EXPAT VIP **BRONZE**

CONDITIONS OF COVERAGE

VUMI

WELCOME TO **VUMI**

We are pleased that you chose us to provide you and your family with the best health care and the most innovative and comprehensive international health insurance coverage. All of our products come with our exclusive VIP medical service no matter where you are, at any time of day or night.

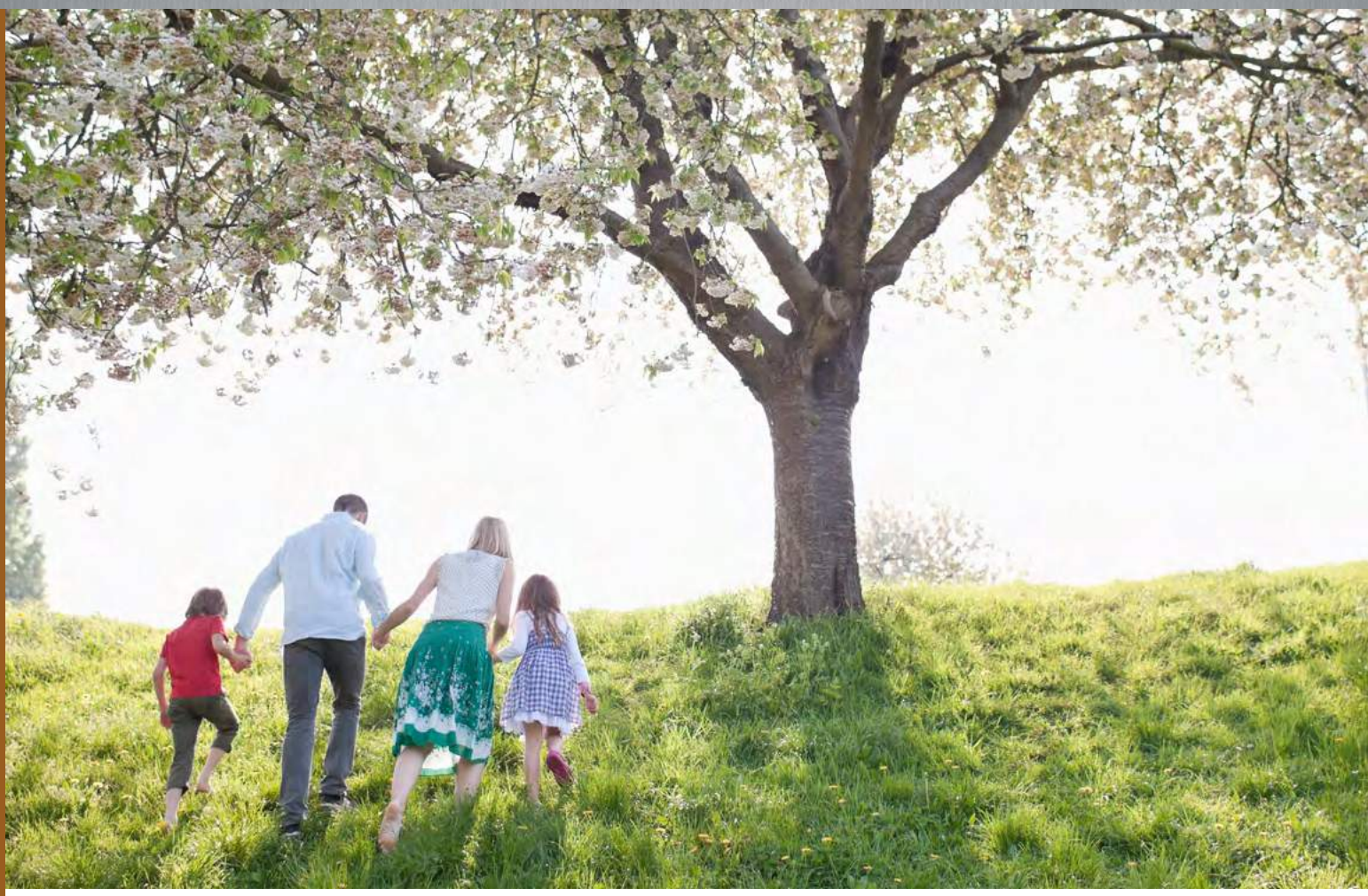
The purpose of this document is to offer you a detailed guide about your policy. The document is divided into nine sections that define the coverage, duration, benefits, exclusions, and eligibility of your policy. Likewise, you will also find general information, your obligations as an insured, and definitions that will help you better understand the functionality and the benefits of your policy.

With our insurance, you will have the peace of mind that your health is in the best hands 24 hours a day, anywhere in the world. Our products are backed by a strong global company with an extensive provider network and exclusive VIP medical service that will guide you when you need it most.

Once again, welcome to VUMI.

David A. Rendall
President & CEO
VIP Universal Medical Insurance Group, Ltd.

EXPAT VIP **BRONZE**



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EFFECTIVE JULY 2018

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VIP Universal Medical Insurance Group, Ltd.
Insurance company registered in the Turks & Caicos Islands, a British Overseas Territory.
Administration services provided by VIP Universal Medical Insurance Group, LLC,
a company registered in Dallas, Texas, U.S.A.

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TABLE OF BENEFITS

Effective **July 2018**

DEDUCTIBLE OPTIONS*

OPTION I	OPTION II	OPTION III	OPTION IV	OPTION V
US$250	US$500	US$1,000	US$2,500	US$5,000

*Only one Deductible per person, per Policy Year applies. For family Policies, a maximum of two Deductibles accumulated per Policy, per Policy Year will be applied.

GENERAL PLAN INFORMATION

DESCRIPTION	COVERAGE		
Geographical coverage	Worldwide (including U.S. coverage)		
Maximum coverage per person, per lifetime	US$1,500,000		
Age limit to apply	74		
Waiting period	30 days		
Coinsurance limit	U.S. IN NETWORK 20% of the first US$5,000 of covered medical charges, after the deductible	U.S. OUT OF NETWORK 50% of covered medical charges, after the deductible	OUTSIDE THE U.S. No coinsurance applies

INPATIENT BENEFITS

DESCRIPTION	U.S. IN NETWORK	U.S. OUT OF NETWORK	OUTSIDE THE U.S.
Adult companion accommodation (related to the hospitalization of a child under the age of 18)	US$100 per night, max. of 30 nights		
Ancillary hospital services (X-rays, medications, bandages, operating room fees, surgical implants)	80%	50%	100%
Extended care facility (max. 30 days)	80%	50%	100%
Intensive Care Unit (ICU)	80% up to US$1,500 per day	50% up to US$1,500 per day	US$1,500 per day
Physician and specialist visits (max. one visit per day, per specialty)	80%	50%	100%
Pre-admission exams (must be performed before a non-emergency hospitalization)	80%	50%	100%
Standard private or semi-private room	80% up to US$600 per day	50% up to US$600 per day	US$600 per day

OUTPATIENT BENEFITS

DESCRIPTION	U.S. IN NETWORK	U.S. OUT OF NETWORK	OUTSIDE THE U.S.
Cancer treatment	80%	50%	100%
Chiropractor	80% up to US$50 per visit	50% up to US$50 per visit	US$50 per visit

OUTPATIENT BENEFITS

DESCRIPTION	U.S. IN NETWORK	U.S. OUT OF NETWORK	OUTSIDE THE U.S.
Diagnostic study services (laboratory tests, pathology, X-rays, MRI/CT/PET scans)	80%	50%	100%
Emergency room (if not admitted to the hospital, a copayment of US$250 will apply)	80%	50%	100%
Nurse care at home	80%	50%	100%
Palliative care for terminal cases (max. 180 days)	80%	50%	100%
Physician and specialist visits	US$70 per visit	50% up to US$70 per visit	US$70 per visit
Preventive health checkup for adults (after a 12-month waiting period)	US$100, no deductible applies		
Preventive health checkup for children under age 19 (after a 12-month waiting period)	US$200, no deductible applies	50% up to US$200, no deductible applies	US$200, no deductible applies
Reconstructive surgery (due to a covered injury or illness)	80%	50%	100%
Rehabilitation and therapeutic services (physical, speech and occupational therapy)	Max. 30 visits		

GENERAL MEDICAL BENEFITS

DESCRIPTION	U.S. IN NETWORK	U.S. OUT OF NETWORK	OUTSIDE THE U.S.
Bariatric surgery (after a 24-month waiting period)	US$5,000 (per lifetime)		
Congenital and hereditary conditions	80% up to US$250,000 (per lifetime)	50% up to US$250,000 (per lifetime)	US$250,000 (per lifetime)
Dialysis	80%	50%	100%
Durable medical equipment	80%	50%	100%
Organ transplant (after a 12-month waiting period)	80% up to US$250,000 (per lifetime)	Not covered	US$250,000 (per lifetime)
Prescription medication	80% up to US$20,000	50% up to US$20,000	US$20,000
Prostheses and medical appliances implanted during surgery	80% up to US$10,000 per prosthesis (up to US$20,000 per lifetime)	50% up to US$10,000 per prosthesis (up to US$20,000 per lifetime)	US$10,000 per prosthesis, (up to US$20,000 per lifetime)
Psychotherapy and mental health (after a 12-month waiting period; outpatient treatment only)	80% up to US$60 per visit	50% up to US$60 per visit	US$60 per visit
Surgery and primary surgeon fees	80%	50%	100%
Surgery – anesthesiologist fees	30% of the primary surgeon approved fees		
Surgery – Assisting Surgeon fees	20% of the primary surgeon approved fees		

