

c. Recommended by the attending Physician who certifies to the above; and

d. Agreed upon by the Insured Person or a Relative of the Insured Person; and

e. Approved in advance and coordinated by the Company; and

f. The condition giving rise to the Emergency Medical Evacuation occurred spontaneously and without advance warning, either in the form of Physician recommendation or symptoms which would have caused a prudent person to seek medical attention prior to the onset of the Emergency.

4. The Company will arrange Emergency Medical Evacuation only to the nearest Hospital which is qualified to provide the Medically Necessary treatment to prevent the Insured Person's loss of life.

5. The Company will use its best effort to arrange any Emergency Medical Evacuation within the least amount of time possible. The Insured Person understands that the timeliness of Emergency Medical Evacuation can be affected by circumstances which are not within the direct control of the Company such as: availability of transportation equipment and staff, delays or restrictions on flights caused by mechanical problems, government officials, telecommunications problems, weather and other acts of God. The Insured Person agrees to hold the Company harmless and the Company shall not be held liable for any delays which are not within the direct and immediate control of the Company.

M. DEFINITIONS

Accident: A sudden and unexpected occurrence resulting in Injury to the Insured Person.

A.I.D.S.: Acquired Immune Deficiency Syndrome, as that term is defined by the United States Centers for Disease Control.

Amateur Athletics: A sport or other athletic activity which is organized and/or sanctioned, involving regular or scheduled practices and/or regular or scheduled games. This definition does not include athletic activities which are non-contact and engaged in by an Insured Person solely for recreational, entertainment or fitness purposes.

Application: The fully answered and signed individual application for which is a part of this Certificate.

Assured: The Global Medical Services Group Insurance Trust, Indianapolis, Indiana.

Cancellation Table: The table used by the Company to calculate Short Rate Earned Premium in the event of Cancellation. A copy of this table is available to the Insured Person upon request.

Certificate: The document issued to the Insured Person which provides evidence of benefits payable under the Master Policy, and which includes the Insured Person's Application.

Coinsurance: The payment by the Insured Person of Eligible Medical Expenses at the percentage specified in the Schedule of Benefits/Limits.

Covered Transplant: Heart, Heart/lung, lung, Kidney, Kidney/Pancreas, Liver and Allogenic and Autologous Bone Marrow.

Custodial Care: That type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist an Insured Person.

Declaration: The Declaration is attached to and forms a part of this Certificate.

Deductible: The dollar amount of Eligible Medical Expenses, specified in the Declaration, that the Insured Person must pay per Period of Insurance.

Dental Treatment: The care of teeth, gums, or bones supporting the teeth, including dentures and preparation for dentures.

Disabled: A person who has a congenital or acquired mental or physical defect that interferes with normal functioning of the body system or the ability to be self-sufficient.

Durable Medical Equipment (DME): Durable Medical Equipment consists of the following items: a standard basic hospital bed; and/or a standard basic wheel chair.

Educational or Rehabilitative Care: Care for restoration (by education or training) of one's ability to function in a normal or near normal manner following an Illness or Injury. This type of care includes, but is not limited to, vocational or occupational therapy, and speech therapy.

Effective Date: The date coverage under this insurance begins. The Effective Date of insurance is the date the Company approves a completed Application with required Premium. No coverage is Effective until the Company notifies the Insured Person in writing. The Effective Date is found on the Declaration.

Emergency: A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within 24 hours.

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

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

Home Health Care Agency: A public or private agency or one of its subdivisions, which operates pursuant to law; and is regularly engaged in providing Home Nursing Care under the supervision of a Registered Nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation and treatment by a Physician.

Home Nursing Care: Services provided by a Home Health Care Agency and supervised by a Registered Nurse, which are directed toward the personal care of a patient; provided always that such care is provided in lieu of Medically Necessary Inpatient care in a Hospital.

