TERMS AND CONDITIONS

BUPA FLEX

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YOUR COVERAGE

GEOGRAPHICAL COVERAGE

Your policy offers coverage in Latin America, the Caribbean, and the United States of America within the provider network. If you need information about your network, please visit www.bupasalud.com or contact us directly. However, the insurer, USA Medical Services, and/or any of their applicable related subsidiaries and affiliates will not engage in any transactions with any parties or in any countries where otherwise prohibited by the laws in the United States of America. Please contact USA Medical Services for more information about this restriction.

DEDUCTIBLE OPTIONS

We offer a range of annual deductible options to help you reduce the price you pay for your coverage —the higher the deductible, the lower the premium. You can choose between the following deductibles.

Deductible (US$)						
Plan	2	3	4	5	6	7
In-country or Out-of-country	500	1,000	2,000	4,000	5,000	10,000
Max. per policy	1,000	2,000	4,000	8,000	10,000	20,000

There is only one deductible per person, per policy year. However, to help you reduce the cost of your family's coverage, we apply a maximum equivalent to two deductibles on your policy, per policy year.

COINSURANCE

All services, hospitalizations, and out-patient treatments are subject to a twenty percent (20%) coinsurance. After meeting the deductible, Bupa will cover eighty percent (80%) of the first ten thousand dollars (US$10,000) per insured, per policy year, or eighty percent (80%) of the first twenty thousand dollars (US$20,000) per policy, per policy year to help you reduce your family's out-of-pocket expense. Once the coinsurance maximum amounts are met, Bupa will pay one hundred percent (100%) of any subsequent covered medical expense.

GENERAL TERMS AND CONDITIONS

NOTES ABOUT YOUR POLICY

- Your policy documents include the Welcome Guide (with general information about Bupa), the Terms and Conditions (with the policy's general conditions, exclusions and limitations, administration, and definitions), the Table of Benefits, your Certificate of Coverage, and your Particular Conditions.
- To learn how your product works, refer to the Benefits, Exclusions and Limitations, Administration, and Definitions sections in this document.
- Maximum coverage for all covered medical and hospital charges while the policy is in effect is limited to the terms and conditions of your policy.
- Unless otherwise stated herein, all benefits are per insured, per policy year.
- All benefits are subject to any applicable deductible and coinsurance, unless otherwise stated.
- Any diagnostic or therapeutic procedure, treatment, or benefit is covered only if resulting from a condition covered under this policy.

- The Bupa Flex policy provides coverage in Latin America, the Caribbean, and the United States of America within the provider network; therefore:
  1. You need to notify USA Medical Services before beginning any treatment.
  2. All hospitalizations and treatments must be rendered within the provider network.
  3. No benefits are payable for services rendered outside the provider network, except as specified under the condition for Emergency Medical Treatment.
- All reimbursements are paid in accordance with the Bupa Fee Schedule for the specific service. The Bupa Fee Schedule contains the maximum amounts the insurer will consider eligible for payment, adjusted for a specific region or geographical area.
- All amounts are in U.S. dollars.
- The insurer, USA Medical Services, and/or any of their applicable related subsidiaries and affiliates will not engage in any transactions with any parties or in any countries where otherwise prohibited by the laws in the United States of America. Please contact USA Medical Services for more information about this restriction..

AGREEMENT

1.1 BUPA INSURANCE COMPANY: (hereinafter referred to as the "insurer") agrees to pay you (hereinafter referred to as the "policyholder") the benefits provided by this policy. All benefits are subject to the terms and conditions of this policy.

1.2 TEN (10) DAY RIGHT TO EXAMINE THE POLICY: This policy may be returned within ten (10) days of receipt for a refund of all premiums paid. The policy may be returned to the insurer or to the policyholder's producer. If returned, the policy is void as though no policy had been issued.

1.3 IMPORTANT NOTICE ABOUT THE APPLICATION: This policy is issued based on the application and payment of the premium. If any information shown on the application is incorrect or incomplete, or if any information has been omitted, the policy may be rescinded or cancelled, or coverage may be modified at the sole discretion of the insurer.

1.4 ELIGIBILITY: This policy can only be issued to residents of Latin America or the Caribbean who are at least eighteen (18) years old (except for eligible dependents), and not older than seventy (70) years old. There is no maximum renewal age for insureds already covered under this policy. This policy cannot be issued and is not available to persons permanently residing in the United States of America for more than one hundred eighty (180) days, continuous or discontinuous, in a period of three hundred sixty-five (365) days, regardless of the type of visa issued to the Insured or their immigration status. Insureds with work assignments, student visas, and other temporary stays within the United States may be covered under certain conditions as long as the policyholder's permanent residence remains outside of the United States. Without prejudice to the aforementioned, the insurer reserves the right to evaluate the Policyholder's eligibility, early cancellation, or non-renewal of the policy, at the discretion of the Insurer in case of a change in country of residence or nationality. Please contact the insurer or your agent for further information related to your individual case.

Eligible dependents under this policy are those who have been identified on the health insurance application and for whom coverage is provided under the policy. Eligible dependents include the policyholder's spouse or domestic partner, biological children, legally adopted children, stepchildren, children to whom the policyholder has been appointed legal guardian by a court of competent jurisdiction, and grandchildren born into the policy from insured dependent children under the age of eighteen (18).

Dependent coverage is available for the policyholder's dependent children up to their twenty-fourth (24th) birthday if single. Coverage for such dependents continues through the next anniversary or renewal date of the policy, whichever comes first after reaching twenty-four (24) years of age if single.

Coverage for dependent sons or daughters with a child will end under their parent's policy on the anniversary date after the dependent son or daughter turns eighteen (18) years old, when he or she must obtain coverage for himself or herself and his or her child under his or her own individual policy.

If a dependent child marries, changes country of residence or if a dependent spouse ceases to be married to the policyholder by reason of divorce or annulment or changes country of residence, coverage for such dependent under this policy will terminate on the next anniversary or renewal date of the policy, whichever comes first.

A dependent child born under the coverage of the insurance policy and who is classified as a Dependent Adult, based on the definition detailed in these Terms and Conditions, may continue to enjoy insurance coverage under this condition after reaching the age of twenty-four (24), for which the rates, benefits, restrictions and limitations corresponding to an adult person and specified in the Terms and Conditions and Table of Benefits of the policy will be applied for each renewal.

Dependents who were covered under a prior policy with the insurer and are otherwise eligible for coverage under their own separate policy, will be approved without underwriting for the same product with equal or higher deductible and with the same conditions and restrictions in effect under the prior policy. The health insurance application of the former dependent must be received before the end of the grace period for the policy which previously afforded coverage for the dependent.

1.5 REQUIREMENT TO NOTIFY THE INSURER: The insured must contact USA Medical Services, the insurer's claims administrator, at least seventy-two (72) hours in advance of receiving any medical care. Emergency treatment must be notified within seventy-two (72) hours of beginning such treatment. In case of an accident, the insured must notify the insurer within seventy-two (72) hours of such accident, unless this is impossible due to a fortuitous event or force majure, in which case notification must be made as soon as the impediment is cleared. Not complying with this requirement may result in the denial of the claim or the application of the usual, customary, and reasonable costs that the insurer would have incurred if the accident had been notified as required. Furthermore, in case of accident, the deductible waiver will not apply if the insured does not notify as required herein.

If the insured fails to contact USA Medical Services as stated herein, he/she will be responsible for thirty percent (30%) of all covered medical and hospital charges related to the claim, in addition to any applicable deductible and/or co-insurance.

1.6 COUNTRY OF RESIDENCE: To be entitled to coverage, the Insured (principal, spouse, and dependent children) must be residents and live permanently in the country declared as residence in the Insurance Application for a minimum of one hundred and eighty (180) continuous or discontinuous days in a period of three hundred and sixty-five (365) days.

This policy is not available to, nor can it be issued or renewed to, persons who reside in the United States of America for more than one hundred and eighty (180), continuous or discontinuous days in a period of three hundred and sixty-five (365) days regardless of the type of visa issued to the Insured or their immigration status, without prejudice to the foregoing, the Insurer reserves the right to evaluate the eligibility, early cancellation, or non-renewal of the policy, if any Insured (principal, spouse and dependent children) resides or is present in another country, other than the one declared as residence in the Insurance Application. The Insurer reserves the right to early cancellation should an Insured (principal, spouse and dependent children) switch their residence to the United States of America or another country other than the one declared as residence in the Insurance Application.

BENEFITS

IN-PATIENT BENEFITS AND LIMITATIONS

(SUBJECT TO DEDUCTIBLE AND COINSURANCE)

2.1 HOSPITAL SERVICES: Coverage is only provided when in-patient hospitalization is medically necessary. Emergency medical treatment out of network is covered as described in 6.4.

2.2 MEDICAL AND NURSING FEES: Physician, surgeon, anesthesiologist, assistant surgeon, specialists, and other medical and nursing fees are covered only when they are medically necessary for the surgery or treatment and approved in advance by USA Medical Services. Medical and nursing fees are limited to the lesser of:

(a) The fees specified in the Bupa Fee Schedule for the procedure, or

(b) Special rates established for an area or country as determined by the insurer.

