

BUPA COMPLETE CARE
TERMS AND CONDITIONS

AGREEMENT

1.1 **BUPA INSURANCE LIMITED:** (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 **FOURTEEN (14) DAY RIGHT TO EXAMINE THE POLICY:** The policyholder can cancel this policy within fourteen (14) days of receiving the first certificate of coverage. The policyholder should simply write to the insurer at 18001 Old Cutler Road, Suite 500, Palmetto Bay, Florida 33157, USA. If no claims have been made under the policy the insurer will refund any premiums paid.

1.3 **POLICY TERMS AND CONDITIONS:** The terms and conditions of this policy include this Membership guide and the information contained in the application. Please read the Membership guide with reference to the definitions in the glossary, where certain words and phrases are defined or explained further.

1.4 **NON DISCLOSURE:** If upon taking out the insurance or subsequently, the policyholder and/or the insured have fraudulently changed the original documents or disclosed incorrect information or withheld facts which may be regarded as being of importance to the insurer, the insurance contract shall be void and shall not be binding on the insurer.

If upon taking out the insurance or subsequently, the policyholder and/or the insured have disclosed incorrect information the insurance contract shall be void, and the insurer shall not be liable if the insurer would not have accepted the insurance should the correct information had been disclosed. If the insurer would have accepted the insurance but under different terms, the insurer shall be liable to the extent to which the insurer would have undertaken the obligations in accordance with the agreed premium.

In the event that the insurance contract is considered void, the insurer shall be entitled to a service charge which is set as a specific percentage of the premium paid.

If upon taking out the insurance, neither the policyholder nor the insureds knew or should have known that the information disclosed by him/her was incorrect, the insurer shall be liable as if such incorrect information had not been disclosed.

1.5 **ELIGIBILITY:** This policy can only be issued to residents of Latin America or the Caribbean who are at least eighteen (18) years old (except for eligible dependents), and not older than seventy-four (74) years old. There is no maximum renewal age for insureds already covered under this policy. This policy cannot be issued to residents of the United States of America.

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

Dependent coverage is available for the policyholder's dependent children up to their nineteenth (19th) birthday if single, or up to their twenty-fourth (24th) birthday if single and full-time students at an accredited college or university (minimum twelve (12) credits per semester) at the time that the policy is issued or renewed. Coverage for such dependents continues through the next anniversary or renewal date of the policy, whichever comes first after reaching nineteen (19) years of age if single, or twenty-four (24) years of age if single and a full-time student.

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, stops being a full-time student after his/her nineteenth (19th) birthday, moves to another country, or if a dependent spouse ceases to be married to the policyholder by reason of divorce or annulment, coverage for such dependent under this policy will terminate on the next anniversary or renewal date of the policy, whichever comes first.

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

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

1.6 NOTIFICATION TO THE INSURER: The insured is asked to contact USA Medical Services, Bupa's claims administrator, at least seventy-two (72) hours in advance of receiving any medical care. Emergency treatment should be notified within seventy-two (72) hours of beginning such treatment.

If the insured does not contact USA Medical Services before their treatment, the insurer cannot make a direct payment to the provider. The insurer will then reimburse the policyholder in accordance with the usual, customary, and reasonable fees for that geographical area.

BENEFITS

NOTES ON BENEFITS AND LIMITATIONS

- Maximum coverage for all covered medical and hospital charges while the policy is in effect is limited to the terms and conditions of this policy. Unless otherwise stated herein, all benefits are per insured, per policy year. All amounts are in U.S. dollars.
- Insureds are not required to obtain treatment from the Bupa 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 Table of benefits is only a summary of coverage. Full details of the policy terms and conditions are in the "Policy Conditions", "Administration", and "Exclusions and limitations" sections.
- Any diagnostic or therapeutic procedure, treatment, or benefit is covered only if resulting from a condition covered under this policy.
- Insureds are asked to notify USA Medical Services prior to beginning any treatment.
- All benefits are subject to any applicable deductible, unless otherwise stated.
- 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 and, solely with respect to the insurer, where otherwise prohibited by the laws in the United Kingdom and/or Denmark. Please contact USA Medical Services for more information about this restriction.