MATERNITY BENEFITS**

DESCRIPTION	U.S. IN NETWORK	U.S. OUT OF NETWORK	OUTSIDE THE U.S.
Cesarean delivery	US$5,000		

MATERNITY BENEFITS**

DESCRIPTION	U.S. IN NETWORK	U.S. OUT OF NETWORK	OUTSIDE THE U.S.
Maternity and newborn complications	80% up to US$50,000 (per lifetime)	50% up to US$50,000 (per lifetime)	US$50,000 (per lifetime)
Normal delivery (prenatal and postnatal care)	US$4,000		

**After a ten (10)-month Waiting Period. This benefit is only available for Deductible options I, II, III and IV. Coverage up to the limits above for the Insured female Policy holder or Insured Dependent spouse only. The Lifetime maximum of seventy-five thousand dollars (US$75,000) combines coverage for all maternity benefits, including Covered Maternity, Maternity Complications, Birth Complications, and newborn Complications.

MEDICAL EVACUATION BENEFITS

DESCRIPTION	U.S. IN NETWORK	U.S. OUT OF NETWORK	OUTSIDE THE U.S.
Emergency transportation by air ambulance	US$50,000, no deductible applies		
Emergency transportation by ground ambulance	80% up to US$1,500 per event	50% up to US$1,500 per event	US$1,500 per event
Emergency transportation for one companion	Not covered		
Insured's return ticket (economy class, for specific medical conditions)	US$500		
Repatriation of mortal remains or local burial	US$25,000 (per lifetime), no deductible applies		

OTHER BENEFITS

DESCRIPTION	U.S. IN NETWORK	U.S. OUT OF NETWORK	OUTSIDE THE U.S.
Emergency dental coverage due to a covered accident	80% up to US$1,000	50% up to US$1,000	US$1,000
Hazardous hobbies and sports (non-professional)	US$50,000 (per lifetime)		
Serious accident	100%, no deductible applies		
Second Medical Opinion VIP	100%, no deductible applies		

Unless otherwise stated, the benefits are offered on a per Insured/per Policy Year basis in which the chosen Deductible applies. All amounts are in US Dollars (USD). The benefits are limited to the medical expenses covered under this Policy and are subject to the Usual, Customary, and Reasonable expenses (UCR) for the geographical area where the expenses were incurred.

SECTION 1. **AGREEMENT**

VIP Universal Medical Insurance Group Limited (VUMI), hereinafter the "Company," undertakes to pay to the Policyholder the benefits detailed in this Policy related to the covered expenses incurred by the Policyholder, his/her Spouse or Domestic Partner, and any Insured Dependents, as a result of any treatment, service or medical supply anywhere in the world after the Effective Date of the coverage of this Policy while it is in effect.

All benefits are subject to the terms and conditions of the Policy, including the applicable Deductibles, maximum benefits and the limits detailed in the Summary of Benefits and the Certificate of Coverage which are a part thereof.

1.1 Right to examine the Policy and reimbursement of the unearned premium

The Policyholder can cancel this Policy and return it to the Company within a period of fifteen (15) days after receipt of this Policy. If during said period no claims have been made under the Policy, the Company will reimburse the premium paid to the Policyholder, minus seventy-five dollars (US$75) for the administrative fee (if applicable), and the Policy will be considered invalid as if it had never been issued. If the Policyholder or the Company cancels the Policy after it has been issued, reinstated or renewed, the Company will reimburse the Policyholder the unearned portion of the premium, minus the seventy-five dollar (US$75)

administrative fee, up to a maximum of sixty-five percent (65%) of the total amount of the premium. The administrative fees and a thirty-five percent (35%) retention by the Company will not be reimbursed.

1.2 Important notice about the Application

This Policy is issued based on the statements provided in good faith by the Policyholder. If any of the information disclosed in the Application is false, incorrect, incomplete, had the intent of misleading or deceiving, or was omitted, resulting in worsening the risk, the Policy will be rescinded and will have no effect, and the Company will not be responsible for any payments of the benefits offered under this Policy. Likewise, if a Provider or any other individual or entity who has rendered medical services to the Policyholder and/or to one of the Insureds should submit false statements in collusion with the Policyholder and/or one of the Insureds with the purpose of claiming payments against this Policy, its articles, and/or its Amendments, the Policy will be rescinded, will have no effect, and the Company will not be responsible for any payment of benefits under this Policy. The Policyholder and/or the Insured(s) would then reimburse the Company for any payments it may have made as a result of an omission, incorrect disclosure or negligence by the Policyholder and/or the Insured(s).

1.3 Entire contract between the Policyholder and the Company. It includes:

- **A** The Policy (this document);
- **B** The Application signed by the Policyholder, which has been used for underwriting to evaluate the risk;
- **C** Any medical exam that may have been required by the Company, as well as any other document that may have been needed at the time of application, including but not limited to the results of the telephone interview done by the underwriter (if any), medical reports, and any other relevant information having to do with the underwriting of the coverage;
- **D** Any document that may be required to add new Dependents to a Policy or to modify the coverage;
- **E** The Certificate of Coverage;
- **F** Amendments (if applicable), which modify the terms and conditions of this Policy; and
- **G** Riders (if acquired), which might include additional coverage.

SECTION 2. **COVERAGE DURATION**

Coverage begins at one (1) minute past midnight (00:01) Eastern Standard Time on the Effective Date of this Policy and ends three hundred and sixty-five (365) days later at midnight (00:00). The coverage has a duration period of twelve (12) months and shall be renewed automatically for a similar period of time with the corresponding premium payment, subject to the definitions, conditions, and other provisions of this Policy, which may be in effect at the time of renewal.

SECTION 3. **ELIGIBILITY**

3.1 Eligibility requirements

This Policy provides coverage for a person who, at the time of the application:

- **A** Is an Expatriate who is a citizen of the United States or Canada;
- **B** Resides in a country outside the U.S., Canada, or any of their territories;
- **C** Is at least eighteen (18) years of age or is authorized by one of his/her parents or a legal guardian; and
- **D** Pays the applicable premium.

3.2 Age at application

When applying for coverage, the Applicant and his/her Spouse or Domestic Partner must be no more than seventy-four (74) years old. They may apply up to the day before their seventy-fifth (75th) birthday. The Dependents are eligible to apply for coverage under the Policyholder's Policy.

3.3 Age at renewal

There is no maximum age for the renewal of this Policy by the Policyholder and his/her Spouse or Domestic Partner. Coverage is available for the Policyholder's Dependent children until the day before their nineteenth (19th) birthday if they are single, or until the day before their twenty-fourth (24th) birthday if they are single and full-time students (with a minimum of twelve (12) credits per semester) at an accredited college or university at the time the Policy is issued or renewed. The Company reserves the right to request certification by a representative of the university in question in reference to the status of the Dependent in said institution. When no longer Dependents under a Policy, the Dependents will be eligible to obtain coverage under their own Policy by paying the applicable premium, with an equal or higher Deductible, with the same conditions and restrictions of the previous Policy, and without the need for underwriting.

3.4 Newborn from Covered Maternity

A newborn child born from a pregnancy covered by this Policy will be included to the Policy as a Dependent and without the need for underwriting. The Company must receive written notice containing the child's name, gender, and date of birth, within the first ninety (90) days after the birth takes place, together with the applicable premium

payment. Coverage for the child will become effective from the date of birth and without a Waiting Period.

3.5 Legal separation or divorce

In the event of a legal separation or divorce, the Insured must notify the Company within thirty (30) days of the event. The Dependent Spouse or Domestic Partner will have coverage until the end of the Policy Year, at which time the Company will offer a separate Policy with the same plan, Deductible, and conditions as the previous Policy. The premium for the new Policy must be paid within thirty (30) days of its Effective Date.

3.6 Dependent child with permanent disabilities

If the Policyholder has a child with permanent physical or mental disabilities from a covered condition, coverage for the child with disabilities may continue past the Dependent child age limit, provided that proof of the permanent disability is submitted to the Company within thirty (30) days of the child reaching the age limit. The disability must have been the result of a condition covered under this Policy and must have occurred before the Dependent child reaches the age limit. The coverage will terminate if the Insured fails to provide proof of continued impairment; if the Insured fails to take a required exam; if the disability ceases; or if coverage must be terminated for a reason other than reaching the age limit. The Company reserves the right to require continuing proof of the disability. The Company, at its own expense, also reserves the right to examine the child as often as it sees fit. After the Dependent child reaches the age limit, an exam will be required annually.

