

BUPA SUPREME
TERMS AND CONDITIONS

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YOUR COVERAGE

GEOGRAPHICAL COVERAGE

Bupa offers you comprehensive worldwide coverage and free choice of providers. If you need information about the provider 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.

OPTIONAL ADDITIONAL COVERAGE

Bupa offers a Maternity and Perinatal Complications Rider for additional coverage, which can be included when you purchase your policy or at renewal time. The benefits provided under this rider are subject to all the terms, conditions, exclusions, limitations, and restrictions of your policy. Please consult your Table of Benefits to find out if this rider is available under your plan.

The Maternity and Perinatal Complications Rider offers a US$500.000 lifetime optional coverage for complications of the pregnancy, complications of delivery, and perinatal complications (not related to congenital or hereditary disorders) such as prematurity, low birth weight, jaundice, hypoglycemia, respiratory distress, and birth trauma. A 10-month waiting period applies after the effective date of the rider. Once issued, the rider will be renewed annually upon the anniversary date of the underlying policy, as long as the additional premium required for the rider is paid. Available for Plans 3, 4, and 5 only.

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	1	2	3	4	5
In-country	2.000	3.500	5.000	10.000	20.000
Max. per policy	4.000	7.000	10.000	20.000	40.000

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.

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 amounts are in U.S. dollars.
- All benefits are subject to any applicable deductible, unless otherwise stated.
- Any diagnostic or therapeutic procedure, treatment, or benefit is covered only if resulting from a condition covered under this policy.
- Insureds are not required to obtain treatment from the provider network.
- All reimbursements are paid in accordance with the Usual, Customary, and Reasonable (UCR) fees for the specific service. UCR is the maximum amount the insurer will consider eligible for payment, adjusted for a specific region or geographical area.
- 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 Master General Agent. 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 a Policyholder whose country of residence is Latin America or the Caribbean and who are a minimum of eighteen (18) years of age (except for eligible dependents), through a maximum of seventy-four (74) years of age. There is no maximum age for coverage under the same terms and conditions of this policy for those Insureds renewing a policy. This policy cannot be issued and is not available to persons whose country of residence is the United States or who otherwise is physically present in the United States of America for at least 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 continue to be covered under certain conditions as long as the policyholder's country of residence remains in Latin America or the Caribbean, and such temporary stay is approved by the Insurer. Notwithstanding the aforementioned, the insurer reserves the right to evaluate the Policyholder's eligibility, and may cancel non-renewal or modify the policy, at the sole discretion of the Insurer, in the event of a change in country of residence. 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, natural born 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 date of the policy, following the attainment of 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 will terminate on the next anniversary date of the policy.

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 or higher deductible and with the same conditions and restrictions in existence under the prior policy which afforded them with the Insurer. The Application of the former dependent must be received before the end of the grace period of the policy which previously afforded the dependent coverage.

1.5 REQUIREMENT TO NOTIFY THE INSURER AND PRE-AUTHORIZE: The Insured must obtain preauthorization from USA Medical Services, acting in its capacity as the Insurer's claims administrator, at least seventy-two (72) hours before receiving any service identified in the Table of Benefits as requiring preauthorization. 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 the plan's deductible.

1.6 COUNTRY OF RESIDENCE: For purposes of this policy, "country of residence" shall mean the country where the Insured (principal and named dependents), physically resides for at least one hundred eighty (180) days, on a continuous or discontinuous basis during a period of three hundred sixty-five (365) days. To be eligible for coverage under this policy, the Insured's (principal and named dependents) country of residence must be in Latin America or the Caribbean.

This policy is not available to, nor can it be issued or renewed to, persons who country of residence is the United States of America, regardless of the type of visa issued to the Insured or their immigration status. As an exception, Insureds with work assignments, student visas, and other temporary stays within the United States may be covered under certain conditions as stated in Section ("EXTENSION OF COVERAGE ABROAD FOR STUDIES OR TEMPORARY WORK"), as long as the Insured's permanent residence remains outside of the United States or the insured does not receive a permanent residence card (green card), the Insurer reserves the right to evaluate the eligibility, modify premium, cancellation, or non-renewal of the policy, if any Insured (principal and named dependents) resides or is physically present in a country outside of Latin America and the Caribbean, or another country, other than the one declared as residence in the Insurance Application.