TABLE OF BENEFITS

Maximum coverage per insured, per policy year	No limit

In-patient benefits and limitations	Coverage
Hospital services	100%
Hospital room and board (standard private/semi private) ◦ In Bupa hospital network ◦ In other hospitals, per day	 100% US$1,000
Intensive care unit ◦ In Bupa hospital network ◦ In other hospitals, per day	 100% US$3,000
Medical and nursing fees	100%
Mental Health while in-patient (must be pre-approved)	100%
Drugs prescribed while in-patient	100%
Diagnostic procedures (pathology, lab tests, X-rays, MRI/CT/PET scan, ultrasound, and endoscopies)	100%
Accommodation charges for companion of a hospitalized child, per day	US$300
Out-patient benefits and limitations	**Coverage**
Ambulatory surgery	100%
Physicians and specialists visits	100%
Prescription drugs: ◦ Following hospitalization or out-patient surgery (for a maximum of 6 months) ◦ Per policy year thereafter ◦ Out-patient or non-hospitalization (with 20% co-insurance)	 100% US$2,000 US$1,000
Diagnostic procedures (pathology, lab tests, X-rays, MRI/CT/PET scan, ultrasound, and endoscopies)	100%
Physical therapy and rehabilitation services (must be pre-approved)	100%
Home health care (must be pre-approved)	100%
Adult Routine health checkup (all inclusive) ◦ No deductible applies	US$600
Pediatric Health check-up, max. per policy year ◦ No deductible applies	US$600
Vaccines (medically necessary) ◦ No deductible applies ◦ Subject to 20% of coinsurance	US$1,600
Urgent Care Facilities or Walk-in Clinics in the U.S.A. Expenses derived from treatment in emergency care centers and convenience clinics in the United States of America that are necessary to treat an injury, illness or medical condition covered under the policy. ◦ US$50 copay ◦ No deductible applies	100%

Maternity benefits and limitations	Coverage
Pregnancy, maternity, and birth, per pregnancy (includes normal delivery, cesarean delivery, all pre- and post-natal treatment, required vitamins during pregnancy and well baby care) ◦ 10-month waiting period ◦ No deductible applies ◦ Plans 1, 2 and 3 only	US$7,500
Complications of pregnancy, maternity, and birth (per lifetime, per policy) ◦ 10-month waiting period ◦ Plans 1, 2 and 3 only ◦ No deductible applies	US$1,000,000
Provisional coverage for newborn children (for a maximum of 90 days after delivery) ◦ Covered pregnancies only ◦ No deductible applies	US$30,000

Evacuation benefits and limitations	Coverage
Medical emergency evacuation: ◦ Air ambulance ◦ Ground ambulance ◦ Return journey ◦ Repatriation of mortal remains Must be pre-approved and coordinated by USA Medical Services.	US$125,000 100% 100% 100%

Other benefits and limitations	Coverage
Cancer treatment (chemotherapy/radiation therapy)	100%
End-stage renal failure (dialysis)	100%
Transplant procedures (lifetime maximum per diagnosis)	US$600,000
Congenital and/or hereditary disorders: ◦ Diagnosed before the age of 18 (lifetime maximum) ◦ Diagnosed on or after the age of 18	US$1,000,000 100%
Prosthetic limbs (lifetime maximum US$120,000)	US$30,000
Special treatments (prosthesis, implants, appliances and orthotic devices, durable medical equipment, radiation therapy, chemotherapy, and highly specialized drugs)	100%
Emergency room (with or without admission)	100%
Emergency dental coverage	100%
Hospice/terminal care	100%
Complementary therapist (maximum 20 visits/sessions)	100%
Custodial care after Alzheimer's diagnosis	US$5,000 per lifetime

SUPPLEMENTARY OPTION WITH THE PURCHASE OF RIDER (not automatically included)

Optional coverage benefits and limitations	Coverage
Maternity and perinatal complications rider (per rider) Additional coverage for complications not related to congenital or hereditary disorders ◦ 10-month waiting period after effective date of rider ◦ Plans 4, 5 and 6 only	US$500,000

POLICY CONDITIONS

IN-PATIENT BENEFITS AND LIMITATIONS

2.1 HOSPITAL SERVICES: Coverage is only provided when in-patient hospitalization is medically necessary.

(a) For coverage outside the Bupa provider network:

i. Standard private or semi-private hospital room and board is limited to a maximum benefit of one thousand dollars (US$1,000) per day.

ii. Room and board within an intensive care unit is limited to a maximum benefit of three thousand dollars (US$3,000) per day.