3.7 Death of Policyholder

In the event of the death of the Policyholder, the Company will pay any benefits that remained unpaid while the Policyholder was alive to the legal heir(s)/heiress(es) or inheriting entity(ies) of the deceased Policyholder, or to the Provider of the medical services.

If there are any Dependents in the Policy, the Policy will be transferred, and the new Policyholder will be the surviving Dependent Spouse or Domestic Partner or, if there is no covered Spouse or Domestic Partner, the oldest Dependent who is eighteen (18) years of age or older. If the only Dependent left in the Policy is under the age of eighteen (18), the Policy may continue if an adult is named to the Policy as a contracting party who will not be covered under the Policy and who will not have to pay a premium payment. The Dependent minor must pay a premium to the amount of the rate for Insureds who are eighteen (18) years old.

SECTION 4. OBLIGATIONS OF THE INSURED

4.1 Deductible

Each Insured will have one (1) Deductible per Policy Year, unless an additional Deductible was applied for a specific medical condition during the underwriting process. For family Policies, a maximum of two (2) Deductibles accumulated per Policy, per Policy Year will be applied. All amounts applied to the Deductible for each of the different members of the family on the same Policy will be taken into account to reach the two Deductibles.

4.2 Change of Country of Residence

The Policyholder must notify the Company, in writing, of any changes to their Country of Residence within the first thirty (30) days after the change occurs. Failure to notify the Company of the change of Country of Residence as indicated may result in a modification, cancellation, or non-renewal of this Policy. Visits to the U.S. or Canada are allowed up to a maximum of one hundred and eighty (180) days per Policy Year, but coverage will terminate at the end of the one hundred and eightieth (180th) day if an Insured remains in the U.S. or Canada for longer than one hundred and eighty (180) consecutive days within a Policy Year.

4.3 Premium payment

Payment of the premium is the responsibility of the Policyholder. The premium is payable according to the mode of payment selected by the Policyholder and/or on the Renewal Date of this Policy. Payment of the premium makes the Policy effective during the period for which the premium has been paid. Any excess premium paid can be reimbursed if requested by the Policyholder and will be reimbursed without adding any interest and in the same manner as paid. Failure to pay the premium will result in the termination of the Policy from the Renewal Date. The renewal of this Policy is guaranteed for life as long as the premium is paid according to the payment terms of the Policy.

4.4 Medical notifications

The Policyholder and/or the Insured must notify the Company prior to receiving those medical services that require notification or pre-authorization, pursuant to Section 8.3 of this Policy, by calling the telephone number or sending a written notification to the e-mail listed on the back of their ID card. If the Policyholder and/or Insured fail to notify the Company accordingly, they will be responsible for thirty percent (30%) of all covered costs in addition to the applicable Deductible.

4.5 Claims

Claims or invoices related to covered expenses under this Policy must be submitted to the Company within the first six (6) months after the service date in order for them to be eligible for coverage.

4.6 Medical records

The Applicant or Policyholder, because of the underwriting and/or claims process, must provide the Company with all the medical information

required. Additionally, the Applicant or Policyholder, as well as his/her Dependents, must authorize the Company to obtain all medical records and/or documents deemed necessary to conclude the underwriting or claim process, as the case may be.

SECTION 5. GENERAL INFORMATION

5.1 Waiting Period

This Policy carries a thirty (30)-day Waiting Period that begins on the Effective Date of the Policy. During this time, the coverage will be limited to the conditions first manifested and whose cause is originated by Injury suffered during an Accident or of Infectious Origin. Any other condition or symptom that is not caused by an Accident or condition of Infectious Origin and that is first manifested during this Waiting Period shall be permanently excluded for that particular Insured for the rest of the time he/she remains Insured under this Policy, with the exception of a pregnancy.

5.2 Waiver of the Waiting Period

The Waiting Period may be waived or eliminated if all of the following requirements are met:

- **A** The prior coverage is disclosed in the Application and the Company receives a copy of the prior Policy as well as the receipt for payment of the prior Policy for its last twelve (12) months;
- **B** The Application is submitted to the Company within thirty (30) days after the termination of the coverage of the former Policy; and
- **C** The Insured was previously covered by a similar medical insurance that was in force for a consecutive period of twelve (12) months immediately after the Effective Date.

If the Waiting Period is waived, the benefits payable under this Policy for any condition that occurred during the waived period are permanently limited to the lesser of the benefits offered by this Policy or the prior Policy for the rest of the time that the Insured remains Insured under this Policy. The waiver of the Waiting Period applies only to the initial thirty (30)-day Waiting Period that begins on the Effective Date of the Policy. All other Waiting Periods including but not limited to maternity care and preventive health check-ups are not affected by the waiver and will apply as per the terms outlined in the Policy.

5.3 Coordination of benefits

When the Insured has other insurance coverage, it must be disclosed to the Company when submitting a claim. The coverage under this Policy will act as secondary to any other active Policy or healthcare plan. When the Insured is eligible for enrollment in a government sponsored plan (for example, Medicare for U.S. citizens) the Insured is responsible for obtaining such coverage in order for the Company to become the secondary payor. The Company will provide benefits after the claims have been submitted to the primary insurance plan first and only when benefits payable under the primary Policy have been satisfied. The Company shall process the coordination of the benefits in which the amounts paid by the other company will be applied to the Deductible in accordance with the benefits and limitations of this Policy.

When filing a claim subject to coordination of benefits, proof of the other insurance coverage must be submitted along with a copy of the itemized invoices, as well as proof of the payments made by the other company. The total amount of payments is not to exceed the total of the expenses incurred; the Company shall not pay any amount reimbursed by the other company even though it may exceed the Deductible of this Policy.

5.4 Network

For U.S. coverage, this Policy utilizes the Expat VIP USA Network. This network includes Providers contracted by the company to offer medical services to Insureds at a discounted rate. Coverage for services provided In-Network are usually greater than coverage for services provided Out-Of-Network. See the Table of Benefits for a comprehensive list of coverage rates. For coverage outside the U.S., no network applies and the coverage amount is determined as listed under the Table of Benefits.

5.5 Currency

All currency values shown in this Policy are in US Dollars. The exchange rate used to pay claims generated in a currency other than US Dollars will be calculated based on the exchange type of legal tender in the country and at the time services are rendered.

5.6 Non-renewal or cancellation of the Policy

The Company reserves the right to non-renew, cancel, modify or rescind this Policy, as well as change the rates and the Deductible in those cases in which any of the following conditions are present:

- **A** The information disclosed in the Application is false, is incomplete or when fraud has been committed, any of which may have caused the Company to approve a Policy when, had the Company been provided the correct information, it would have issued the Policy with certain conditions or would have deemed that the Applicant was a non-insurable person;
- **B** The Insured changes Country of Residence and fails to notify the Company;
- **C** The Policyholder requests the cancellation of the coverage in writing or does not pay the premium as stipulated in this Policy; or
- **D** The Insured submits a claim or information deemed fraudulent by the Company. In the event such fraud should occur, the Policyholder shall be responsible and shall have to reimburse the Company for any payments made in connection with the claim in question, whether payment was made directly to the Provider(s) or in the form of a reimbursement to the Insured.

5.7 Policy issuance

This Policy is deemed issued when the Policyholder receives it in his/her Host Country of Residence.

5.8 Methods of Policy payment

Premiums can be paid annually, semi-annually, quarterly or according to the payment mode established by the Company.

5.9 Grace Period

The Company grants a thirty (30)-day Grace Period to pay the premium corresponding to the Policy, which starts on the day after the Expiration Date, in accordance with the specific mode of payment selected. If the full premium is not received by the Company before the end of the Grace Period, this Policy shall be deemed terminated as of its Expiration Date. No benefits or payments will be provided for expenses incurred after the Expiration Date. If the premium gets paid during this period, the Policy will be renewed.

5.10 Rate changes

The Company has the right to change the premium rates annually for new Policies or for existing Policies at the time of their renewal, based on the age segments defined in the premium rate table, and/or depending on the number of children who qualify as Dependents and annually as of the age of seventy-four (74). This shall be done in each Renewal Date. In no event will the Company modify the rates of an individual Insured based on his or her claim history.

5.11 Policy reinstatement

After the cancellation of a Policy for non-payment of the required premium after the Grace Period has expired, this Policy may be reinstated if a new Application is submitted. The Company reserves the right to approve such new Application.

5.12 Tools and resources for the Insured

Insureds have access to MyVUMI, an online portal where they can:

- A View information about the Policy such as Dependents, Exclusions, Amendments, and upcoming premium payments;
- B Review Policy documents such as their welcome letter, Certificate of Coverage, and member ID cards;
- C Access the informative booklet and conditions of coverage of their plan;
- D Download claim and payment forms;
- E Submit a claim or medical notification;
- F Contact VUMI; and
- G Obtain contact information for their agent.

myVUMI

Insureds have access to MyVUMI through **www.myvumiportal.com**, the Apple® App Store®, and Google Play™.