2.3 PRESCRIPTION DRUGS: Drugs prescribed while in-patient are covered as described in your Table of Benefits.

2.4 PROVIDER NETWORK: Your policy provides coverage as described in your Table of Benefits within the provider network only. There is no coverage outside the provider network, except to emergencies, as described under 6.4.

(a) The list of hospitals and physicians in the provider network is available from USA Medical Services or online at www.bupasalud.com, and may change at any time without prior notice.

(b) In order to ensure that the provider of medical services is part of the provider network, all treatments must be coordinated by USA Medical Services.

(c) In those cases where the provider network is not specified in the insured's country of residence, there is no restriction on which hospitals may be used in the insured's country of residence.

OUT-PATIENT BENEFITS AND LIMITATIONS

(SUBJECT TO DEDUCTIBLE AND COINSURANCE)

3.1 AMBULATORY SURGERY: Ambulatory or out-patient surgical procedures performed in a hospital, clinic, or doctor's office are covered according to the Table of benefits. These surgeries allow the patient to go home the same day that they have the surgical procedure.

3.2 OUT-PATIENT SERVICES: Coverage is only provided when medically necessary.

3.3 PRESCRIPTION DRUGS: Prescription drugs first prescribed after an in-patient hospitalization or out-patient surgery for a medical condition covered by the policy, as well as prescription drugs prescribed for out-patient treatments or non-hospitalizations related to a medical condition covered by this policy, are covered as described in your Table of Benefits.A copy of the prescription from the treating physician must accompany the claim. All covered expenses, up to the maximum benefit, will first be applied towards the deductible. Once the expenses exceed the deductible amount, the insurer will pay the difference between the amount of expenses applied to the deductible and the amount of the out-patient prescription drug benefit limit.

3.4 PHYSICAL THERAPY AND REHABILITATION SERVICES: Physical therapy and rehabilitation sessions are covered as described in your Table of Benefits and must be pre-approved. Updated evidence of medical necessity and a treatment plan are required in advance to obtain each approval. A session may include multiple disciplines such as physical therapy, occupational therapy, and speech language pathology, and will be treated as one session if all are scheduled together, or will be treated as separate sessions if scheduled on different days or times.

3.5 HOME HEALTH CARE: Home health care is covered as described in your Table of Benefits and must be pre-approved. Updated evidence of medical necessity and a treatment plan are required in advance to obtain each approval.

3.6 TREATMENT AT URGENT CARE FACILITIES OR WALK-IN CLINICS: Treatment at urgent care facilities or walk-in clinics in the United States of America are covered at a hundred percent (100%) with a fifty-dollar (US$50) co-payment. These treatments are not subject to deductible.

3.7 VACCINES: VACCINES: The company will cover the costs and administration of medically required vaccines, according to the national vaccination program (children and adults), including the Human Papillomavirus (HPV) vaccine to protect against cervical cancer, influenza vaccine (flu), legally vaccinated required for travel vaccines against pneumococcus, and medicines against malaria.

MATERNITY BENEFITS AND LIMITATIONS

4.1 PREGNANCY, MATERNITY, AND BIRTH (Plans 2 and 3 only):

(a) The maximum benefits covered per pregnancy is described in your Table of Benefits.

(b) Pre- and post-natal treatment (Including noninvasive genetic prenatal screening, detection of free fetal DNA), required vitamins during pregnancy, childbirth, cesarean deliveries, well baby care, and umbilical cord blood storage are included in this benefit.

(c) Covered pregnancies are those for which the estimated date of delivery is at least ten (10) calendar months after the effective date of coverage for the respective insured female.

(d) In addition to the above, the following conditions regarding pregnancy, maternity, and birth apply to eligible dependent sons or daughters and their children. On the anniversary date after the insured dependent son or daughter turns eighteen (18) years old, he or she must obtain coverage for himself or herself and his or her child under his or her own individual policy if he or she wants to maintain coverage for his or her child. He or she must submit written notification, which will be approved without underwriting for a product with the same or lower pregnancy, maternity, and birth benefits, with the same or higher deductible, and with the same conditions and restrictions in effect under the prior policy.

(e) To be eligible for pregnancy, maternity, and birth coverage, an insured dependent daughter age eighteen (18) or older must submit written notification. The notification must be received before the actual date of delivery, and will be approved without underwriting for a product with the same or lower pregnancy, maternity, and birth benefits, with the same or higher deductible, and with the same conditions and restrictions in effect under the prior policy. If there is no gap in coverage, the ten (10) calendar month waiting period for the daughter's policy will be reduced by the time she was covered under her parent's policy.

(f) Complications of maternity are not covered under this benefit, as they are limited to the maximum benefit described in 4.3.

4.2 NEWBORN COVERAGE:

(a) Provisional coverage:

If born from a covered pregnancy, each newborn will automatically be covered for complications at birth and for any injury or illness during the first ninety (90) days after birth, as described in your Table of Benefits. If not born from a covered pregnancy, there is no provisional coverage for the newborn.

(b) Permanent coverage:

i. Automatic addition: For the purpose of adding a newborn child to the parent's policy without underwriting, the parent's policy must have been in effect for at least ten (10) consecutive calendar months. To be added, a copy of the birth certificate including the newborn's full name, gender, and date of birth must be submitted within ninety (90) calendar days of birth. If the birth certificate is not received within ninety (90) calendar days of birth, an Individual Health Insurance Application is required for the addition and will be subject to underwriting.

The premium for the addition is due at the time of the notification of birth. Coverage with applicable deductible will then be effective as of the date of birth up to the policy limits.

ii. Non-automatic addition: The addition of children born before the parent's policy has been in effect for at least ten (10) consecutive calendar months is subject to underwriting. To be added to their parent's policy, a completed Individual Health Insurance Application, birth certificate, and premium payment are required.

The addition of adopted children, children born as a result of a fertility treatment, and children born by a surrogate mother are subject to underwriting. An Individual Health Insurance Application and a copy of the birth certificate must be submitted in these cases, which will be subject to the standard underwriting procedures.

(c) Well baby care is only covered as stated in 4.1 (b).

4.3 COMPLICATIONS OF PREGNANCY, MATERNITY, AND BIRTH (Plans 2 and 3 only): Maternity complications and/or newborn complications of birth (not related to congenital or hereditary disorders), such as prematurity, low birth weight, jaundice, hypoglycemia, respiratory distress, and birth trauma are covered as follows:

(a) This benefit shall apply only if all the stipulations under 4.1 and 4.2 of this policy have been met.

(b) This benefit does not apply to complications related to any condition excluded or not covered by the policy, including but not limited to maternity and newborn complications of birth in a pregnancy that is the result of any type of fertility treatment or any type of assisted fertility procedure, or pregnancies where the actual date of delivery takes place during the ten (10) calendar month maternity waiting period.

(c) Ectopic pregnancies and miscarriages are covered up to the maximum amount listed in this benefit.

(d) For the purpose of this policy, a cesarean delivery is not considered a complication of pregnancy, maternity, and birth.

(e) Complications caused by a covered condition that was diagnosed before the pregnancy, and/or any consequences thereof, will be covered up to policy limits.

EVACUATION BENEFITS AND LIMITATIONS

(SUBJECT TO DEDUCTIBLE AND COINSURANCE)

5.1 MEDICAL EMERGENCY EVACUATION: Emergency transportation (by ground or air ambulance) is covered as described in your Table of Benefits only if related to a covered condition for which treatment cannot be provided locally, and transportation by any other method would result in loss of life or limb. Emergency transportation must be provided by a licensed and authorized transportation company to the nearest medical facility. The vehicle or aircraft used must be staffed by medically trained personnel and must be equipped to handle a medical emergency. Prior authorization must be obtained from the Insurer. Failure to obtain prior authorization from the Insurer may result in the denial of coverage.

The selection of the closest medical transfer facility will be made according to the following prioritization:

(a) Nearest medical center within the country where the insured had the emergency and/or where the insured is located at the time when transport is requested or,

(b) Closest medical center in the country bordering the country where the insured had the emergency and/or where the insured is located at the time when transport is requested or,

(c) Medical center in another country within the region where the insured had the emergency and/or where the insured is located at the time when transport is requested or,

(d) In the case of medical evacuation to the United States of America, the appropriate medical center in the city closest to the country where the insured is hospitalized will be considered. The Insurer will not authorize transfers to another city in the United States of America unless medically necessary due to the availability of treatment at the nearest facility.

In cases where a ground ambulance is required, due to an accident, the insurer must be notified within seventy-two (72) hours of the occurrence of the event.

Scheduled care that is not considered an emergency will not be covered by the Emergency Medical Evacuation benefit.

Air ambulance transportation:

(a) All air ambulance transportation must be evaluated, pre-approved and coordinated by USA Medical Services. If the insured does not obtain prior authorization, the Insurer reserves the right not to pay expenses.

(b) The insured agrees to hold the insurer, USA Medical Services, and any company affiliated with the insurer or USA Medical Services by way of similar ownership or management, harmless from negligence resulting from such services, or negligence resulting from delays or restrictions on flights caused by the pilot, mechanical problems, or governmental restrictions, or due to operational conditions.