1.7 EXTENSION OF COVERAGE ABROAD FOR STUDIES OR TEMPORARY WORK: Those Insured individuals who, due to temporary work or studies, must remain abroad for a period longer than that stipulated in Section (“COUNTRY OF RESIDENCE”), may request an extension of coverage abroad for up to the annual term of the policy, renewable for an additional annual term at the discretion of the Insurer, provided that the Insured’s permanent residence remains in THE COUNTRY DECLARED IN THE INSURANCE APPLICATION. This extension of coverage and its conditions will be approved at the discretion of the Insurer.

Notwithstanding the above, the Insurer reserves the right to assess the eligibility of the Insured if they maintain presence or residence in a country other than THE ONE DECLARED AS RESIDENCE IN THE INSURANCE APPLICATION. A change in the country of residence under this scenario may result in changes to the coverage, deductible, or premium depending on the geographical area, subject to the procedures of the Insurer.

The extension of coverage will not apply if the Insured loses their status as a student or temporary worker and becomes a permanent resident of the United States of America or any other country other than THE ONE DECLARED AS RESIDENCE IN THE INSURANCE APPLICATION, regardless of the type of visa issued to the Insured or their immigration status.

BENEFITS

IN-PATIENT BENEFITS AND LIMITATIONS

2.1 HOSPITAL SERVICES: Coverage is provided as described in your Table of Benefits only when in-patient hospitalization is medically necessary.

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 usual, customary and reasonable fees 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 COMPANION OF A HOSPITALIZED CHILD: Charges included in the hospital bill for overnight hospital accommodations for the companion of a hospitalized insured child under the age of eighteen (18) will be payable as described in your Table of Benefits.

OUT-PATIENT BENEFITS AND LIMITATIONS

3.1 AMBULATORY SURGERY: Ambulatory or out-patient surgical procedures performed in a hospital, clinic, or doctor’s office are covered as described in your 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 as described in your Table of Benefits when medically necessary.

3.3 PRESCRIPTION DRUGS: Prescription drugs first prescribed after 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 treatment plan are required in advance to obtain each approval.

3.6 ROUTINE HEALTH CHECKUP: Routine physical examinations may include diagnostic studies and vaccinations.

3.7 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.

3.8 TELEMEDICINE: Access to remote health care services may be made available through blua, Bupa's digital health platform. These services may include general medicine video consultations, medical counseling in selected specialties, and other digital tools designed to support health care management and wellness. The Insured may access these services through the "My Bupa Latin America" application or the Company's website at www.bupasalud.com. All available digital features and health programs will be identified and described through the blua platform.

MATERNITY BENEFITS AND LIMITATIONS

4.1 PREGNANCY, MATERNITY, AND BIRTH (Plans 1 and 2 only):

(a) The maximum benefit 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, and cesarean deliveries are included under 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 covered under 4.3.

4.2 NEWBORN COVERAGE:

(a) Provisional coverage:

If born from a covered pregnancy, each newborn will automatically be covered for complications of 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 International Healthcare Solutions 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 International Healthcare Solutions 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 International Healthcare Solutions Insurance Application and a copy of the birth certificate must be submitted, which will be subject to the standard underwriting procedures.

(c) Well baby care is covered as described in your Table of Benefits.

4.3 COMPLICATIONS OF PREGNANCY, MATERNITY, AND BIRTH (Plans 1 and 2 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 in 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 andcmiscarriages 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 consequences thereof, will be covered up to policy limits.

Consult your Table of Benefits to confirm if your plan offers the option to purchase the Maternity and Perinatal Complications Rider. However, this rider is not available for dependent children.

EVACUATION BENEFITS AND LIMITATIONS

5.1 MEDICAL EMERGENCY EVACUATION: Emergency transportation (by ground or air ambulance) is covered as described in your Table of Benefits 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 pay the charges toward repatriation of the deceased's remains to his/her country of residence 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 disorders 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 highly specialized drugs 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): 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: Transplant procedures are covered as described in your Table of Benefits. 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, and is subject to all the terms, conditions and exclusions of the policy.

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, stem cell or cord blood 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 COMPLEMENTARY THERAPIST: Out-patient treatment received from an osteopathic doctor, a chiropractor, a podiatrist, and/or a psychiatrist as well as acupuncture, homeopathic treatment, or treatment for behavioral and developmental disorders including medically prescribed short term speech therapy and sleep disorders are covered as described in your Table of Benefits.

6.11 DIETETIC GUIDANCE: Medically prescribed consultations with an authorized dietician are covered as described in your Table of Benefits. In all cases, a copy of the prescription from the treating physician must accompany the claim.