5.13 Denial of liability

The Company and the Policyholder are not responsible for the quality of medical services provided under this Policy. The Insured agrees to defend, indemnify, and hold harmless the Company from any claim, demand, cause of action, liability, loss, damage, and/or Injury resulting from negligence by a Provider or a Hospital.

5.14 Important notice regarding the Patient Protection and Affordable Care Act (PPACA)

This Policy is not subject to PPACA and does not provide certain benefits required in its provisions. In some circumstances, tax penalties may be imposed on U.S. citizens and U.S. residents who fail to obtain PPACA compliant coverage. Insureds are solely responsible for determining if PPACA applies to them.

SECTION 6. **BENEFITS AND PROVISIONS**

Unless otherwise stated, the benefits are offered on a per Insured/per Policy Year basis in which the chosen Deductible applies. All amounts are in US Dollars (USD). The benefits are limited to the medical expenses covered under this Policy and are subject to the Usual, Customary, and Reasonable expenses (UCR) for the geographical area where the expenses were incurred.

6.1 Geographical coverage

This plan provides coverage with free choice of Hospitals and Doctors anywhere in the world, including the U.S. For U.S. coverage, most benefits will have greater coverage if a Provider from the Expat VIP USA Network is utilized, but Out-Of-Network Providers will still be covered at a lower rate. There is no preferred Provider's network outside the U.S.

6.2 Inpatient and Outpatient physician and specialist visits

Inpatient and Outpatient physician and specialist visits are covered at eighty percent (80%) for In-Network coverage in the U.S., fifty percent (50%) for Out-Of-Network coverage in the U.S., and one hundred percent (100%) for coverage outside the U.S. For Inpatient visits, there is a maximum of one visit per day, per specialty.

6.3 Inpatient and Outpatient surgery

For Inpatient and Outpatient surgery, the surgery and primary surgeon fees are covered at eighty percent (80%) for In-Network coverage in the U.S., fifty percent (50%) for Out-Of-Network coverage in the U.S., and one hundred percent (100%) for coverage outside the U.S. Anesthesiologist fees are covered at thirty percent (30%) of the primary surgeon-approved fees, and Assisting Surgeon fees are covered at

twenty percent (20%) of the primary surgeon-approved fees. These benefits do not apply to bariatric surgery, which is covered according to the limits detailed in Section 6.14.

6.4 Adult companion accommodation related to the Hospitalization of a child

The coverage for this benefit is one hundred dollars (US$100) per night up to a maximum of thirty (30) nights. Charges must be included in the Hospital bill for overnight Hospital accommodation for the companion of a Hospitalized Insured child under eighteen (18) years old.

6.5 Hospitalization and Ancillary Hospital services

Hospital admissions are covered at eighty percent (80%) for In-Network coverage in the U.S., fifty percent (50%) for Out-Of-Network coverage in the U.S., and one hundred percent (100%) for coverage outside the U.S. This benefit must be for a covered condition and includes:

- A Any pre-admission exams, which must be performed before a non-emergency Hospital admission;
- B Standard private or semi-private room, with a maximum of six hundred dollars (US$600) per day,
- C Intensive Care Unit (ICU), with a maximum of one thousand five hundred dollars (US$1,500) per day; and
- D Ancillary Hospital services including X-rays, medications, bandages, operating room fees, and Surgical Implants (excluding Prostheses and Medical Appliances, which are covered as detailed in Section 6.19) administered during the covered Hospital stay.

6.6 Extended Care Facility

Extended Care Facility stays are covered at eighty percent (80%) for In-Network coverage in the U.S., fifty percent (50%) for Out-Of-Network coverage in the U.S., and one hundred percent (100%) for coverage outside the U.S. This benefit has a maximum of thirty (30) days. This benefit is covered when it occurs immediately after or instead of a Hospital stay for a covered condition, and it excludes services from custodial, homelike care, intermediate, and residential care facilities. Services covered under this benefit include:

- A Skilled Nurse care for a covered condition;
- B Special treatment rooms for treatments administered under the direct supervision of a physician or specialist; and
- C One Doctor's visit per day, per specialty.

Doctor's visits in an Extended Care Facility that are administered as a standard procedure for pre- or post-operative care will be covered according to the surgery benefits listed in Section 6.3. This benefit must be coordinated and approved in advance by the company.

6.7 Cancer treatment

Cancer treatment is covered at eighty percent (80%) for In-Network coverage in the U.S., fifty percent (50%) for Out-Of-Network coverage in the U.S., and one hundred percent (100%) for coverage outside the U.S. This benefit includes tests, prescription medication, treatment (chemotherapy and/or radiotherapy), and one (1) wig.

For breast cancer, this benefit also includes breast Prosthesis, reconstructive surgery to the affected breast and to the opposite breast for symmetry if required, and treatment for mastectomy or reconstruction complications. Reconstructive surgery for the breast must occur within twelve (12) months of the covered mastectomy.

6.8 Chiropractor

Chiropractic services are covered at eighty percent (80%) up to fifty dollars (US$50) per visit for In-Network coverage in the U.S. and fifty percent (50%) up to fifty dollars (US$50) per visit for Out-Of-Network coverage in the U.S. The benefit is covered up to fifty dollars (US$50) per visit for coverage outside the U.S. This coverage must be coordinated and approved in advance by the company.

6.9 Nurse care at home

Nurse care at home is covered at eighty percent (80%) for In-Network coverage in the U.S., fifty percent (50%) for Out-Of-Network coverage in the U.S., and one hundred percent (100%) for coverage outside the U.S. It must be coordinated and approved in advance by the Company. This benefit includes medical home care that has been prescribed by the treating Doctor, which includes services from certified professionals (Nurses or therapists) and does not include Custodial Care.

6.10 Palliative Care for terminal cases

Palliative Care for terminal cases is covered at eighty percent (80%) for In-Network coverage in the U.S., fifty percent (50%) for Out-Of-Network coverage in the U.S., and one hundred percent (100%) for coverage outside the U.S. The benefit applies toward palliative services to terminal ill patients with a prognosis of one hundred and eighty (180) days or less. This service must be provided by a medically supervised team of professionals, it must relate to a medical condition covered by this Policy with a diagnosis of a terminal Illness from a medical Doctor, and it must be rendered in an accredited hospice. This service must be coordinated and approved in advance by the Company.

6.11 Preventive health check-ups

Annual preventive health check-ups for children under nineteen (19) years of age are covered up to two hundred dollars (US$200) for In-Network coverage in the U.S. and for coverage outside the U.S. and fifty percent (50%) up to two hundred dollars (US$50) for Out-Of-Network coverage in the U.S. Annual preventive health check-ups for adults who are nineteen (19) years of age and older are covered up to one hundred dollars (US$100). This benefit is subject to a twelve (12)-month Waiting Period and has no Deductible. This benefit includes coverage for a nutritionist, smoking cessation treatments, physical evaluations, diagnostic procedures, and/or vaccinations.

6.12 Reconstructive surgery

Reconstructive surgery is covered at eighty percent (80%) for In-Network coverage in the U.S., fifty percent (50%) for Out-Of-Network coverage in the U.S., and one hundred percent (100%) for coverage outside the U.S. This benefit is covered if and when it is Medically Necessary as a result of a covered medical condition. In the case of treatment provided for nasal or septum malformations, coverage will be provided if caused by trauma received during an Accident covered by the Policy or due to the treatment of nasal cancer. Copies of the films and reports of the radiological exams or CT scans performed will be required.

6.13 Rehabilitation and therapeutic services

Rehabilitation and therapeutic services including physical, speech, and occupational therapy are covered for a maximum of thirty (30) visits. In all cases, the Company must receive the treatment plan, the estimated fees, and evidence of Medical Necessity for said treatment plan. Coverage for this care or treatment must be pre-authorized by the Company. The Company may authorize the extension of said care or treatment if it is Medically Necessary.

6.14 Bariatric and gastric bypass surgery for obesity

Bariatric and gastric bypass surgery is covered up to five thousand dollars (US$5,000) per Lifetime. This benefit is subject to a twenty-four (24)-month Waiting Period and it includes any complications that may arise from this procedure for the rest of the time the Insured is covered under this Policy or any other plan with the Company. The Company must receive notification about the procedure as soon as the Insured is informed that he/she has been selected as a candidate to receive this procedure and, therefore, everything related to the procedure must be coordinated in advance with the Company. If the Insured requests a change of plan where this benefit is higher, the lower benefit offered in the previous plan will prevail during two (2) years from the date of approval of the change of plan.

6.15 Congenital and Hereditary conditions

Congenital and Hereditary Disorders that manifest before the Insured's eighteenth (18th) birthday are covered at eighty percent (80%) up to two hundred and fifty thousand dollars (US$250,000) per Lifetime for In-Network coverage in the U.S. and at fifty percent (50%) up to two hundred and fifty thousand dollars (US$250,000) per Lifetime for Out-Of-Network coverage in the U.S. This benefit is covered up to two hundred and fifty thousand dollars (US$250,000) per Lifetime outside the U.S. In the event of multiple births covered by the Policy, each newborn will have the right to the Lifetime maximum of this benefit, providing that each newborn is included in the Policy in accordance with the described stipulations. Benefits for Congenital or Hereditary Disorders which first manifest on or after the eligible Insured's eighteenth (18th) birthday will be covered at one hundred percent (100%). These benefits exclude conditions resulting from any type of fertility treatment or procedures for assisted fertility.