(c) In the event that the insured is transported for the purpose of receiving treatment, he/she and the accompanying person, if any, shall be reimbursed for the expenses for a return journey to the place from where the insured was evacuated. The return journey shall be made no later than ninety (90) days after treatment has been completed. Coverage shall only be provided for traveling expenses equivalent to the cost of an airplane ticket on economy class, as a maximum. Transportation services must be pre-approved and coordinated by USA Medical Services. If the insured does not obtain prior authorization, the Insurer reserves the right not to pay expenses.

(d) The Insurer will not pay any other costs related to the transfer, such as travel expenses..

5.2 REPATRIATION OF MORTAL REMAINS: In the event an insured dies outside of his/her country of residence, the insurer will cover the expenses toward repatriation of the deceased's remains to his/ her country of residence as indicated in your Table of Benefits if the death resulted from a covered condition under the terms of the policy. Coverage is limited to only those services and supplies necessary to prepare the deceased's body and to transport the deceased to his/her country of residence. Arrangements must be coordinated in conjunction with USA Medical Services.

OTHER BENEFITS AND LIMITATIONS

6.1 CONGENITAL AND/OR HEREDITARY DISORDERS: Congenital and/or hereditary conditions are covered as described in your Table of Benefits. The benefit begins once the congenital and/or hereditary condition has been diagnosed by a physician. The benefit is retroactive to any period prior to the identification of the current condition.

6.2 PROSTHETIC LIMBS: Prosthetic limb devices include artificial arms, hands, legs, and feet, and are covered as described in your Table of Benefits. The benefit includes all the costs associated with the procedure, including any therapy related to the usage of the new limb.

Prosthetic limbs will be covered when the individual is capable of achieving independent functionality or ambulation with the use of the prosthesis and/or prosthetic limb device, and the individual does not have a significant cardiovascular, neuromuscular, or musculoskeletal condition which would be expected to adversely affect or be affected by the use of the prosthetic device (i.e., a condition that may prohibit a normal walking pace).

Repair of the prosthetic limb is covered only when anatomical or functional change or reasonable wear and tear renders the item nonfunctional and the repair will make the equipment usable. Replacement of the prosthetic limb is covered only

when anatomical or functional change or reasonable wear and tear renders the item nonfunctional and non-reparable. Initial coverage, repair, and/or replacement of prosthetic limbs must be pre-approved by USA Medical Services.

6.3 SPECIAL TREATMENTS: Prosthesis, appliances, orthotic durable medical equipment (implanted during surgery), implants, radiation therapy, chemotherapy, and the following highly specialized drugs: Interferon beta-1a, PEGylated Interferon Alfa-2a Alfa, Interferon beta-1b, Etanercept, Adalimumab, Bevacizumab, Cyclosporine A, Azathioprine, and Rituximab will be covered but must be approved and coordinated in advance by USA Medical Services. If special treatments are not pre-approved and coordinated as required, they will be paid or reimbursed at the usual, customary, and reasonable cost that the insurer would have incurred. For coverage of prosthetic limbs, please refer to 6.2.

6.4 EMERGENCY MEDICAL TREATMENT (with or without admission): Your policy covers emergency medical treatment outside the provider network only when the insured's life or physical integrity is in immediate danger, and the emergency has been notified to USA Medical Services, as provided in 1.5. All medical expenses from a non-network provider in relation to emergency medical treatment will be paid as if the insured had been treated at a network hospital.

6.5 EMERGENCY DENTAL TREATMENT: Only emergency dental treatment needed as a result of a covered accident, and that takes place within ninety (90) days of the date of such accident, will be covered under this policy.

6.6 PALLIATIVE CARE COVERAGE FOR TERMINAL PATIENTS: Palliative care will be understood as care provided to patients who do not respond to the curative procedure and are in the terminal stage with a life expectancy of six (6) months or less. Derived from this coverage, the Insurer will pay for the services if the Insured receives a diagnosis of a terminal illness and if he or she can no longer receive treatment that leads to recovery for up to a maximum of twelve (12) months.

The Insurer will pay only for one of the following options:

1. Services of specialized centers for terminal patients and palliative care, the service consists of:
   - Accommodation in a hospice.
   - Care of a professional nurse, qualified by the competent national authority where the treatment or service is received.
   - Prescribed medications and therapies to reduce body pain.
   - Physical, psychological, social, and spiritual care.
2. Home nursing services for terminally ill and palliative care patients, the service consists of:
   - Care of a professional nurse, qualified by the competent national authority where the treatment or service is received.
   - Prescription medications and therapies to reduce body pain.
   - Custodial care provided by a qualified professional nurse.

These services must be approved in advance by the Insurer.

6.7 NOSE AND NASAL SEPTUM DEFORMITY: When nose or nasal septum deformity is the result of trauma during a covered accident, surgical treatment will only be covered if authorized in advance by USA Medical Services. The evidence of trauma in the form of fracture must be confirmed radiographically (X-rays, CT scan, etc.).

6.8 PRE-EXISTING CONDITIONS: Pre-existing conditions fall into two (2) categories:

(a) Disclosed at the time of the application:

i. Free of symptoms, signs, and treatment during the five (5) year period prior to the effective date of the policy, pre-existing conditions are covered upon expiration of the sixty-day (60-day) waiting period, unless specifically excluded by an amendment to the policy.

ii. With symptoms, signs, or treatment any time during the five (5) year period prior to the effective date of the policy, pre-existing conditions will be covered after two (2) years from the effective date of the policy, unless specifically excluded by an amendment to the policy.

(b) Not disclosed at the time of application: Pre-existing conditions not disclosed at the time of the application will NEVER be covered during the lifetime of the policy. Furthermore, the insurer retains the right to rescind, cancel or modify the policy based on the insured's failure to disclose any such conditions.

6.9 TRANSPLANT PROCEDURES: Coverage for transplantation of human organs, cells and tissues is provided only within the insurer's provider network for transplant procedures. There is no coverage outside the provider network for transplant procedures. This transplant benefit begins once the need for transplantation has been determined by a physician, has been certified by a second surgical or medical opinion, and has been approved by USA Medical Services.

This benefit includes:

(a) Pre-transplant care, including those services directly related to evaluation of the need for transplantation, evaluation of the insured for the transplant procedure, and preparation and stabilization of the insured for the transplant procedure.

(b) Pre-surgical workup, including all laboratory and X-ray exams, CT scans, Magnetic Resonance Imaging (MRI's), ultrasounds, biopsies, scans, medications and supplies.

(c) The costs of organ, cell or tissue procurement, transportation, and harvesting including bone marrow and stem cell storage or banking.

(d) The donor workup, including testing of potential donors for a match.

(e) The hospitalization, surgeries, physician and surgeon's fees, anesthesia, medication, and any other treatment necessary during the transplant procedure.

(f) Post-transplant care including, but not limited to any medically necessary follow-up treatment resulting from the transplant and any complications that arise after the transplant procedure, whether a direct or indirect consequence of the transplant.

(g) Medication or therapeutic measures used to ensure the viability and permanence of the transplanted organ, cell or tissue.

(h) Home health care, nursing care (e.g. wound care, infusion, assessment, etc.), emergency transportation, medical attention, clinic or office visits, transfusions, supplies, or medication related to the transplant.

6.10 HAIR PROSTHESIS (WIG): Coverage is subject to the following conditions:

(a) When the Insured is undergoing treatment for cancer.

(b) The hair loss is directly and exclusively a consequence of the cancer treatment.

(c) Must be pre-authorized by the Insurer.

EXCLUSIONS AND LIMITATIONS

This policy does not provide coverage or benefits for any of the following, unless specifically included in your Table of Benefits:

7.1 CHARGES RELATED TO NON-COVERED TREATMENT: Treatment of any illness, injury, or charges arising from any treatment, service or supply:

(a) That is not medically necessary, or

(b) For an insured who is not under the care of a physician, doctor or licensed professional, or

(c) That is not authorized or prescribed by a physician or doctor, or

(d) That is related to custodial care, or

(e) That takes place at a hospital, but for which the use of hospital facilities is not necessary.

Any particular exclusion of the policy excludes from coverage any medical treatment or service to the area, organ and/or system related to that exclusion. Therefore, such treatment or service will never be covered under this policy, regardless of the primary and/or secondary cause, including but not limited to morbid causes and/or accidents.

7.2 SELF-INFLICTED ILLNESS OR INJURY, SUICIDE, FAILED SUICIDE, AND/OR HARMFUL OR DANGEROUS USE OF ALCOHOL, DRUGS AND/OR MEDICINES: Any medical care or treatment due to self-inflicted injuries, illnesses, or ailments, or caused by another person upon the insured's request, suicide, failed suicide, or caused by the insured's negligent use of alcohol, not medically prescribed drugs, recreational drugs, illegal or psychotropic substances, or illegal use of controlled substances. This includes any accident or complication resulting from any of the aforementioned criteria. In the case of vehicular or motorized transport accidents (i.e., automobiles, motorcycles, trucks, boats, etc.) in which the insured is involved as driver or operator and which result in a hospitalization or emergency room visit, the insured reserves the right to request a drug or alcohol blood test taken when the first medical attention is provided and/or any relevant reports by the corresponding authorities to complete the ruling. Coverage is excluded when alcohol blood level is over the limit established by law where the accident took place, or when blood tests reveal the presence of illegal drugs.