6.12 HIV/AIDS: Diseases related to AIDS and HIV antibodies (HIV positive) are covered as described in your Table of Benefits if proven to be caused by a blood transfusion received after the effective date of the policy. The HIV virus will also be covered if proven to have been contracted as a result of an accident occurring during the course of a normal occupation for the following professions: doctors, dentists, nurses, laboratory personnel, ancillary hospital workers, medical and dental assistants, ambulance personnel, midwives, fire brigade personnel, police officers, and prison officers. The insured shall notify the insurer within fourteen (14) days after such accident, and at the same time provide a negative HIV antibody test dated prior to the accident.

6.13 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.

6.14 COMPREHENSIVE CANCER TREATMENT: The Insurer shall cover expenses from cancer treatment once the disease has been diagnosed, including bone marrow transplantation, fees related to the planning and administration of cancer treatment, laboratory tests, physicians' fees directly associated with the planning and delivery of oncological treatment, diagnostic imaging studies, chemotherapy, medical consultations, reconstructive surgery provided it is medically necessary and directly related to the treatment of cancer, and prescribed medications. All benefits under this provision are payable up to the maximum limit per Membership Year specified in the Table of Benefits.

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, (except protocol exams in outpatient consultations) 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: Naturopathic treatment, naturopathic or homeopathic medications, and any type of alternative medicine, except as described in your Table of Benefits.

7.5 TREATMENT DURING 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 diagnostic, 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: In-patient diagnostic procedures and/or treatment of psychiatric disorders, mental illnesses, and/or behavioral or developmental disorders, unless resulting from treatment for a covered condition.

7.11 CHARGES IN EXCESS OF UCR: Any portion of any charge in excess of the usual, customary and reasonable charge for the 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, except when coverage is included in your Table of Benefits.

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 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, or other tissue or cell, except umbilical cord blood 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, including vaccinations and the issuance of medical certificates and examinations as to the suitability for employment or travel, except as described in your Table of Benefits.

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 DISEASES: 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 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.

7.32 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.

7.33 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 agent has the authority to change the policy or to waive any of its provisions. You further agree that your coverage shall be solely determined by the terms and conditions of this policy and not by any statements or representations made by the agent. After issuance, no change in the policy 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, the terms and conditions, the application, the Certificate of Coverage and any riders or amendments thereto constitute the entire agreement between the parties and supersedes all prior or contemporaneous understandings, agreements, and representations, whether written or oral, relating to the subject matter hereof. The Policyholder acknowledges that it has not relied on any representation or warranty, express or implied, other than those expressly set forth herein. The Spanish translation is 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. If any provision of this policy shall be found by any court or administrative body of competent jurisdiction to be invalid or unenforceable, such invalidity or unenforceability shall not affect the other provisions of this policy which shall remain in full force and effect. If any provision of this policy is so found to be invalid or unenforceable but would be valid or enforceable if some part of the provision were deleted, the provision in question shall apply with such modification(s) as may be necessary to make it valid upon good faith negotiation and agreement between the Insurer and the Insured.

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.

9.1 POLICY ISSUANCE: This policy cannot be issued or delivered in the U.S.A., except as may be specifically permitted under the laws of the State of Florida. 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 thirty-day (30-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.

The Policy shall remain in force for an initial period of twelve (12) months and, upon timely payment of the applicable renewal premium, shall automatically renew for successive twelve (12)-month periods. Each renewal shall be subject to the definitions, terms, conditions, and other provisions of the Policy in effect as of the applicable renewal premium due date.

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 with no guaranteed right of renewal. Premiums are to be paid annually, unless the insurer authorizes other modes 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 thirty (30) 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 the Insured's country of residence within a maximum period of thirty (30) calendar days of its occurrence. Changes of country of residence may, at the Insurer's sole discretion, result in modification of coverage, non-renewal and/or cancellation of the policy. Changes of country of residence to the United States of America will result in non-renewal of the policy. THE INSURED'S COUNTRY OF RESIDENCE CANNOT BE THE UNITED STATES OF AMERICA. Failure to notify the Insurer of any change of the Insured's country of residence may result in cancellation of the policy, non-renewal or modification of coverage on the next anniversary date, at the Insurer's sole discretion. .

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 Master General Agent 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 CONDITION OF RENEWAL: In accordance with applicable regulations, the Insurer shall not decline to renew the Policy based on claims experience or the Insured's age, provided that all premiums have been paid within the applicable time frames. The Policy will not be renewed if the Policyholder provides the Insurer with written notice of the Policyholder's intention not to renew at least thirty (30) business days before the renewal premium due date. Any renewal shall be issued based on the same underwriting terms and conditions consistent as those originally contracted for and duly registered.