(b) For coverage within the Bupa provider network:

i. Standard private or semi-private hospital room and board is covered up to one hundred percent (100%) of the usual, reasonable and customary hospital charges.

ii. Room and board within an intensive care unit is covered up to one hundred percent (100%) of the usual, reasonable and customary hospital charges.

(c) Emergency medical treatment is covered as provided in policy condition 6.4.

2.2 MEDICAL AND NURSING FEES: Physician, surgeon, anesthesiologist, assistant surgeon, specialists, and other medical and nursing fees are covered only when they are medically necessary for the surgery or treatment. 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 at a hundred percent (100%).

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 up to three hundred dollars (US$300) per day.

2.5 MENTAL HEALTH WHILE IN HOSPITALIZATION: The company will cover the fees related to psychiatric and/or psychological treatment as long as it is medically necessary as a result of a covered illness, and therapies are performed during hospitalization.

The insured should contact the company to receive a prior authorization before undergoing a treatment. The company is entitled to not paying this benefit if no prior authorization has been granted.

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 according to the Table of benefits. These surgeries allow the patient to go home the same day that they have the surgical procedure.

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

3.3 PRESCRIPTION DRUGS: Prescription drugs first prescribed after an in-patient hospitalization or out-patient surgery for a medical condition covered by the policy are covered up to a maximum period of six (6) continuous months after the date of discharge or surgery. Thereafter, the maximum benefit for prescription drugs is two thousand dollars (US$2,000) per insured, per policy year. A copy of the prescription from the treating physician must accompany the claim.

Prescription drugs prescribed for out-patient treatments or non-hospitalizations related to a medical condition covered by this policy are limited to a maximum benefit of one thousand dollars (US$1,000) per insured, per policy year. A copy of the prescription from the treating physician must accompany the claim.

(a) A co-insurance of twenty percent (20%) applies to all expenses.

(b) Eighty percent (80%) of 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 must be pre-approved. An initial period of up to thirty (30) sessions will be covered if approved in advance by USA Medical Services. Any extensions in increments of up to thirty (30) sessions must be approved in advance or the claim will be denied. 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: An initial period of up to thirty (30) days will be covered if approved in advance by USA Medical Services. Any extensions in increments of up to thirty (30) days must be approved in advance or the claim will be denied. Updated evidence of medical necessity and a treatment plan are required in advance to obtain each approval.

3.6 ROUTINE HEALTH CHECKUP: Routine physical examinations are covered up to a maximum of six hundred dollars (US$600) per insured, per policy year, with no deductible. Routine physical examinations may include diagnostic studies. Pediatric routine health checkups apply to insured dependants from twelve (12) months to seventeen (17) years; adult routine health checkups apply to insured eighteen and up.

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

3.8 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.

MATERNITY BENEFITS AND LIMITATIONS

4.1 PREGNANCY, MATERNITY, AND BIRTH (Except Plans 4, 5 and 6):

(a) There is a maximum benefit of seven thousand five hundred dollars (US$7,500) for each covered pregnancy, with no deductible, for the respective insured female.

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

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

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

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

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

4.2 NEWBORN COVERAGE:

(a) Provisional coverage:

If born from a covered pregnancy, each newborn will automatically be covered for complications at birth and for any injury or illness during the first ninety (90) days after birth, up to a maximum of thirty thousand dollars (US$30,000) with no deductible.

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, a Changes and Additions 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 babies 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 Changes and Additions 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. A Changes and Additions Application and a copy of the birth certificate must be submitted in these cases, which will be subject to the standard underwriting procedures.

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

4.3 COMPLICATIONS OF PREGNANCY, MATERNITY, AND BIRTH (Except for Plans 4, 5 and 6): 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) There is a maximum lifetime benefit of one million dollars (US$1,000,000) per policy, which includes any benefit already paid under any other Bupa plan and/or maternity rider.

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

(c) 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.