7.3 EXAMINATIONS AND AIDS FOR EYES AND EARS: Routine eye and ear examinations, hearing aids, eye glasses, contact lenses, radial keratotomy and/or other procedures to correct eye refraction disorders, except when coverage is specified in your Table of Benefits.

7.4 ALTERNATIVE MEDICINE: Chiropractic care, naturopathic or homeopathic treatment, naturopathic or homeopathic medications, acupuncture and any type of alternative medicine.

7.5 TREATMENT DURING GENERAL WAITING PERIOD: Any illness or injury not caused by an accident or a disease of infectious origin which is first manifested within the first sixty (60) days from the effective date of the policy.

7.6 COSMETIC SURGERY OR TREATMENT: Cosmetic or elective surgery or treatment for beautification purposes, or treatment that is not medically necessary, except when resulting from an injury, deformity, accident, or illness that compromises functionality, that first occurred while the insured was covered under this policy, for which an invoice has been issued, and that can be documented by a medical imaging method (X-rays, CT scan, etc.). Any surgical treatment of nasal deformities or nasal septum not caused by trauma is also excluded from coverage.

7.7 PRE-EXISTING CONDITIONS: Any charges in connection with pre-existing conditions, except as defined and addressed in this policy.

7.8 EXPERIMENTAL OR OFF-LABEL TREATMENT: Any treatment, service, or supply that is not scientifically or medically recognized for a specific diagnosis, or that is considered as off label use, experimental and/or not approved for general use by the U.S. Food and Drug Administration.

7.9 TREATMENT IN GOVERNMENTAL FACILITY: Treatment in any governmental facility, or any expense if the insured would be entitled to free care. Service or treatment for which payment would not have to be made had no insurance coverage existed, or that have been placed under the direction of government authority.

7.10 MENTAL AND BEHAVIORAL DISORDERS: Diagnostic procedures or treatment of psychiatric disorders, unless resulting from treatment for a covered condition. Mental illnesses and/or behavioral or developmental disorders, chronic fatigue syndrome, sleep apnea, and any other sleep disorders.

7.11 CHARGES IN EXCESS OF THE BUPA FEE SCHEDULE: Any portion of any charge in excess of the Bupa Fee Schedule charge for a particular service or supply for the geographical area, or appropriate level of treatment being received.

7.12 COMPLICATIONS OF NON-COVERED CONDITIONS: Treatment or service for any medical, mental, or dental condition related to or arising as a complication of those medical, mental, or dental services or other conditions specifically excluded by an amendment to, or not covered by, this policy.

7.13 DENTAL TREATMENT NOT RELATED TO COVERED ACCIDENT: Any dental treatment or service not related to a covered accident, or that occurs beyond ninety (90) days from the date of a covered accident.

7.14 POLICE OR MILITARY RELATED INJURIES: Treatment of injuries resulting while in service as a member of a police or military unit, or from participation in war, riot, civil commotion, illegal activities, and resulting imprisonment.

7.15 HIV/AIDS: The Acquired Immune Deficiency Syndrome (AIDS), HIV positive or AIDS-related illnesses.

7.16 ELECTIVE HOSPITAL ADMISSION: An elective admission more than twenty-three (23) hours before a planned surgery, unless authorized in writing by the insurer.

7.17 TREATMENT BY IMMEDIATE FAMILY MEMBER: Treatment performed by the spouse, parent, sibling, or child of any insured under this policy.

7.18 MEDICATION WITHOUT PRESCRIPTION: Any medication, sold over the counter or not, for which a medical prescription has not been issued, as well as the following:

(a) Drugs that are not medically necessary, including any drugs given in connection with a service or supply that is not medically necessary.

(b) Any contraceptive medication or device, except when its primary purpose is not contraceptive but rather medically necessary to treat a medical condition or diagnosis.

(c) Drugs or immunizations to prevent disease or allergies.

(d) Drugs for tobacco dependency.

(e) Cosmetic drugs, even if ordered for non-cosmetic purposes.

(f) Drugs taken at the same time and place where the prescription is ordered.

(g) Charges for giving, administering or injecting drugs.

(h) Any refill that is more than the number of refills ordered by the physician, or is made more than one year after the latest prescription was written.

(i) Therapeutic devices, appliances or injectables, including colostomy supplies and support garments, regardless of intended use.

(j) Progesterone suppositories.

(k) Any food, nutritional supplement, or complement, including vitamins and infant formula, even when prescribed to insureds with illnesses or conditions covered under this policy, regardless of the cause, except when this is the only possible feeding method to preserve the patient's life, or when coverage is specified in the Table of Benefits.

7.19 PERSONAL OR HOME-BASED ARTIFICIAL KIDNEY EQUIPMENT: Personal or home-based artificial kidney equipment, unless authorized in writing by the insurer.

7.20 TISSUE AND/OR CELL STORAGE: Storage of bone marrow, stem cell, umbilical cord blood, or other tissue or cell, except as provided for under the conditions of the policy. Cost related to the acquisition and implantation of an artificial heart, other artificial or animal organs, and all expenses for cryopreservation of more than twenty-four (24) hours.

7.21 TREATMENT RELATED TO RADIATION OR NUCLEAR CONTAMINATION: Injury or illness caused by, or related to, ionized radiation, pollution or contamination, radioactivity from any nuclear material, nuclear waste, or the combustion of nuclear fuel or nuclear devices.

7.22 MEDICAL EXAMINATIONS AND CERTIFICATES: Any medical examination or diagnostic study which is part of a routine physical examination, and the issuance of medical certificates and examinations as to the suitability for employment or travel purposes.

7.23 OBESITY TREATMENT: Any treatment for or resulting from obesity or weight control, including food supplements, medication and nutritional advice, except when coverage is specified in the Table of Benefits.

7.24 GROWTH TREATMENT: Treatment by a bone growth stimulator, bone growth stimulation or treatment relating to growth hormone, regardless of the reason for prescription.

7.25 CONDITIONS RELATED TO SEX OR GENDER ISSUES AND SEXUALLY TRANSMITTED: Any expense for gender reassignment, sexual dysfunction including but not limited to impotence, inadequacies, and any other sexually transmitted diseases.

7.26 FERTILITY AND INFERTILITY TREATMENTS: Any kind of fertility and infertility treatment and procedure, including but not limited to tubal ligation, vasectomy, and any other elective procedure to prevent pregnancy that is meant to be permanent, as well as reversal of voluntary sterilization, artificial insemination, and the use of a surrogate mother.

7.27 FERTILITY AND INFERTILITY TREATMENT COMPLICATIONS: Maternity complications as a result of any type of fertility and infertility treatment or any type of assisted fertility procedure.

7.28 MATERNITY TREATMENT DURING WAITING PERIOD: All maternity-related treatment to a mother or a newborn during the ten (10) month pregnancy and maternity waiting period.

7.29 ABORTION: Any voluntarily induced termination of pregnancy, unless the mother's life is in imminent danger.

7.30 PODIATRIC CARE: Cosmetic or medically necessary podiatric care, as well as pedicure, special shoes and supports of any type or shape and/or podiatric care to treat functional disorders of the feet, except when coverage is specified in your Table of Benefits.

7.31 TREATMENT OF THE JAW: Any expenses associated with the treatment of the upper maxilla, the jaw, and/or the complex of muscles, nerves, or other tissue related to the temporomandibular joint caused by a dental condition, previous dental treatment, and/or their complications, including but not limited to any diagnosis where the primary condition is dental.

7.32 PROFESSIONAL SPORTS OR HAZARDOUS ACTIVITIES: Treatment for injuries resulting from the participation in any sport or hazardous activity for compensation or as a professional.

7.33 EPIDEMIC/PANDEMIC DISEASES: Treatment for or arising from any epidemic and/or pandemic disease and vaccinations, medicines, or preventive treatment for or related to any epidemic and/or pandemic disease are not covered , except the vaccines that are specified in the vaccination benefit and/or in the Table of Benefits.

7.34 EUTHANASIA OR ASSISTED DEATH: This policy does not cover any expense derived from euthanasia or assisted death, in any of its modalities (active voluntary, passive voluntary or assisted suicide), even if in the country where the insured is located, such procedure is legalized and/or regulated.

7.35 HAIR PROSTHESIS (WIGS): Acquisition expenses for hair prosthesis as a consequence of a diagnosis for cancer are excluded if:

(a) They are not pre-authorized by the insurer.

(b) They are associated with maintenance of wigs, including, but not limited to wig holders, styling services, hair care products and necessary adjustments

ADMINISTRATION

GENERAL

8.1 **AUTHORITY:** No producer has the authority to change the policy or to waive any of its conditions. After the policy has been issued, no change shall be valid unless approved in writing by an officer or the chief underwriter of the insurer, and such approval is endorsed by an amendment to the policy.