10.5 POLICY CANCELLATION OR NON-RENEWAL: The insurer retains the right to cancel, modify, non-renew or rescind the policy if statements on the application, or any statements made to the Insurer thereafter, are found to be misrepresentations, incomplete or that 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.

The insurer retains the right to cancel or modify a policy in terms of rates, deductibles or benefits, generally and specifically, if the insured changes country of residence, regardless of how many years the policy has been in force. During the policy term, if an Insured's country of residence is or becomes the United States of America, at the Insurer's sole discretion, the policy may be modified, non-renewed or cancelled. 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 "class" basis as defined in this policy. No individual insured shall be independently penalized by cancellation or modification of the policy due solely to a poor claim record.

10.6 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.

CLAIMS

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 for treatment in-country or out-of-country according to the plan selected by the policyholder. 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 in-country or out-of-country maximum amounts of the policy. Once the maximum deductible amounts of the policy are 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 through my Bupa at www.bupasalud.com, or send request to servicio@bupalatinamerica.com, including a 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.

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 usual, customary, and reasonable fees 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 CLAIMS APPEALS: In the event of any disagreement between the insured and the insurer regarding this insurance policy and/or its conditions, the Insured, before commencing any arbitration or legal proceedings, 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 what decision should be reviewed and why. Said appeals shall be sent to the attention of the Bupa Insurance Company Appeals Coordinator, c/o USA Medical Services. Upon the 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 such. Within thirty (30) days thereafter, the Appeals Committee will notify the insured of its decision and the underlying rationale.

11.10 CLAIMS ARBITRATION, LEGAL ACTIONS, AND JURY WAIVER: Any dispute, claim or disagreement (collectively "dispute") that is not resolved by the Appeals Committee, shall first be submitted to non-binding mediation governed by the International Mediation Rules of the International Centre for Dispute Resolution ("ICDR"). The appointed mediator shall have at least ten (10) years of experience in the health insurance industry. The mediation shall be held within sixty (60) days after the decision by the Appeals Committee is issued. No arbitration or litigation proceedings may commence until the Insurer and Insured participate in good faith in such mediation. The reasonable costs associated with mediation shall be paid by the Insurer so long as the Insured participates in the mediation in good faith.

If mediation is not successful as determined by the appointed mediator, the dispute shall be exclusively resolved by binding arbitration pursuant to the International Arbitration Rules of the ICDR. The Insured and the Insurer will cooperate in the selection of a single neutral and conflict-free arbitrator who shall have at least ten (10) years of experience in the health insurance industry. Either the Insured or the Insurer may initiate arbitration by filing with the ICDR and concurrently submitting to the other party a detailed written notice demanding arbitration and setting forth the factual and legal basis for its claim. Arbitration shall take place in Miami-Dade County, Florida, U.S.A. or if approved by the Insurer, in the Policyholder's country of residence. The expenses of the arbitration shall be shared equally between the parties. All issues of arbitrability shall be deferred to the arbitrator. The arbitrator shall issue a written and reasoned award and judgment on that award rendered by the arbitrator may be entered in any court of competent jurisdiction. The parties will each be responsible for paying their own attorneys' fees and costs of the arbitration, subject to any remedies to which a party may later be entitled or a reasonable award of fees and costs made by the arbitrator. All arbitration proceedings shall be considered confidential and any information exchanged between the parties or filed with the arbitrator shall be treated as confidential information. The language of the arbitration shall be in English.

NOTWITHSTANDING, IF THE INSURED DOES NOT WISH TO BE BOUND BY THE ABOVE BINDING ARBITRATION PROVISION IN THIS POLICY, THE INSURED MAY OPT-OUT BY PROVIDING WRITTEN NOTICE TO BUPA GLOBAL LATIN AMERICA, ATTN: LEGAL DEPARTMENT, 18001 OLD CUTLER ROAD, SUITE 500. PALMETTO BAY, FLORIDA 33157. SUCH WRITTEN NOTICE MUST BE PROVIDED WITHIN THIRTY (30) DAYS OF THE POLICY EFFECTIVE DATE AND MUST INCLUDE THE INSURED'S NAME, POLICY NUMBER, AND A CLEAR STATEMENT THAT THE INSURED IS OPTING OUT OF THE ARBITRATION PROVISION. IF THE INSURED DOES NOT OPT-OUT WITHIN THE SPECIFIED TIMEFRAME, THE ARBITRATION AGREEMENT WILL BE BINDING AND ENFORCEABLE.