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

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

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

There is an optional rider available to cover complications of pregnancy, maternity, and birth for mother and child for Plans 4, 5 and 6. However, this rider is not available for dependent children.

EVACUATION BENEFITS AND LIMITATIONS

2.6 MEDICAL EMERGENCY EVACUATION: Emergency transportation (by ground or air ambulance) is only covered 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.

Air ambulance transportation:

(a) All air ambulance transportation must be pre-approved and coordinated by USA Medical Services.

(b) The maximum amount payable for this benefit is one hundred twenty-five thousand dollars (US$125,000) per insured, per policy year.

(c) 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.

(d) 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.

5.1 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: Coverage under this policy for congenital and/or hereditary disorders is as follows:

(a) The maximum benefit for disorders first manifested before the insured's eighteenth (18th) birthday is one million dollars (US$1,000,000) per insured, per lifetime, including any benefits already paid on a Bupa policy or rider, after the applicable deductible.

(b) Benefits for disorders first manifested on or after the insured's eighteenth (18th) birthday are equal to the maximum policy limit herein, after the applicable deductible.

(c) The benefit starts 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 actual condition.

6.2 PROSTHETIC LIMBS: Prosthetic limb devices include artificial arms, hands, legs, and feet, and are covered up to a maximum of thirty thousand dollars (US$30,000) per insured, per policy year, with a lifetime maximum of one hundred twenty thousand dollars (US$120,000). The benefit includes all the costs associated with the procedure, including any therapy related to the usage of the new limb.

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

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

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

6.3 SPECIAL TREATMENTS: Prosthesis, appliances, orthotic durable medical equipment (implanted during surgery), implants, radiation therapy, chemotherapy, and the following highly specialized drugs: Interferon beta-1a, PEGylated Interferon alpha-2a, Interferon beta-1b, Etanercept, Adalimumab, Bevacizumab, Cyclosporine A, Azathioprine, and Rituximab will be covered but must be approved and coordinated in advance by USA Medical Services. For coverage of prosthetic limbs, please refer to condition 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 HOSPICE/TERMINAL CARE: Hospice accommodations and terminal care treatment and services are covered at one hundred percent (100%) for patients that have received a diagnosis for a terminal condition with a life expectancy of six (6) months or less, and need physical, psychological, and social care, as well as special equipment fitting or adaptation, nursing care, and prescribed drugs. This care must be approved in advance by USA Medical Services.

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 thirty-day (30-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: The maximum amount payable for the transplantation of human organs, cells, and tissue benefit is six hundred thousand dollars (US$600,000) per insured, per diagnosis, per lifetime after the applicable deductible. 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, provisions, 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 are covered up to a maximum of twenty-five thousand dollars (US$25,000) per diagnosis, which is included as part of the maximum transplant benefit. The donor workup, including testing of potential donors for a match is included in this benefit.

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

(e) 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.

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

(g) 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: Only out-patient treatment received from an osteopathic doctor, a chiropractor, and/or a psychiatrist will be covered under this benefit. There is a maximum of twenty (20) visits/sessions per insured, per policy year under this benefit.

6.11 CUSTODIAL CARE AFTER ALZHEIMER´S DIAGNOSIS: This coverage will only be effective if the insured is diagnosed with Alzheimer's disease. Maximum limit is up to five thousand dollars (US$5,000) per insured, per lifetime, including aid or assistance to carry out daily activities such as bathing, dressing, cleaning, eating, going to the bathroom, etc., that are provided by personnel with technical training or expertise.

EXCLUSIONS AND LIMITATIONS

This policy does not provide coverage or benefits for any of the following:

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, except when coverage is specified in the Table of Benefits, or

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

7.2 SELF-INFLICTED ILLNESS OR INJURY: Any care or treatment, while sane or insane, received due to self-inflicted illness or injury, suicide, attempted suicide, alcohol use or abuse, drug use or abuse, or the use of illegal substances or illegal use of controlled substances, including any accident resulting from any of the aforementioned criteria.

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

7.4 ALTERNATIVE MEDICINE: Homeopathic treatment, acupuncture or any type of alternative medicine, except as provided for under the conditions of this policy.