6.16 Durable Medical Equipment

Durable Medical Equipment is covered at eighty percent (80%) for In-Network coverage in the U.S., fifty percent (50%) for Out-Of-Network coverage in the U.S., and one hundred percent (100%) for coverage outside the U.S. This benefit applies if the Durable Medical Equipment is Medically Necessary. This includes but is not limited to wheelchairs, canes, crutches, respirators, pressure mattresses, and walkers, provided that such equipment is prescribed by a physician and is customary useful to a patient during an Illness or an Injury. The allowable rental fee of the equipment must not exceed the purchase price. This coverage must be coordinated and approved in advance by the Company. Durable Medical Equipment excludes: motor-driven wheelchairs or beds; robotic devices (prosthetic or not); comfort items such as telephone accessories and over the bed tables; items used to modify air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies; exercycles; sun or heat lamps; heating pads; bidets; toilet seats; bathtub seats; sauna baths; elevators; whirlpool baths; exercise equipment and/or similar items; or the cost of instructions for the use and care of any medical device. Adaptations to any residential area or vehicle are also excluded.

6.17 Organ Transplant

Organ Transplant is covered at eighty percent (80%) up to two hundred and fifty thousand dollars (US$250,000) per Lifetime for In-Network coverage in the U.S. and is not covered if performed Out-Of-Network in the U.S. The benefit is covered up to two hundred and fifty thousand dollars (US$250,000) per Lifetime for coverage outside the U.S. This benefit is subject to a twelve (12)-month Waiting Period and includes:

- A Up to forty thousand dollars (US$40,000) for medical expenses related to the Live Donor;
- B All pre-Transplant care, which includes services directly related to the evaluation that established the need for the Transplant, the evaluation of the Insured to receive the Transplant procedure, and the preparation and stabilization of the Insured for said procedure;
- C All pre-surgery exams including laboratory exams, X-rays, CT scans, MRIs, ultrasounds, biopsies, Prescription Medication and supplies;
- D The cost of obtaining the organ and tissues and their harvesting and transportation;
- E The procedure to Transplant the organ;
- F All post-Transplant care directly related to the Transplant including but not limited to any follow up, any Medically Necessary treatment resulting from the Transplant, and any complication that may arise after the Transplant, whether it may be a direct or indirect consequence of the procedure; and
- G Any Medication or therapeutic measure used to ensure the viability and permanence of the Transplanted organ.

The following requirements must be met for a Transplant to be covered:

- A It is Medically Necessary;
- B It is not considered elective, Experimental or Investigative;

C No other procedures and/or treatments are available that will lead to the same level of results and care to treat the medical condition or Illness that has caused the need for the Transplant;
D It is not originated as a result of a Transplant where the receiver obtains a mechanical artifact or artificial equipment aimed to replace human organs, or when the Donor is an animal; and
E It is not performed due to an initial failed Transplant carried out prior to the Effective Date of this Policy or a non-approved Transplant that was carried out after the Effective Date of this Policy.

The Company must be notified as soon as it is determined that an Insured is a candidate for a Transplant in order to be coordinated and pre-authorized by the Company. The Company reserves the right to submit the medical documentation related to the Transplant to one or more medical specialists in Transplant procedures to determine the Medical Necessity and relevance of the procedure.

6.18 Prescription Medication

Prescription Medication is covered at eighty percent (80%) up to twenty thousand dollars (US$20,000) per Policy Year for In-Network coverage in the U.S. and at fifty percent (50%) up to twenty thousand dollars (US$20,000) per Policy Year for Out-Of-Network coverage in the U.S. This benefit is covered up to twenty thousand dollars (US$20,000) per Policy Year outside the U.S. A copy of the prescription written by a physician to treat a condition covered by this Policy must be sent along with the claim. This benefit excludes over-the-counter prescriptions and/or those not approved by the Food and Drug Administration of the United States of America (FDA) for the treatment of the medical condition suffered by the Insured.

6.19 Prostheses and surgical Medical Appliances

Prostheses and Medical Appliances implanted during surgery are covered at eighty percent (80%) up to ten thousand dollars (US$10,000) per Prosthesis with a Lifetime maximum of twenty thousand dollars (US$20,000) for In-Network coverage in the U.S. and at fifty percent (50%) up to ten thousand dollars (US$10,000) per Prosthesis with a Lifetime maximum of twenty thousand dollars (US$20,000) for Out-Of-Network coverage in the U.S. The benefit is covered up to ten thousand dollars (US$10,000) per Prosthesis with a Lifetime maximum of twenty thousand dollars (US$20,000) for coverage outside the U.S. Prostheses included under this benefit are artificial arms, legs, eyes, hips, and knees. This benefit will only be covered if:

A It is the result of a covered condition or Injury that initially took place after the Effective Date of this Policy;
B It is prescribed by a Doctor as part of a treatment plan for the covered condition or Injury; and
C It generally helps the Insured meet his or her basic needs after a condition or Injury.

6.20 Psychotherapy and mental health

Psychotherapy and mental health benefits are covered at eighty percent (80%) up to sixty dollars (US$60) per visit for In-Network coverage in the U.S. and at fifty percent (50%) up to sixty dollars (US$60) per visit for Out-Of-Network coverage in the U.S. This benefit is covered up to sixty dollars (US$60) per visit outside the U.S. This benefit includes treatment by a psychiatrist or a psychologist, is subject to a twelve (12)-month Waiting Period, and must be coordinated and approved in advance by the Company. This Policy only provides coverage for Outpatient treatment.

6.21 Maternity care (Options I, II, III, and IV)

Maternity care with a normal delivery, including prenatal and postnatal care, is covered up to four thousand dollars (US$4,000). Cesarean delivery is covered up to five thousand dollars (US$5,000). This benefit has a Lifetime maximum of fifty thousand dollars (US$50,000) and has a ten (10)-month Waiting Period. This benefit only applies for Deductible options I, II, III, and IV and includes natural deliveries, cesarean deliveries, Maternity and Birth Complications, and pre- and post-natal treatment. This benefit will cover only one (1) pregnancy at a time.

A For same-sex Domestic Partners, only one of them has the right to maternity care benefits.
B This benefit does not apply to Dependent daughters.
C The Lifetime maximum of fifty thousand dollars (US$50,000) listed above combines coverage for Covered Maternity, Maternity Complications, Birth Complications, and newborn Complications.

6.22 Maternity and Birth Complications

Maternity and Birth Complications are covered at eighty percent (80%) up to fifty thousand dollars (US$50,000) per Lifetime for coverage in the Special Maternity Network in the U.S. and fifty percent (50%) up to fifty thousand dollars (US$50,000) per Lifetime for coverage outside the Special Maternity Network in the U.S. The benefit is covered up to fifty thousand dollars (US$50,000) per Lifetime for coverage outside the U.S.

A Coverage is not provided for Complications of Birth in a pregnancy that is the result of any type of fertility treatment or assisted fertility procedure or in non-covered pregnancies under this Policy.
B Bed rest prescribed by a physician which does not require Hospitalization, as well as any other traditional symptoms of a pregnancy, will not be considered a Maternity Complication.
C This benefit does not apply to Dependent daughters.
D The Lifetime maximum of fifty thousand dollars (US$50,000) listed above combines coverage for Covered Maternity, Maternity Complications, Birth Complications, and newborn Complications.

6.23 Newborn complications

Newborn complications are covered at eighty percent (80%) up to fifty thousand dollars (US$50,000) per Lifetime for coverage in the Special Maternity Network in the U.S. and fifty percent (50%) up to fifty thousand dollars (US$50,000) per Lifetime for coverage outside the

Special Maternity Network in the U.S. The benefit is covered up to fifty thousand dollars (US$50,000) per Lifetime for coverage outside the U.S. Medical expenses for Injury or Illness of the newborn, such as respiratory distress, prematurity, hypoglycemia, low birth weight, and birth trauma, which were diagnosed within the first thirty (30) days of life, will receive coverage under this benefit. The child must have been born from a Covered Maternity under this Policy and must have been added to the Policy in the first ninety (90) days of life, and the premium must be paid. This benefit excludes conditions related to Congenital or Hereditary Disorders. The Lifetime maximum of fifty thousand dollars (US$50,000) listed above combines coverage for Covered Maternity, Maternity Complications, Birth Complications, and newborn Complications.