In the event the Insured opts-out of arbitration, the Insured confers exclusive jurisdiction and venue in Miami-Dade County, Florida to resolve any dispute and for determination of any rights under this policy. The Insured shall not bring any legal action arising out of or relating to this policy in the Insured's country of residence. Each party shall bear its own costs and expenses, including attorneys' fees incurred in connection with any litigation commenced.

The policy and its execution, performance or non-performance, interpretation, construction and all claims or causes of action (whether in contract, in tort, at law or otherwise) that may be based upon, arise out of, or relate to this policy, or the transactions contemplated hereby, shall be exclusively governed by, and construed in accordance with, the laws of the State of Florida, USA without reference or regard to its principles of conflicts of laws. The agreement to arbitrate below shall also be governed by the Federal Arbitration Act, 9 U.S.C. § 1, et seq. ("FAA").

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.

11.11 SUBROGATION AND INDEMNITY: Upon payment of any claim under this policy, the Insurer shall be subrogated to all rights of recovery of the Insured against any third party responsible for the causing of the claim. Furthermore, the Insurer shall have the right to proceed at its own expense to pursue recovery in the name of the Insured, and the Insured agrees to assign such rights to the Insurer to the extent of the payments made. This includes, but is not limited to, the right to bring legal action, negotiate settlements, and take any other necessary actions to recover the amount paid under this policy. The Insured agrees to cooperate fully with the Insurer, at no expense to the Insurer, in the exercise of its subrogation rights. This cooperation includes, but is not limited to, providing necessary information and documents, completing and executing documents and questionnaires, and attending legal proceedings as required by the Insurer. The Insured shall promptly provide written notice to the Insurer as soon as reasonably practicable when the Insured becomes aware of a potential subrogation claim against a third party responsible for the harm caused to the Insured. The Insured shall not do anything to negatively impact or prejudice the Insurer's subrogation rights, including, but not limited to, settling or compromising any claim against a responsible third party without the Insurer's consent. Any non-cooperation by the Insured in the Insurer's subrogation efforts may lead to non-renewal of the Insured's policy.

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.

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

BRAND-NAME DRUGS (PROPRIETARY DRUGS): Medications marketed and sold under a proprietary trade name or registered trademark rather than under the name of their active ingredient.

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.

COMPLICATIONS 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.

COMPLICATIONS 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: 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.

CURRENT PROCEDURAL TERMINOLOGY (CPT): A standardized coding system consisting of descriptive terms and identifying codes used to document and report health care services and procedures performed by medical professionals.

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.

DIALYSIS: A procedure or therapy that performs certain functions of the kidneys when both kidneys have failed or are unable to function adequately, including the removal of waste products and excess fluid from the blood.

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).

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 Food and Drug Administration (FDA) in the United States of America 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.

GENERIC DRUGS: Medications marketed and sold under the name of their active ingredient and having the same active ingredient, strength, dosage form, and route of administration as the corresponding brand-name drug.

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.

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.

INTERNATIONAL HEALTHCARE SOLUTIONS INSURANCE 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 International Healthcare Solutions 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.

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.

MEDICAL UNDERWRITING: Internal process in which the Insurer evaluates risks associated with applicants’ health. The process includes review of medical information, health history, demographic profile, lifestyle, among other factors that may be related to the current and/or future medical needs of the members, including but not limited to the following analysis: limitation and/or exclusion of general and/or particular coverage of the policy, and/or rejection of the applicant’s request.

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 that may legally be dispensed only pursuant to a physician's prescription. This coverage includes legally authorized generic and brand-name drugs. Such medications are covered when purchased from a duly licensed pharmacy, subject to the terms and limits set forth in the Schedule of Benefits applicable to the selected plan.

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.

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.

RIDER: A document added to the policy by the insurer which adds and details an optional coverage.

ROUTINE HEALTH CHECKUP: A medical examination taken at regular intervals to verify a normal state of health or discover a disease in its early stages. A checkup does not include any test or consultation to follow-up on a disease already diagnosed.

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.

SPECIFIC WAITING PERIOD: The specified period of time for certain coverages during which insured will not be able to file a claim for services related to such benefits that have been performed before the corresponding waiting period indicated in the Table of Benefits has been completed. Benefits with specific waiting period us eliminate or waive under no circumstances.

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.

USUAL, CUSTOMARY, AND REASONABLE (UCR): It is the maximum amount the insurer will consider eligible for payment under a health insurance plan. This amount is determined based on a periodic review of the prevailing charges for a particular service adjusted for a specific region or geographical area.

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

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