8.2 **CURRENCY:** All currency values stated in this policy are in U.S. dollars (US$).

8.3 **ENTIRE CONTRACT-CONTROLLING CONTRACT:** The policy (this document), the health insurance application, the certificate of coverage, and any riders or amendments thereto, shall constitute the entire contract between the parties. Translations are provided for the convenience of the insured. The English version of this policy will prevail and is the controlling contract in the event of any question or dispute regarding this policy.

8.4 **PPACA RIGHTS AND DISCLAIMER:** This policy does NOT provide all of the rights and protections of the Affordable Care Act (i.e., the U.S. health care law). These include, but are not necessarily limited to, one or more of the protections of the Public Health Service Act. A Health Insurance Marketplace, through which individuals may enroll in a qualified health plan and possibly qualify for federal subsidies, is not currently available outside of the continental United States. To learn more about the Health Insurance Marketplace and protections under the U.S. health care law, visit www.HealthCare.gov or call 1-800-318-2596.

POLICY

9.1 **POLICY ISSUANCE:** The policy is deemed issued or delivered upon its receipt by the policyholder in his/her country of residence.

9.2 **GENERAL WAITING PERIOD:** This policy contains a general sixty-day (60-day) waiting period, during which only illnesses or injuries caused by an accident occurring within this period, or diseases of infectious origin that first manifest themselves within this period, will be covered. Some benefits also have specific waiting periods, which are stated in your Table of Benefits.

9.3 **BEGINNING AND ENDING OF INSURANCE COVERAGE:** Subject to the conditions of this policy, benefits begin on the effective date of the policy and not on the date of application for insurance. Coverage begins at 00:01 hours Eastern Standard Time (USA) on the policy's effective date and terminates at 24:00 hours Eastern Standard Time (USA):

(a) On the expiration date of the policy, or

(b) Upon non-payment of the premium, or

(c) Upon written request from the policyholder to terminate his/her coverage, or

(d) Upon written request from the policyholder to terminate a dependent's coverage, or

(e) Upon written notification from the insurer, as allowed by the conditions of this policy.

If a policyholder would like to terminate coverage for any reason, he/she may only do so as from the anniversary date with two (2) months written notice.

9.4 **POLICY MODE:** All policies are deemed annual policies. Premiums are to be paid annually, unless the insurer authorizes other mode of payment.

9.5 **CHANGE OF PRODUCT OR PLAN:** The policyholder can request to change a product or plan at any anniversary date. When the policyholder request to change a product or plan, must be notified in writing by the Insurer, once the request is received prior anniversary date. The following conditions apply:

(a) The benefits earned by seniority of the insured (except for accumulated deductibles) will not be affected as long as the new product or plan contemplates them.

If the previous product or plan did not include a benefit included in the new product or plan, the specific waiting period established in the Benefits Table of the Policy Cover must be met.

(b) During the first sixty (60) days from the effective date of the change, benefits payable for any illness or injury not caused by accident or disease of infectious origin, will be limited to the lesser of benefits provided by the new plan or the prior plan.

(c) Benefits related to maternity, maternity complications and coverage of the newborn that occur during the ten (10) months following the effective date of the change, will be limited to the lesser of the benefit provided by either the new plan or prior plan.

(d) Benefits with insured sums per lifetime that occur during the six (6) months following the effective date of the change, will be limited to the lesser of the benefit provided by either the new plan or prior plan.

(e) The benefits with insured amounts per lifetime that have already had claims paid under the coverage of the previous product or plan, will be reduced in the proportion of the expense already paid. When the total benefit in the new product or plan is less than the amount already paid under the benefit in the previous product or plan, the benefit is considered exhausted and coverage under the new product or plan will no longer apply.

(f) Nevertheless, the insurer reserve the right to to carry out standard underwriting procedures.

9.6 CHANGE OF COUNTRY OF RESIDENCE: The insured must notify the insurer in writing of any change of his/her country of residence within a maximum period of thirty (30) calendar days of its occurrence. A change of country of residence may result in modification of coverage, deductible, or premium according to the geographical area, subject to the insurer's procedures.

9.7 TERMINATION OF COVERAGE UPON TERMINATION OF POLICY: In the event a policy terminates for any reason, coverage ceases on the effective date of the termination, and the insurer will only be responsible for any covered treatment under the terms of the policy that took place before the effective date of termination of the policy. There is no coverage for any treatment that occurs after the effective date of the termination, regardless of when the condition first occurred or how much additional treatment may be required.

9.8 REFUNDS: If a policyholder cancels the policy after it has been issued, reinstated or renewed, the insurer will not refund the unearned portion of the premium. If the insurer cancels the policy for any reason under the terms of this policy, the insurer will refund the unearned portion of the premium minus administrative charges and policy fees, up to a maximum of sixty-five percent (65%) of the premium. The policy fee, USA Medical Services fee, and thirty-five percent (35%) of the base premium are non-refundable. The unearned portion of the premium is based on the number of days corresponding to the payment mode, minus the number of days the policy was in effect.

9.9 WAIVING OF GENERAL WAITING PERIOD: The insurer will waive the waiting period only if:

(a) Other medical expense insurance for the insured was in effect with another company for at least one (1) continuous year, and

(b) The effective date of this policy begins within sixty (60) days of the expiration of the previous coverage, and

(c) The prior coverage is disclosed in the health insurance application, and

(d) We receive the prior policy and a copy of the receipt for the last year's premium payment, with the health insurance application.

If the waiting period is waived, benefits payable for any condition manifested during the first sixty (60) days of coverage are limited, while the policy is in effect, to the lesser benefit provided by either this policy or the prior policy.

This elimination of the general waiting period does not apply to benefits covered with specific waiting periods.

9.10 EXTENDED COVERAGE TO ELIGIBLE DEPENDENTS UPON DEATH OF POLICYHOLDER: In the event of the death of the policyholder, the insurer will provide continued coverage as described in your Table of Benefits, for the surviving dependents insured under this policy at no charge if the cause of the death of the policyholder results from a covered condition under this policy. This benefit only applies to covered dependents under the existing policy, and will automatically terminate in the event of marriage of the surviving spouse/domestic partner, or for surviving dependents who are not otherwise eligible for coverage under this policy and/or are issued their own separate policy. This extended coverage does not apply to any optional rider. The extended coverage goes into effect as per the next renewal date or anniversary date, whichever comes first, after the death of the policyholder.

RENEWAL

10.1 PREMIUM PAYMENT: The policyholder is responsible for paying the premium on time. Premium payment is due on the renewal date of the policy or any other due date authorized by the insurer. Premium notices are provided as a courtesy, and the insurer provides no guarantee of delivering such notices. If a policyholder has not received a premium notice thirty (30) days prior to the premium payment due date, and the policyholder does not know the amount of the premium payment, he/she should contact his/her producer or the insurer. Payment may also be made online at www.bupasalud.com.

10.2 PREMIUM RATE CHANGES: The insurer retains the right to change the premium at the time of each renewal date. This right will be exercised on a "class" basis only on the renewal date of each respective policy.

10.3 GRACE PERIOD: If premium payment is not received by the due date, the insurer will allow a grace period of thirty (30) days from the due date for the premium to be paid. If the premium is not received by the insurer prior to the end of the grace period, this policy and all of its benefits will be deemed terminated as of the original due date of the premium. Benefits are not provided under the policy during the grace period.

10.4 POLICY CANCELLATION OR NON-RENEWAL: The insurer retains the right to cancel, modify or rescind the policy if statements on the health insurance application are found to be misrepresentations, incomplete, or if fraud has been committed, leading the insurer to approve an application when, with the correct or complete information, the insurer would have issued a policy with restricted coverage or declined to provide insurance.

If the insured changes country of residence, and the insured's current plan is not available in the insured's new country of residence, the insurer retains the right not to renew or to modify a policy in terms of rates, deductibles or benefits, generally and specifically, in order to offer the insured the closest equivalent insurance coverage available, if any.

Submission of a fraudulent claim is also grounds for rescission or cancellation of the policy.

The insurer retains the right to cancel, non-renew or modify a policy on a "block" basis as defined in this policy, and the insurer will offer the insured the closest equivalent insurance coverage available, if any. No individual insured shall be independently penalized by cancellation or modification of the policy due solely to a poor claim record.

10.5 REINSTATEMENT: If the policy was not renewed within the grace period, it can be reinstated within sixty (60) days after the grace period at the insurer's discretion, if the insured provides new evidence of insurability consisting of a new health insurance application and any other information or document required by the insurer. No reinstatement will be authorized after ninety (90) days of the termination date of the policy.

11.1 DIAGNOSIS: For a condition to be considered a covered illness or disorder, copies of laboratory tests results, X-rays, or any other report or result of clinical examinations on which the diagnosis was based, are required as part of the positive diagnosis by a physician.