6.24 Medical evacuation through Emergency Air and Ground Ambulance

The benefit for Emergency Air Ambulance transportation is up to fifty thousand dollars (US$50,000) with no Deductible, and it includes up to five hundred dollars (US$500) for the Insured's return ticket to the place from which the Insured was evacuated, provided that the return occurs within ninety (90) days of discharge and is coordinated by the Company. The following requirements must be met:

- **A** The medical condition must be covered by this Policy and the treatment required cannot be provided or is not available in any manner in the area or place where the Insured finds himself/herself at that moment;
- **B** The transportation will be authorized to the closest location where the Insured can receive treatment by qualified entities;
- **C** The transportation is to be provided by an entity licensed for such purposes; and
- **D** The Air Ambulance transportation must be pre-authorized and coordinated in advance with the Company.

The benefit for Emergency transportation by Ground Ambulance is covered at eighty percent (80%) up to one thousand five hundred dollars (US$1,500) per event for In-Network coverage in the U.S., fifty percent (50%) up to one thousand five hundred dollars (US$1,500) per event for Out-Of-Network coverage in the U.S., and up to one thousand five hundred dollars (US$1,500) for coverage outside the U.S.

The Insured agrees to hold the Company and any of its affiliates harmless from any negligence resulting from such transportation services, as well as for delays or restrictions caused by mechanical problems or governmental restrictions; errors, omissions, or negligence by the pilot, driver, or crew; or operational, weather, or any other adverse conditions.

6.25 Repatriation of mortal remains or local burial

The repatriation of mortal remains to the deceased's Country of Residence or Home Country or the local burial or cremation of the deceased is covered up to twenty-five thousand dollars (US$25,000) per Lifetime with no Deductible in the event that the Insured dies outside his/her Country of Residence or Home Country, provided that the death resulted from a condition covered by this Policy. This coverage is limited to all basic costs incurred in the repatriation process or the process of cremation of the remains, pursuant to the requirements of the pertinent authorities. For local burial or cremation in the place where the deceased died, reasonable customs must be followed. This benefit must be coordinated and approved in advance by the Company.

6.26 Emergency dental coverage

Emergency dental treatment for Injuries resulting from a covered Accident is covered at eighty percent (80%) up to one thousand dollars (US$1,000) per Policy Year for In-Network coverage in the U.S. and fifty percent (50%) up to one thousand dollars (US$1,000) per Policy Year for Out-Of-Network coverage in the U.S. The benefit is covered up to one thousand dollars (US$1,000) per Policy Year for coverage outside the U.S. The treatment must be rendered within the first one hundred and eighty (180) days after the date of the Accident. This benefit is limited to a Medical Necessity to restore or replace sound natural teeth that have been damaged and/or lost in a covered Accident.

6.27 Hazardous Hobbies and non-Professional Sports

Hazardous Hobbies and Non-Professional Sports are covered up to fifty thousand (US$50,000) per Lifetime. The benefit includes all medical expenses resulting from Accidents caused by the practice of Hazardous Hobbies and non-Professional Sports and must be coordinated and approved in advance by the Company.

6.28 Elimination of the Deductible in case of a Serious Accident

Serious Accidents are covered at one hundred percent (100%) with no Deductible. The Deductible will be eliminated for the first medical treatment in an Emergency room, Hospital, or Emergency facility for an Insured who has suffered a Serious Accident anywhere in the world, provided that medical care is received within the first twenty-four (24) hours after the Serious Accident. Any subsequent Hospitalization or medical service will be subject to the selected Deductible.

SECTION 7. **EXCLUSIONS**

This Policy excludes coverage for treatment, causes, and complications related to:

7.1 Expenses for non-Medically Necessary, alternative, Investigative, or non-approved treatments

Any treatment, Injury or Illness, or charges related to services or supplies

that are not Medically Necessary, or provided to an Insured who is not under the care of a physician or medical professional who is legally qualified in the area or country in which he/she practices; or has not been prescribed by a physician or medical professional; or is considered homeopathic or alternative care; or is not scientifically recognized; or is still in an Investigative phase or clinical trial, as well as those that have not been approved by the U.S. Food and Drug Administration (FDA) or equivalent governmental entities in the Insured's Home Country or Country of Residence.

7.2 Illness or Injury due to self-infliction or criminal acts

Any care or treatment for self-inflicted Illnesses or Injuries, whether the individual is sane or insane; suicide; failed suicide; alcohol abuse; drug use or abuse; use of Illicit Substances or illicit use of controlled substances; being under the influence of alcohol or drugs; and fights or criminal acts in which the Insured or members of his or her family take part in a negligent manner, unless they are acting, legitimately, in self-defense.

7.3 Routine examinations

Any routine exam that is part of a preventive study; routine examinations of the ear; procedures to correct eye refraction disorders including radial keratotomy; prophylactic treatments including vaccinations; and the issuance of medical certificates and exams for work or travel, except as provided in Section 6.11 of this Policy.

7.4 Illness during the 30-day Waiting Period

Any medical expense that is not related to an infectious disease or Accident that takes place within the first thirty (30) days of the Effective Date of this Policy, unless the Waiting Period has been exonerated.

7.5 Aesthetic treatments and orthopedic devices

Alopecia, pedicures and elective cosmetic surgeries or treatments whose principal purposes are aesthetic. Special shoes or orthopedic devices of any type. This includes any treatment for nasal or septum deformities, except as specifically provided in Section 6.12 of this Policy.

7.6 Undeclared Pre-existing Conditions

Any Pre-existing Condition not declared in the Application. This also includes any complication and treatment related to any individual condition excluded in this Policy. The Company reserves the right to rescind, cancel, non-renew or modify the Policy based on the omission of a Pre-existing Condition.

7.7 Treatment covered by third party entity

Any treatment received or expense incurred within a private or governmental establishment where the Insured has the right to receive free care or in the case where a third party is responsible for the medical expenses of the Insured, be it because of contractual obligations or due to civil responsibility, including the treatment of declared epidemics.

7.8 Mental procedures or treatments

Mental procedures or treatments due to psychiatric Illnesses and conduct or growth-related disorders, except if they are required to treat a complication of a covered condition as defined in the terms and limits of this Policy and except as specifically provided in Section 6.20 of this Policy.

7.9 Excessive expenses

Any portion of a medical expense that exceeds the Usual, Customary and Reasonable expenses, even when the benefit is covered at one hundred percent (100%).

7.10 Complications from sterilization, birth control, fertilization, and sex change treatments

Any portion of a medical expense incurred in male or female sterilization; sterilization reversal; sex change; birth control; infertility treatments; artificial insemination; in vitro fertilization; conditions suffered by the mother or the newborn as a result of any type of fertilization treatment; treatments or Prostheses used to improve erectile impotence or other sexual deficiencies, even if the treatments or Prostheses are secondary to a condition covered by this Policy. Disorders related to Human Papilloma Virus (HPV), genital herpes and its complications.

7.11 Treatment for obesity and weight control

Any special food or food supplement, as well as any expense incurred or service, treatment or procedure received due to obesity or weight control, except as provided in Section 6.14 of this Policy.

7.12 Growth hormones

Treatments with growth hormones or bone growth stimulants.

7.13 Maternity or newborn complications under a non-Covered Maternity

Any expense for the treatment of the mother or the newborn related to a non-Covered Maternity, including any complication thereof. Any voluntary termination of a pregnancy, unless the mother's life might have been in imminent danger.

7.14 Dental and orthodontic treatment

Any expense for dental or orthodontic treatment, except as provided in Section 6.26 of this Policy, including but not limited to: abnormalities of the upper maxillary; disorders of the mandible or the mandibular articulation, including but not limited to its anomalies and malformations; Temporomandibular Joint Syndrome (TMJ); craneomandibular disorders; or any other mandibular condition or any condition of the articulations that join the mandible and the cranium, as well as other tissues that are related to said articulations.

7.15 Active duty, war, and riot

The treatment of Injuries that may result when an individual is an active

member of the police force, the army or other military force of any country, or is directly or indirectly participating in a war or a military conflict, a disturbance, rebellion or any illegal activity, including the possible arrest and incarceration resulting from said participation.

7.16 Pre-admission to Hospital greater than twenty-three (23) hours

Any admission to a Hospital for more than twenty-three (23) hours the day before a programmed surgery or the admission to a Hospital to receive Outpatient medical Services, unless said admission was approved by the Company.

7.17 Non-Prescription Medication

Any Medication that may be acquired without facultative prescription, food supplements needed as a result of digestive intolerance, hunger suppressants, vitamins, and anti-aging Medications or products.

7.18 Artificial kidney equipment

Any portable or home-use artificial kidney equipment.

7.19 Artificial or animal organs, cryopreservation, and tissue and Stem Cell storage

Any expense related to the acquisition and implant of an artificial heart or animal organs; cryopreservation; and the storage of tissues and Stem Cells for more than twenty-four (24) hours, with the exception of an exam to determine a diagnosis.

7.20 Radiation Injuries or Illness

The treatment of Injuries or Illnesses caused by radioactivity resulting from any nuclear or atomic material, nuclear waste, pollution and/or asbestos.