Hospital: An institution which operates as a hospital pursuant to law; and is licensed by the State or Country in which it operates; and operates primarily for the reception, care, and treatment of sick or injured persons as Inpatients; and provides 24-hour nursing service by Registered Nurses on duty or call; and has a staff of one or more Physicians available at all times; and provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical or mental/nervous conditions on its premises; and is not primarily a long-term care facility, Extended Care Facility, nursing, rest, custodial care, or convalescent home, a place for the aged, drug addicts, alcoholics or runaways; or similar establishment.

Illness: A sickness or disease. Illness does not include learning disabilities, attitudinal disorders or disciplinary problems.

Injury: Bodily Injury resulting from an Accident.

Inpatient: A person who is an overnight resident patient of a Hospital, using and being charged for room and board.

Insured Person: The person named on the Declaration of this Certificate.

Intensive Care Unit: A Cardiac Care Unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Investigational, Experimental, or for Research Purposes: Terms used to describe procedures, services or supplies that are by nature or composition, or are used or applied, in a way which deviates from generally accepted standards of current medical practice.

Medically Necessary: A service, medicine or supply which is necessary and appropriate for the diagnosis or treatment of an Illness or Injury based on generally accepted current medical practice as determined by the Company. A service, medicine or supply will not be considered Medically Necessary if it is provided only as a convenience to the Insured Person or provider; and/or is not appropriate for the Insured Person's diagnosis or symptoms; and/or exceeds (in scope, duration

or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment.

Mental or Nervous Disorder: A mental or emotional disease or disorder which generally denotes a disease of the brain with predominant behavioral symptoms; or a disease of the mind or personality, evidenced by abnormal behavior; or a disorder of conduct evidenced by socially deviant behavior. Mental or Nervous Disorders include: psychosis; depression; schizophrenia; bipolar affective disorder; and those psychiatric illnesses listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association. Mental or Nervous Disorders does not include learning disabilities, attitudinal disorders or disciplinary problems. For purposes of this insurance, Mental or Nervous Disorders does not include Substance Abuse.

Newborn: An infant from the moment of birth through the first 31 days of life.

Outpatient: A person who receives Medically Necessary treatment by a Physician for Injuries or Illnesses which do not require an overnight stay in a Hospital.

Physician: A duly licensed practitioner of the medical arts. A Physician must be currently licensed by the state in which the services are provided, and the services must be within the scope of that license.

Period of Insurance: The period beginning on the Effective Date and ending on the Termination Date specified in the Declaration. The Period of Insurance can be no more than 12 consecutive months.

Plan Administrator: International Medical Group, Inc., 407 North Fulton Street, Indianapolis, Indiana, 46202, Telephone Number 317/655-4500, or 1-800-628-4664, Fax Number 317/655-4505

Pre-existing Condition: Any Injury, Illness or Mental or Nervous Disorder which existed at the initial Effective Date of this Insurance and/or any chronic or recurring Illness and/or chronic or recurring Mental or Nervous Disorder which existed at or prior to the initial Effective Date of this Insurance. Pre-existing Condition also includes any complications or consequences associated with these conditions.

Pregnancy: The physical condition of being pregnant, including complications of pregnancy.

Registered Nurse: A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." after his or her name.

Relative: Parent, guardian, spouse, or immediate family member of the Insured Person.

Routine Physical Exam: Examination of the physical body by a Physician for preventative or informative purposes only, and not for the diagnosis or treatment of any condition.

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

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

Usual, Reasonable and Customary: The most common charge for similar services, medicines, or supplies within the area in which the charge is incurred, so long as those charges are Reasonable. What is defined as Usual, Reasonable and Customary Charges will be determined by the Company. In determining whether a charge is Usual, Reasonable and Customary, the Company may consider one or more of the following factors: the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or service as compared to the length of time required to perform other similar services; the severity or nature of the Illness or Injury being treated; the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; such other factors as the Company, in the reasonable exercise of its discretion, determines are appropriate.

N. HOW TO FILE A CLAIM

Notice of Claim, Claim Forms and Proof of Claim must be mailed to International Medical Group, Inc.