11.2 REQUIRED SECOND SURGICAL OPINION: If a surgeon has recommended a non-emergency surgical procedure, the insured must notify USA Medical Services at least seventy-two (72) hours prior to the scheduled procedure. If a second surgical opinion is deemed necessary by either the insurer or USA Medical Services, it must be conducted by a physician chosen and arranged by USA Medical Services. Only those second surgical opinions required and coordinated by USA Medical Services are covered. In the event the second surgical opinion contradicts or does not confirm the need for surgery, the insurer will also pay for a third surgical opinion from a physician chosen in agreement between the insured and USA Medical Services. If the second or third surgical opinion confirms the need for surgery, benefits for the surgery will be paid according to this policy.

Consult your Table of Benefits for more details on this clause's requirements and if your policy includes a fee for non-compliance.

11.3 DEDUCTIBLE:

(a) All insureds under the policy have a deductible responsibility per policy year. When applicable, the corresponding deductible amount is applied per insured, per policy year before benefits are paid or reimbursed to the insured. All deductible amounts paid accumulate towards the corresponding maximum deductible per policy, which is equivalent to the sum of two individual deductibles. All insureds under the policy contribute to meeting the maximum deductible amount of the policy. Once the maximum deductible amount of the policy is met, the insurer will consider all individual deductible responsibilities as met.

(b) Any eligible charges incurred by an insured during the last three (3) months of the policy year will apply to that policy year's deductible and will also be carried over to be applied towards that insured's deductible for the following policy year, as long as there are no expenses incurred during the first nine (9) months of the policy year. If the benefit is granted to carry over the insured's deductible to the following policy year, and subsequently the insured submits claims or requests for reimbursement for eligible expenses that occurred during the first nine (9) months of the policy year, the benefit will be reversed, and the insured will be responsible for the following policy year's deductible. This benefit does not apply to additional deductibles to the regular annual deductible of the policy, which may be applied for certain limitations of the Insured.

(c) In case of a serious accident, no deductible shall apply for the period of the first hospitalization only. For all hospitalizations thereafter, the corresponding deductible shall apply. The insured must notify the accident to the insurer within seventy-two (72) hours of such accident. If the accident is not notified as required, the deductible waiver will not be applied.

11.4 PROOF OF CLAIM: The insured must request reimbursement throught my Bupa at www.bupasalud.com, or send an email to servicio@bupalatinamerica.com including copy of detailed invoices, medical records and proof of payment within one hundred eighty (180) days after the treatment or service date. Without exception, to be considered valid, all invoices must comply with all current fiscal and legal requirements in the country where the service was provided. The Insurer reserves the right to request a copy of the corresponding proof of payment. Failure to do so will result in the claim being denied. For claims related to car accidents, the following additional documentation is required for review: police reports, first insurance proof of coverage, emergency medical report, and results of toxicological screening. Bills received in currencies other than U.S. dollars (US$) will be processed in accordance with the exchange rate determined on the date of service at the insurer's discretion. Additionally, the insurer reserves the right to issue the payment or reimbursement in

the currency in which the service or treatment was invoiced. In order for benefits to be paid under this policy, dependent children, after their nineteenth (19th) birthday, must provide a written statement signed by the policyholder that the dependent child's marital status is single.

In the event that the Insured does not agree with what was determined by the Insurer in relation to any claim (closed) or in the event that the insurer needs additional information, they will have up to 180 days from the date of issuance of the explanation of benefits to present such information.

11.5 PAYMENT OF CLAIMS: It is the insurer's policy to make payments directly to physicians and hospitals worldwide. When this is not possible, the insurer will reimburse the policyholder either the contractual rate given to the insurer by the provider involved or in accordance with the Bupa Fee Schedule charges for that geographical area, whichever is less. Any charges or portions of charges in excess of these amounts are the responsibility of the insured. If the policyholder is deceased, the insurer will pay any unpaid benefits to the beneficiary or estate of the deceased policyholder. USA Medical Services must receive the complete medical and non-medical information required in order to determine compensability before: 1) direct payment is approved; or 2) policyholder is reimbursed.

The insurer, USA Medical Services, and/or any of their applicable related subsidiaries and affiliates will not engage in any transactions with any parties or in any countries where otherwise prohibited by the laws in the United States of America. Please contact USA Medical Services for more information about this restriction.

11.6 COORDINATION OF BENEFITS: If the insured has another policy that provides benefits also covered by this policy, benefits will be coordinated. All claims incurred in the country of residence must be submitted in the first instance against the other policy. This policy shall only provide benefits when such benefits payable under the other policy have been paid out and the policy limits of such policy have been exhausted. Outside the country of residence, Bupa Insurance Company will function as the primary insurer and retains the right to collect any payment from local or other insurers. The following documentation is required to coordinate benefits: Explanation of Benefits (EOB) and copy of bills covered by the local insurance company containing information about the diagnosis, date of service, type of service, and covered amount.

11.7 PHYSICAL EXAMINATIONS: The insurer shall have the right and opportunity to request a physical examination at its own expense, of any insured whose illness or injury is the basis of a claim, when and as often as considered necessary by the insurer before the claim is agreed.

11.8 DUTY TO COOPERATE: The insured shall make all medical reports and records available to the insurer and, when requested by the insurer, shall sign all necessary authorization forms for the insurer to obtain medical reports and records. Failure to cooperate with the insurer or failure to authorize the release of all medical records requested by the insurer may cause a claim to be denied.

11.9 SUBROGATION AND INDEMNITY: The insurer has a right of subrogation or reimbursement from or on behalf of an insured to whom it has paid any claims, if such insured has recovered all or part of such payments from a third party. Furthermore, the insurer has the right to proceed at its own expense in the name of the insured, against third parties who may be responsible for causing a claim under this policy, or who may be responsible for providing indemnity of benefits for any claim under this policy.

11.10 CLAIMS APPEALS: In the event of a disagreement between the insured and the insurer regarding this insurance policy and/or its conditions, before beginning any arbitration or legal proceeding, the insured shall request a review of the matter by the Bupa Insurance Company appeals committee. In order to begin such review, the insured must submit a written request to the appeals committee. This request shall include copies of all relevant information sought to be considered, as well as an explanation of the decision that should be reviewed and why. The request shall be sent to the attention of the Bupa Insurance Company appeals coordinator, c/o USA Medical Services. Upon submission of a request for review, the appeals committee

will determine whether any further information and/or documentation is needed and act to timely obtain it. The appeals committee will notify the insured of its decision and the underlying rationale within thirty (30) days.

11.11 CLAIMS ARBITRATION, LEGAL ACTIONS, AND JURY WAIVER: Any disagreement that may persist upon completion of the claims appeal as determined herein, must first be submitted for arbitration. In such cases, the insured and the insurer will submit their difference to three (3) arbiters: Each party selecting an arbiter, and the third arbiter to be selected by the arbiters named by the parties herein. In the event of disagreement between the arbiters, the decision will rest with the majority. Either the insured or the insurer may initiate arbitration by written notice to the other party demanding arbitration and naming its arbiter. The other party shall have twenty (20) days after receipt of said notice within which to designate its arbiter. The two (2) arbiters named by the parties, within ten (10) days thereafter, shall choose the third arbiter and the arbitration shall be held at the place hereinafter set forth ten (10) days after the appointment of the third arbiter. If the other party does not name its arbiter within twenty (20) days, the complaining party may designate the second arbiter and the other party shall not be aggrieved thereby. Arbitration shall take place in Miami-Dade County, Florida, USA, or if approved by the insurer, in the policyholder's country of residence. The insured and the insurer agree that each party will pay their own expenses in regards to the arbitration.

The insured confers exclusive jurisdiction in Miami-Dade County, Florida for the determination of any rights under this policy. The insurer and any insured covered by this policy hereby expressly agree to trial by judge in any legal action arising directly or indirectly from this policy. The insurer and the insured further agree that each party will pay their own attorneys' fees and costs, including those incurred in arbitration.

11.12 PAYMENT OF NON COVERED CLAIMS: The Insurer is under not obligated to provide coverage and/or pay excluded claims or claims not covered under the Terms and Conditions of the policy under any circumstances (such as, but not limited to, those cases where: the Insurer, by an error, on its part, made payments of a claim that is subsequently identified as excluded or not covered under the Terms and Conditions of the policy.)

Any payment for excluded conditions or conditions not covered by the Terms and Conditions of the policy shall be considered an error that in no way constitutes a right on the part of the Insured. Such payments shall not constitute a precedent and/or reference for other and/or future coverage related to the same or similar diagnosis or any related claim; therefore, the Insured does not have the right to demand coverage for any claim derived from the same event and/or any event, claim, or excluded condition or not covered under the Terms and Conditions of the policy.

In those cases where The Insurer makes payments on claims not covered by the Terms and Conditions of the policy, the Insurer may, at its sole discretion: i. request the return of any monies made in error to the Policyholder Insured (refund must be made within thirty days from the date of collection by the Insurer from the Insured); ii. reduce the paid amount in error from any pending or future claims; iii. reduce the paid amount in error from the unearned premium; iv. execute any necessary action to obtain a refund of the related amount to the claims paid in error.