7.21 Duplicate Medical Equipment or treatment

Any expense related to the duplication of functions by a medical team or device for the same purpose, as well as the loss of Medical Equipment, its repair or replacement, except when its life cycle has expired if said equipment was originally covered by this Policy.

7.22 Additional medical assistants

The participation of more than one (1) medical or surgical assistant or instrumentalist in a surgery, unless such participation has been previously approved by the Company.

7.23 Miscellaneous therapy and homelike care

Any expense related to recreational or educational therapy, Custodial Care and services or supplies commonly used in a home.

7.24 Extended Care and fitness memberships

Treatments in psychiatric institutions, nursing homes for the elderly, assisted living facilities, Hospices, health spas, and memberships to gymnasiums, except as provided in Sections 6.3 and 6.7 of this Policy.

7.25 Expenses in sanctioned countries

Any expense incurred for the treatment, services, or supplies rendered in countries or by or for the benefit of persons and/or companies subject to economic or political sanctions, trade restrictions, and/or embargoes imposed by the government of the United States or by any of its agencies.

7.26 HIV/AIDS

Any expense related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS).

SECTION 8. MANAGEMENT OF BENEFITS

8.1 Change of Deductible

Before the Renewal Date, the Insured can request to change the Deductible within the same plan. If the change is for a higher Deductible, it will be approved under the same conditions of the current plan. If the change is for a lower Deductible, it will be subject to underwriting evaluation and shall require approval by the Company. Once the change has taken place, during the first thirty (30) days following the Effective Date of the change in question, the larger Deductible shall be applied to any Illness or Injury not caused by an Illness of Infectious Origin or an Accident that has occurred as of the date of the change. If the new Deductible option includes maternity care benefits, these will be subject to a ten (10)-month Waiting Period.

8.2 Change of plan

Before the Renewal Date, the Policyholder can request to change to any of the other plans offered by the Company. If the change is for a plan with less coverage, it will be approved under the same conditions of the current plan. If the change is for a plan with higher coverage, it will be subject to underwriting evaluation and shall require approval by the Company who reserves the right to accept or reject any change for any reason. Once the change has taken place, during the first thirty (30) days following the Effective Date of the change in question, the lesser of the benefits shall be applied to any Illness or Injury not caused by an Illness of Infectious Origin or an Accident that has occurred as of the date of the change. If the new plan includes maternity care benefits, these will be subject to a ten (10)-month Waiting Period.

8.3 Notifications and/or pre-authorizations

It is necessary that the Insured notifies the Company when receiving medical treatment, be it in the Hospital or as an Outpatient. This will give the Company the opportunity to improve and maximize the Insured's level of coverage by making suggestions about medical

attention, providing logistical support and, whenever possible, making arrangements to establish direct payment to the Hospital or Doctor of choice, thereby reducing the possibility that the Insured will have to incur an unexpected out-of-pocket expense. This will also allow the Company to verify that the treatment is covered by the Policy. In order to guarantee direct payment and the coordination of benefits, notification is required. Therefore, the Insured must notify the Company in advance and obtain the necessary authorizations for any of the following benefits:

- A All Hospital admissions;
- B All Hospital or Outpatient surgeries;
- C Any major procedures, such as MRIs, CT scans, PET scans, gastroscopies, colonoscopies, biopsies, etc.;
- D Physical and rehabilitative therapy, home health care or Private Nurse;
- E Nasal surgery, reconstructive, cosmetic or bariatric;
- F Emergency transportation by Air Ambulance;
- G Durable Medical Equipment or any special medical device; and
- H Repatriation of mortal remains or local burial.

The Insured must notify the Company at least **seventy-two (72) hours** prior to receiving those medical services that require notification or pre-authorization. The Company must also be given notice of all medical emergencies that require notification within seventy-two (72) hours after the occurrence that caused the Emergency. If the Policyholder and/or the Insured fail to notify the Company accordingly, they shall then be responsible for thirty percent (30%) of all covered costs after the Deductible has been applied.

To notify the Company, email **notify@vumigroup.com** or complete the medical notification form on MyVUMI.

8.4 Claims

The Company will make payments directly to physicians and Hospitals worldwide in legal currency for covered expenses, pursuant to the terms and conditions of the Policy. When this is not possible, the Company will reimburse the costs to the Insured in accordance with the applicable Usual, Customary and Reasonable fees.

When direct payment is not made to the Provider, the Company will reimburse the Policyholder the amount of the compensable costs as they were presented to the Company and based on the Usual, Customary and Reasonable charges. The Company shall receive all medical and non-medical information required. In order for the claims process to begin, the Company must receive the proof of claim, which must consist of the following:

- A All itemized bills from the Provider with proof of payment;
- B A recent medical history or any other medical information that the Company may consider pertinent;
- C For pharmacy expenses, a copy of the medical prescription must be submitted; and
- D In the event of an Accident, all information related to said Accident, as well as the circumstances surrounding it, pursuant to what is required by the Company, including but not limited to Accident reports, police reports, or other reports, when issued by the pertinent authorities or any other third parties involved.

If the information provided should be considered inadequate or is incomplete, it may create a delay in the payment or reimbursement process or may cause the claim to be temporarily closed until the necessary information is received. The Company reserves the right to request the original receipts, medical records and/or any other relevant documentation in order to process the claim.

8.5 Claims appeals

In the event of any disagreement between the Insured and the Company regarding a claim, before any other steps are taken, the Policyholder or Insured must submit the claim to the Company's Appeals Department for review. The Insured must submit a letter appealing the claim to: appeals@vumigroup.com. Such letter must include all relevant information, as well as copies of all documents considered necessary. The Company's Appeals Department will notify the Insured of its decision in writing within thirty (30) days from receipt of the appeal letter and/or all pertinent documentation. The Company's Appeals Department will have the right to request any additional information or documentation from the Insured, or from other third parties, should it deem it necessary to accurately process the appeal's review.

8.6 Clerical errors

In the event of a clerical error by the Company:

- A The Insured will not be denied coverage that should have been provided;
- B Coverage will not be extended if it should have been terminated; and
- C A premium adjustment will occur if required.

8.7 Arbitration

Any discrepancy, controversy, claim or disagreement that may persist upon completion of the claims appeal process must be presented for arbitration which can be initiated by the Company when it notifies the second party in writing, who shall then have twenty (20) days from the date of receipt of said written communication to select an arbitrator. Otherwise, the claimant shall have the right to select a second arbitrator. A third arbitrator shall be selected within a ten (10)-day period, and within an additional ten (10)-day period after his/her designation, the place where the arbitration is to take place shall be decided. The Company shall select an arbitrator, the Insured shall select the second arbitrator, and the third arbitrator shall be selected by the first two. The arbitration will need to take place in the city of Dallas, Texas, USA. Each

party shall pay its own expenses for the arbitration process. If there is a disagreement between the arbitrators, the decision will be made by majority vote.

The Insured grants exclusive jurisdiction to the city of Dallas, Texas, to determine his/her rights under this Policy. The Insured and the Company hereby agree that the resolution of legal disputes, which may arise from this Policy, shall be resolved by a non-jury trial.

8.8 Subrogation and indemnity

The Company has the right of subrogation or reimbursement of payments made if the Insured has recovered all or part of said payments from a third party. The Insured must cooperate with the Company with everything necessary.

SECTION 9. **DEFINITIONS**

9.1 Accident

A violent, sudden, unforeseen and unintentional event provoked exclusively by external causes resulting, inDependently of other causes, in bodily Injuries to the Insured.

9.2 Agent

The individual or company authorized by the Company for the distribution of this Policy. The Agent shall have access to the Insured's health and medical information which may be delivered to the Company or any one of its affiliates. No Agent has the authority to modify the Policy or to remove any of its terms and conditions.

9.3 Air Ambulance

An aircraft staffed by professional personnel and equipped with the necessities and supplies to provide medical care during the air transportation. This service is provided by an entity that is licensed and authorized to do so.

9.4 Amendment

A declaration added to the Policy by an authorized official of the Company to explain, modify and/or restrict the coverage of this Policy for a particular Insured or for the Policy in general.

9.5 Anesthesiologist Fees

Fees charged by an anesthesiologist for the administration of anesthesia and/or pain control.

9.6 Application

A written declaration designed by the Company which is completed and signed manually or electronically by the Policyholder, and contains information about him or herself and his/her Dependents. This form is used by the Company to determine the insurability of the Applicant and his or her Dependents. Any information or questionnaires submitted to the Company with the Application is considered part of the Application.

9.7 Assisting Surgeon or Assisting Physician Fees

Fees charged by the assisting surgeon or physician when providing assistance services during a medical procedure.

9.8 Birth Complications

Any disorder related to a newborn not caused by genetic factors and which manifests during the first thirty (30) days of life.

9.9 Certificate of Coverage

Document of the Policy which specifies the effective coverage period, its conditions and limitations, lists all individuals covered and, in addition, is part of the Policy.

9.10 Company

VIP Universal Medical Insurance Group, Limited (VUMI).

9.11 Congenital and/or Hereditary Disorders

Any Illness, disorder, malformation, embryopathy, persistency of fetal tissue or structure existing before birth, which can be diagnosed before or after the birth.