DEFINITIONS

ACCIDENT: Damage, trauma, or injury caused by an external, unexpected, fortuitous, and violent force. Accidents must be notified within seventy-two (72) hours of such event. Events where the first medical attention is not received within thirty (30) days will not be considered accidents. In those cases, the claim will be processed as an illness or ailment. In cases of injury to nose, ligaments, spinal column, knee, and major joints, only those where fracture or rupture, as applicable, or polytrauma is present will be considered accidents.

ACCIDENTAL BODILY INJURY: Damage inflicted to the body caused by a sudden and unforeseen external cause.

AIR AMBULANCE TRANSPORTATION: Emergency air transportation from the hospital where the insured is admitted to the nearest suitable hospital where treatment can be provided.

AMENDMENT: A document added to the policy by the insurer that clarifies, explains, or modifies the policy.

ANNIVERSARY DATE: Annual occurrence of the effective date of the policy.

APPLICANT: The individual who completes the health insurance application for coverage.

APPLICATION: Written statements on a form by an applicant about themselves and/or their dependents, used by the insurer to determine acceptance or denial of the risk. The health insurance application includes any oral statements made by an applicant during a medical interview held by the insurer, medical history, questionnaire, and other document provided to, or requested by, the insurer prior to the issuance of the policy.

BLOCK: The insureds of a policy type (including deductible) or a territory.

BUPA FEE SCHEDULE: Contains the maximum amounts the insurer will consider eligible for payment for specific treatments under a health insurance plan. These amounts are determined by the insurer based on a periodic review of the prevailing charges for particular services adjusted for a specific region or geographical area.

CALENDAR YEAR: January 1 through December 31 of any given year.

CERTIFICATE OF COVERAGE: Document of the policy that specifies the effective date, conditions, extent and limitations of coverage, and lists the policyholder and each covered dependent.

CLASS: The insureds of all policies of the same type, including but not limited to benefits, deductibles, age group, country, plan, year groups, or a combination of any of these.

COINSURANCE: Is the percentage of eligible medical expenses that insured must pay, after meeting/meeting the deductible, for the benefits listed in their benefit table, within and/or outside the country of residence and taking into consideration your benefit limits.

COMPLICATION OF NEWBORN: Any disorder related to the birth of a newborn, not caused by congenital or hereditary factors, manifested during the first thirty-one (31) days of life, including but not limited to hyperbilirubinemia (jaundice), cerebral hypoxia, hypoglycemia, prematurity, respiratory distress and birth trauma.

COMPLICATION OF PREGNANCY, MATERNITY, AND/OR BIRTH: Any condition caused by, and/or that occurs as a result of the pregnancy, maternity, or birth (not related to congenital or hereditary disorders). For the purpose of this coverage, cesarean deliveries are not considered a complication of pregnancy, maternity, and/or birth.

CONGENITAL AND/OR HEREDITARY DISORDER: Any disorder or illness acquired during conception or the fetal stage of development as a result of the genetic make-up of the parents or environmental factors, whether or not it is manifested or diagnosed before birth, at birth, after birth, or years later.

CONTINUITY OF COVERAGE (NO LOSS-NON-GAIN): Continuity of coverage ensures that there is no coverage period when changing from one product or plan to another within the same company or for transfers between Bupa group companies. However, changes and transfers are subject to a non-loss-no-profit provision, whereby the least of the benefits payable between the products or plans involved in the exchange or transfer are applied during a given period in advance. The benefits earned by seniority of the insured will not be affected as long as the new product or plan contemplates them. If the previous product or plan did not contemplate a benefit included in the new product or plan, the specific waiting period of that benefit established in the Benefits Table must be met. Granting continuity of coverage does not mean that they do not apply the corresponding risk assessment procedures.

COPAYMENT: The copayment is the fixed rate of covered expenses that every insured must pay directly to the medical or hospital service provider before receiving services regardless of benefit limits and is indicated in your Table of Benefits.

COUNTRY OF RESIDENCE: The country where the Insured (principal, spouse and dependent children) has declared in the Insurance Application to have his/her physical residence

based on a minimum of one hunder and eighty (180) continuous or discontinuous days in a period of three hundred and sixty-five (365) days and has indicated to have his/ her physical residence, or his/her country of origin, or the country he/she has informed the insurer to be his/her residence afterwards in writing.

COVERED PREGNANCY: Covered pregnancies are those for which the policy provides pregnancy benefits and the actual date of delivery is at least ten (10) calendar months after the effective date of coverage for the respective insured female. This ten (10) calendar month waiting period applies regardless of whether or not the sixty (60) day waiting period for coverage under this policy has been waived.

CUSTODIAL CARE: Assistance with the activities of daily living that can be provided by non-medical/nursing trained personnel (bathing, dressing, grooming, feeding, toileting, etc.).

DEDUCTIBLE: The individual deductible is the amount of covered charges that must be paid by each insured each policy year before policy benefits are payable, except when otherwise stated. The family deducible is the maximum deductible amount per policy for covered charges equivalent to the sum of two individual deductibles per policy year.

DEPENDENT: Eligible dependents under this policy are those who have been identified on the health insurance application and for whom coverage is provided under the policy. Eligible dependents include:

(a) The policyholder's spouse or domestic partner

(b) Biological children

(c) Legally adopted children

(d) Stepchildren

(e) Children to whom the policyholder has been appointed legal guardian by a court of competent jurisdiction

(f) Grandchildren born into the policy from insured dependent children under the age of eighteen (18).

DEPENDENT ADULT: A person who presents long-term or permanent functional limitation or disability, understood as a restriction in their physical, mental, intellectual, or sensory capacity, determined by an authorized physician or legally declared; therefore, requiring assistance from a third party.

DIAGNOSTIC PROCEDURES: Medically necessary procedures and laboratory testing used to diagnose or treat medical conditions, including pathology, X-rays, ultrasound, and MRI/CT/PET scans.

DOMESTIC PARTNER: A person of the opposite or same sex with whom the policyholder has established a domestic partnership.

DOMESTIC PARTNERSHIP: A relationship between the policyholder and one other person of the opposite or same sex. All the following requirements apply to both persons:

(a) They must not be currently married to, or be a domestic partner of, another person under either statutory or common law.

(b) They must share the same permanent residence and the common necessities of life.

(c) They must be at least eighteen (18) years of age.

(d) They must be mentally competent to consent to contract.

(e) They must be financially interdependent and must have furnished documents to support at least two (2) of the following conditions of such financial interdependence:

i. They have a single dedicated relationship of at least one (1) year

ii. They have joint ownership of a residence

iii. They have at least two (2) of the following:

- A joint ownership of an automobile
- A joint checking, bank or investment account
- A joint credit account
- A lease for a residence identifying both partners as tenants
- A will and/or life insurance policy which designates the other as primary beneficiary

The policyholder and domestic partner must jointly sign the required affidavit of domestic partnership.

DONOR: Person dead or alive from whom one or more organs, cells or tissue have been removed with the purpose of transplanting to the body of another person (recipient).

ELIGIBLE EXPENSES: Refers to those expenses incurred by the insured and that would be covered by the policy provided as long as is indicated under the Table of Benefits, even if those expenses are applied to the deductible.

EMERGENCY: A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the insured's life or physical integrity in immediate danger if medical attention is not provided within twenty-four (24) hours.

EMERGENCY DENTAL TREATMENT: Treatment necessary to restore or replace damaged or lost teeth in a covered accident.

EMERGENCY MEDICAL TREATMENT: Medically necessary attention or services due to an emergency.

EPIDEMIC: The occurrence of more cases than expected of a disease or other health condition in a given area or among a specific group of persons during a particular period, and declared as such by the World Health Organization (WHO), or the Pan American Health Organization (PAHO) in Latin America, or the United States Centers for Disease Control and Prevention (CDC), or a local government or equivalent body (i.e. local ministry of health) where the epidemic is developing. Usually, the cases are presumed to have a common cause or to be related to one another in some way.

EUTHANASIA OR ASSISTED DEATH: Voluntary, explicit, and consented act of ending the life of a person who has been previously diagnosed with a terminal phase of an illness/(terminal prognosis), through predetermined medical procedures, as they suffer from a severe and incurable disease, or a severe, chronic, irreversible, and incapacitating condition, causing constant and intolerable physical or psychological suffering.

EXPERIMENTAL: The service, procedure, device, drug, or treatment that does not adhere to the standard of practice guidelines accepted in the United States of America regardless of the place where the service is performed. Drugs must have approval from the U.S. Food and Drug Administration (FDA) for use for the diagnosed condition, or other federal or state government agency approval required in the United States of America, independent of where the medical treatment is incurred or where bills are issued.

GENERAL WAITING PERIOD: The period of time during which the insured will not have any benefit, except for illnesses and injuries caused by an accident that occurs within this period, or those diseases of infectious origin that first manifest themselves during this period.

GRACE PERIOD: The thirty-day (30-day) period after the policy's due date during which the insurer will allow the policy to be renewed.

GROUND AMBULANCE TRANSPORTATION: Emergency transportation to a hospital by ground ambulance.

HAIR PROSTHESIS (WIGS): The hair prosthesis is a piece formed by a special base in the form of a mesh to which hair fibers are attached.

HAZARDOUS ACTIVITIES: Any activity that exposes the participant to any foreseeable danger or risk. Examples of hazardous activities include, but are not limited to: aviation sports, rafting or canoeing involving white water rapids in excess of grade 5, tests of velocity, scuba diving at a depth of more than thirty (30) meters, bungee jumping, and participation in any extreme sport, or participation in any sport as a professional or for compensation.

HIGHLY SPECIALIZED DRUGS: Medications with a special mechanism of action designed to treat highly complex and chronic medical conditions, with a high monthly cost and whose follow-up is done under the strict supervision of a specialist. The Insurer will evaluate and determine if it will cover the active component in any of its generic or commercially available presentations.

HOME HEALTH CARE: Care of the insured in the insured's home, prescribed and certified in writing by the insured's treating physician, as required for the proper treatment of the

illness or injury, and used in place of in-patient treatment in a hospital. Home health care includes the services of a skilled licensed professional (nurse, therapist, etc.) outside the hospital, and does not include custodial care.

HOSPITAL: Any institution legally licensed as a medical or surgical facility in the country in which it is located, that is a) primarily engaged in providing diagnostic and therapeutic facilities for clinical and surgical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians; and b) not a place of rest, a place for the aged, a nursing or convalescent home or institution, or a long-term care facility.

HOSPITAL SERVICES: Hospital staff, nurses, scrub nurses, standard private or semi-private room and board, and other medically necessary treatments or services ordered by a physician for the insured who is admitted to a hospital. These services also include local calls, TV, and newspapers. Private nurse and standard private room upgrade to a suite or junior suite are not included in hospital services.

ILLNESS: An abnormal condition or health alteration manifested by signs, symptoms, and/or abnormal findings in medical exams, which make this condition different than the normal state of the body.

IN-PATIENT HOSPITALIZATION: Medical or surgical care that due to its intensity must be rendered during a hospital stay of twenty-four (24) hours or more. The severity of the illness must also justify the medical necessity of hospitalization. Treatment limited to the emergency room is not considered in-patient hospitalization.

INFECTIOUS DISEASE: A clinical condition resulting from the presence of pathogenic microbial agents, including pathogenic viruses, pathogenic bacteria, fungi, protozoa, multicellular parasites, and aberrant proteins known as prions, that can be transmitted from person to person.

INJURY: Damage inflicted to the body by an external cause.

INSURED: An individual for whom a health insurance application has been completed, the premium paid, coverage approved and initiated by the insurer. The term “insured” includes the policyholder and all dependents covered under this policy.

MAXIMUM COINSURANCE (Stop Loss): Is the total sum of coinsurance money that insured must pay annually, in addition to the deductible, before the company can pay 100% benefits. The maximum coinsurance or "Stop Loss" is reached when the insured has paid the deductible and reached the maximum annual amount of direct disbursement for coinsurance.

MEDICALLY NECESSARY: A treatment, service, or medical supply prescribed by a treating physician and approved and coordinated by USA Medical Services. A treatment, service, or medical supply will not be considered medically necessary if:

(a) It is provided only as a convenience to the insured, the insured’s family, or the provider (e.g. private nurse, standard private room upgrade to suite or junior suite, etc.), or

(b) It is not appropriate for the insured’s diagnosis or treatment, or

(c) It exceeds the level of care needed to provide adequate and appropriate diagnosis or treatment, or

(d) Falls outside the standard of practice, as established by professional boards by discipline (MD, physical therapy, nursing, etc.), or

(e) It is custodial in nature.

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

NOTIFICATION: The Insured has a mandatory obligation to communicate a notification to the Insurer about the occurrence of an accident or the need to receive emergency treatment. This notification must be made within the first seventy-two (72) hours from the onset of the need for treatment. A third party may provide the notification on behalf of the Insured should the Insured be unable to do so themself. All notifications must be communicated through the accepted support channels, which are specified on the insurance card.

NURSE: A professional legally licensed to provide nursing care in the country where the treatment is provided.

OUT OF POCKET MAXIMUM: Is the maximum amount that insured must pay for covered medical expenses in a policy year. This amount includes the deductible, coinsurance, and copayment.

OUT-PATIENT SERVICES: Medical treatments or services provided or ordered by a physician for the insured when he/she is not admitted in a hospital. Out-patient services include services performed in a hospital or emergency room if these services have a duration of less than twenty-four (24) hours.

PALLIATIVE CARE: Palliative care will be understood as care provided to patients who do not respond to the curative procedure and are in the terminal stage. They represent an approach to improving the quality of life of patients and their families facing the problems associated with life-threatening diseases. It includes the prevention and relief of suffering through the early identification, assessment and treatment of pain and other physical, psychosocial, and spiritual problems. Palliative radiotherapies or chemotherapies for treatment of pain are not included.

PANDEMIC: An epidemic occurring over a widespread area (multiple countries or continents) and usually affecting a substantial proportion of the population.

PHYSICIAN OR DOCTOR: A professional legally licensed to practice medicine in the country where treatment is provided while acting within the scope of his/her practice. The term "physician" or "doctor" shall also apply to a professional legally licensed to practice as a dentist.

POLICY DUE DATE: The date on which the premium is due and payable.

POLICY EFFECTIVE DATE: The date stated in the certificate of coverage, on which coverage under this policy begins.

POLICY YEAR: The period of twelve (12) consecutive months beginning on the effective date of the policy and any subsequent twelve-month period thereafter.

POLICYHOLDER: The named applicant on the health insurance application. This individual is the person entitled to receive reimbursement for covered medical expenses and the return of any unearned premium.

PRE-EXISTING CONDITION: A condition:

(a) That is diagnosed by a physician prior to the effective date of the policy or its reinstatement, or

(b) For which medical advice or treatment was recommended by, or received from, a physician prior to the effective date of the policy or its reinstatement, or

(c) For which any symptom and/or sign, if presented to a physician prior to the effective date of the policy, would have resulted in the diagnosis of an illness or medical condition.

PRESCRIPTION DRUGS: Medications whose sale and use are legally restricted to the order of a physician.

PROFESSIONAL OR COMPENSATORY SPORT: The practice of sports professionally or for compensation refers to a voluntary sports practice carried out by athletes, either on their own account or within the organization or direction of a club, league, sports entity or similar, through an established relationship of a regular nature and receiving or with the intention to receive, in exchange, a remuneration derived from this sporting practice in the form of salary, sponsorship or another type of financing or remuneration, and including the respective training even when no compensation is received for it.

PROVIDER NETWORK: A group of hospitals and physicians approved and contracted to treat insureds on behalf of the insurer. The list of hospitals and physicians in the provider network is available from USA Medical Services or online at www.bupasalud.com, and may change at any time without prior notice.

PROVIDER NETWORK FOR TRANSPLANT PROCEDURES: A group of hospitals and physicians contracted on behalf of the insurer for the purpose of providing transplant benefits to the insured. The list of hospitals and physicians in the provider network for transplant procedures is available from USA Medical Services and may change at any time without prior notice.

RECIPIENT: The person who has received, or is in the process of receiving an organ, cell or tissue transplant.

REHABILITATION SERVICES: Treatment provided by a legally licensed health professional intended to enable people who have lost the ability to function normally through a serious injury, illness, surgery, or for treatment of pain, to reach and maintain their normal physical, sensory, and intellectual function. These services may include: medical care, physical therapy, occupational therapy and others.

RENEWAL DATE: This is the date when the premium payment is due. It may occur on a date different from the anniversary date, depending on the mode of payment authorized by the insurer.

SECOND SURGICAL OPINION: The medical opinion of a physician other than the current treating physician.

SERIOUS ACCIDENT: An unforeseen trauma occurring without the insured's intention, which implies a sudden external cause and violent impact on the body, resulting in demonstrable bodily injury that requires immediate in-patient hospitalization for twenty-four (24) hours or more within the next few hours after the occurrence of the severe injury to avoid loss of life or physical integrity. Severe injury shall be determined to exist upon agreement by both the treating physician and the insurer's medical consultant, after review of the triage notes, emergency room and hospital admission medical records.

STEPCHILD: Child born to or adopted by the spouse or domestic partner of a policyholder, whom the policyholder has not legally adopted.

TERMINAL CONDITION: An active, progressive, and irreversible illness or condition that, without life-sustaining procedures, will result in death in the near future, or a state of permanent unconsciousness from which recovery is unlikely.

TRANSPLANT PROCEDURE: Procedure in which an organ, cell (e.g. stem cell, bone marrow, etc.), or tissue is implanted from one person to another, or when an organ, cell, or tissue is removed from the same individual and then received back.

TREATMENT IN URGENCY CARE CENTERS AND CONVENIENCE CLINICS: Are the treatments received in classified Urgent Care Centers in the United States of America. This is a type of medical service center specializing in the diagnosis and treatment of serious or acute medical conditions, which generally require immediate attention; but do not pose an imminent risk to life or health. This service is an intermediate care between the primary doctor and the emergency service. Services in hospital emergency centers or others that are not Urgent Care will not be covered under this benefit.

WELL BABY CARE: Routine medical care provided to a healthy newborn.

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