9.12 Country of Residence

The country in which the Insured resides for an uninterrupted period of more than one hundred and eighty (180) days within a year while this Policy is in effect.

9.13 Covered Maternity

When a pregnancy ends by natural or cesarean delivery after the Waiting Period of ten (10) months after the Effective Date of the mother's coverage.

9.14 Custodial Care

Services rendered which include but are not limited to personal assistance that does not require professional or training skills, for example: wash, feed and dress an individual, among others.

9.15 Deductible

The portion of covered expenses that must be paid by the Insured before the benefits of this Policy become payable.

9.16 Doctor

A professional legally licensed to practice medicine in the location where the services are provided.

9.17 Domestic Partner
Person of the opposite sex or the same sex with whom the Insured has established a relationship of domestic life.

9.18 Durable Medical Equipment
Any medical equipment designed for continuous use. This includes but is not limited to wheelchairs, Hospital beds, respirators and crutches.

9.19 Effective Date
The date when the Policy becomes effective.

9.20 Emergency
A sudden medical condition, serious and acute, that requires immediate medical attention.

9.21 Expat VIP USA Network
List of Hospitals in the U.S. contracted by the Company.

9.22 Expatriate
A person who does not reside in his or her Home Country.

9.23 Experimental or Investigative
Any treatment, procedure, equipment, Medication, combination of Medication, device, supply or Hospitalization which, at the time the service or supply is provided, does not meet the approved norms of the medical practice in the United States, and has not been approved for the specific indication or application to the condition by the FDA or other applicable federal agency of the government of the USA, and whose approval is required regardless of the location where the medical expenses are incurred.

9.24 Expiration Date
The date on which the term of the Policy ends according to the selected payment mode.

9.25 Extended Care Facility
A skilled nursing facility or other healthcare institution that provides long-term care.

9.26 Grace Period
The period of thirty (30) days after the Expiration Date during which the Policy may be renewed.

9.27 Ground Ambulance
Ground transportation equipped with medical equipment and medically trained personnel that can transport individuals who are injured or ill.

9.28 Hazardous Hobbies and Sports
Activities that increase the risk of death or Illness of the person who practices them. Examples of Hazardous Hobbies and Sports include, but are not limited to, diving, rock climbing, parachuting, bungee jumping, paragliding, parasailing or mountain biking.

9.29 Home Country
The country in which a person holds citizenship.

9.30 Hospital, Clinic or Medical Facility
An institution legally licensed to provide clinical and surgical services under the supervision of medical professionals.

9.31 Hospital Services
Treatments, general or medical services and supplies provided by a Hospital for the use of its facilities.

9.32 Host Country
The Country declared in the Application where an Insured Person and his or her Dependent(s) maintain legal domicile outside his Home Country.

9.33 Illicit Substances
Pharmaceuticals, psychoactive substances or similar chemicals defined by the federal government of the United States of America as illegal, such as cocaine and heroin.

9.34 Illness
Condition or disorder of internal or external cause that affects the human body and that requires medical attention.

9.35 Illness of Infectious Origin
A medical condition caused by pathogenic agents such as bacteria, viruses, fungi and parasites.

9.36 In-Network
Providers within the Expat VIP USA Network. For coverage in the U.S., Insureds will receive equal or greater coverage if they use an In-Network Provider instead of an Out-Of-Network Provider.

9.37 Injury
Damage inflicted to the human body due to some cause.

9.38 Inpatient Services
Services or treatments that require a Hospital admission or Hospital stay for more than twenty-three (23) hours.

9.39 Insured
The term Insured refers to the Policyholder and the covered Dependents.

9.40 Insured Dependent
Biological children, stepchildren and legally adopted children of the main Insured; or the children or grandchildren for whom the main Insured has

been named legal guardian.

9.41 Lifetime
The maximum amount that the Company will pay for a specific benefit during the life of the Policy.

9.42 Live Donor
A live person who donates an organ, tissue or cell.

9.43 Maternity Complications
Pathology or treatment resulting from the abnormal course of pregnancy and/or delivery.

9.44 Medical Appliance
Device used to treat a condition or to support or sustain life, including but not limited to artificial pacemakers and implantable defibrillators.

9.45 Medical Necessity or Medically Necessary
Treatment, medical service or medical supply deemed necessary by the Company, in mutual agreement with the Insured's physician, to diagnose and/or treat an Illness or Injury. It is not Medically Necessary if the service:

- **A** Is provided as a matter of convenience to the Insured or his/her family or the Hospital/Physician;
- **B** Is not appropriate for the diagnosis or treatment of the specific condition;
- **C** Exceeds the level of care required for the diagnosis or treatment of a specific condition;
- **D** Is outside the scope of the standard practices established for Doctors and Hospitals; or
- **E** Is a substitution of a Standard or Private Room for a suite.

9.46 Medically Prescribed through a Facultative Prescription
This refers to the use and sale of a Medication that is permitted by law but whose acquisition is conditioned by the authorization of a professional and is dispensed by a pharmacy.

9.47 Out-Of-Network
Providers not included in the Expat VIP USA Network. For coverage in the U.S., Insureds will receive lesser coverage for certain benefits if they use an Out-Of-Network Provider instead of an In-Network Provider.

9.48 Outpatient Services
Services or treatments that do not require a Hospital admission or Hospital stay for more than twenty-three (23) hours.

9.49 Palliative Care
Treatment provided to patients suffering from advanced, progressive and incurable Illnesses with a prognosis of less than six (6) months of life.

9.50 Policy
Document where the general and particular conditions agreed by the Company and the Policyholder are described and which governs the insurance contract.

9.51 Policy Year
The consecutive twelve (12)-month period that starts on the Effective Date of this Policy and all subsequent twelve (12)-month periods thereafter.

9.52 Policyholder or Applicant
The individual who signs the insurance Application and the principal Insured under the Policy who has the authority to request changes in the Policy and receives the reimbursements of medical payments covered under this Policy, as well as any unearned premium reimbursement.

9.53 Pre-existing Condition
A condition which was diagnosed by a physician prior to the Effective Date of this Policy or its reinstatement, or for which medical advice or treatment was received or recommended by a physician; or for which symptoms and signs presented and, had a physician been consulted, a diagnosis of an Illness or medical condition or some form of treatment would have been received.

9.54 Private Nurse
An individual legally licensed and/or certified to provide care to the sick according to the place where services are rendered.

9.55 Professional Sports
It refers to the practice of sports for which a person receives compensation.

9.56 Prosthesis
Internal or external artificial replacement of body parts, including but not limited to prosthetic arms, legs, eyes, hips, and knees.

9.57 Provider
Hospitals, Clinics, physicians, diagnostic centers, pharmacies and other entities or individuals legally authorized to provide medical services.

9.58 Region
This refers to and can include a group of countries and/or a geographical area within one country.

9.59 Renewal Date
The Policy's anniversary date or the first day of the next Policy Year.

9.60 Rider
A document attached to the Policy by the Company when acquired and paid by the Policyholder and provides additional optional coverage.

9.61 Routine or Preventive Health Checkups
Preventive medical examinations conducted by a certified physician and/or a medical Provider institution.

9.62 Serious Accident
A violent, sudden, unforeseen and unintentional event that is provoked exclusively by external causes that result in bodily Injuries to the Insured and that require urgent medical care with a Hospitalization of twenty-four (24) hours or more.

9.63 Special Maternity Network
List of Hospitals contracted by the Company and approved to provide additional coverage as specifically provided in Sections 6.22 and 6.23 of this Policy.

9.64 Spouse
The person with whom the Policyholder is legally married to in accordance with the regulations of the jurisdiction where the marriage ceremony took place.

9.65 Standard Private Hospital Room
Hospital room equipped to accommodate only one (1) patient.

9.66 Stem Cells
Adult Stem Cells (Hematopoietic Cells) obtained from umbilical cord blood at birth and stored by cryopreservation.

9.67 Surgical Implants
Any medically necessary device or tool required during surgery, including but not limited to pins, wires, plates, and screws.

9.68 Transplant
Medical procedure to transfer an organ, tissues, or cells from a living or deceased Donor to the recipient or to re-implant it in the same person.

9.69 US$, US Dollars
Currency of the United States of America.

9.70 United States, U.S., USA
The United States of America.

9.71 Usual, Customary and Reasonable (UCR)
The lower of:

A. The Provider's usual reimbursement for furnishing the treatment, service, or supply; or
B. The amount determined by the Company to be the general rate accepted by Providers of the same category who provides such treatments, services or supplies to persons: (1) who reside in the same geographical area; and (2) whose Injury or Illness is comparable in nature and severity.

9.72 Waiting Period
A period of time defined by the Company during which the coverage of some benefits is excluded.

VIP Universal Medical Insurance Group, Ltd.

Insurance company registered in the Turks & Caicos Islands, a British Overseas Territory.
Administration services provided by VIP Universal Medical Insurance Group, LLC,
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