7.5 TREATMENT DURING GENERAL WAITING PERIOD: Any illness or injury not caused by an accident or a disease of infectious origin which is first manifested within the first thirty (30) days from the effective date of the policy.

7.6 COSMETIC SURGERY: Cosmetic surgery or medical treatment which is primarily for beautification, unless required due to the treatment of an injury, deformity or illness that compromises functionality and that first occurred while the insured was covered under this policy. This also includes any surgical treatment for nasal or septal deformity that was not induced by trauma.

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

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

7.9 TREATMENT IN GOVERNMENTAL FACILITY: Treatment in any governmental facility, or any expense if the insured would be entitled to free care. Service or

treatment for which payment would not have to be made had no insurance coverage existed, or epidemic/pandemic diseases which have been placed under the direction of government authority.

7.10 MENTAL AND BEHAVIORAL DISORDERS: Diagnostic procedures or in-patient treatment of psychiatric disorders, unless resulting from treatment for a covered condition. Mental illnesses and/or behavioral or developmental disorders, chronic fatigue syndrome, sleep apnea, and any other sleep disorders except when coverage is specified in the Table of Benefits.

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: Acquired immune deficiency syndrome (AIDS), HIV positive or AIDS related illnesses. However, diseases related to AIDS and HIV antibodies (HIV positive) are covered 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.

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 OVER-THE-COUNTER AND NON-PRESCRIPTION DRUGS: Over the counter or non-prescription drugs, 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 drugs or devices, even if ordered for non-contraceptive purposes.

(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, cord blood, or other tissue or cell, except as provided for under the conditions of the policy. Cost related to the acquisition and implantation of an artificial heart, other artificial or animal organs, and all expenses for cryopreservation of more than twenty-four (24) hours.

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

7.22 MEDICAL EXAMINATIONS AND CERTIFICATES: The issuance of medical certificates and examinations as to the suitability for employment.

7.23 WEIGHT RELATED TREATMENT: Any expense, service or treatment for obesity, weight control, or any form of food supplement.

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 10-MONTH 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 COSMETIC PODIATRIC CARE: Pedicure, special shoes and supports for the structure of the feet, of any type or shape.

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, except the vaccines that are specified in the table of benefits.

ADMINISTRATION

GENERAL

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

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

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

8.4 **APPLICABLE LAW:** Your insurance policy is governed by Danish law. Any dispute that cannot otherwise be resolved will be dealt with by courts in Denmark. If any dispute arises as to the interpretation of this document, the English version of this document shall be deemed to be conclusive and taking precedence over any other language version of this document. You can obtain a copy at any time by contacting our Customer Service at +1 (305) 398 7400.

8.5 **CONFIDENTIALITY:** The confidentiality of patients and customer information is of paramount concern to the companies in the Bupa group. To this end, the insurer fully complies with the data protection legislation and medical confidentiality guidelines. The insurer sometimes uses third parties to process data on our behalf. Such processing, which may be undertaken outside the European Economic Area (EEA), is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the United Kingdom's Data Protection Act.

8.6 **TAXES:** Depending on your country of residency and type of policy purchased, you may be subject to applicable taxes or other charges which may be collected and included as part of your total invoiced premium.

POLICY

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

9.2 **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.

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

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

9.5 CHANGE OF PRODUCT OR PLAN: The policyholder can request to change a product or plan at any anniversary date. This request must be submitted in writing and received before the anniversary date. When the policyholder request to change a product or plan, the following conditions apply:

a) 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 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) Some requests are subject to underwriting evaluation.

9.6 CHANGE OF COUNTRY OF RESIDENCE: The insured must notify the insurer in writing of any change of his/her country of residence within thirty (30) days of its occurrence. A change of country of residence may result in modification of coverage, at the insurer's discretion. Failure to notify any change of the insured's country of residence to insurer may result in cancellation of the policy or modification of coverage on the next anniversary date or the next renewal date, whichever comes first, at the insurer's 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 thirty (30) 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 thirty (30) 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 for the surviving dependents insured under this policy by affording two (2) years worth of coverage at no charge if the cause of the death of the policyholder results from a covered condition under this policy. This benefit only applies to covered dependents under the existing policy, and will automatically terminate in the event of marriage of the surviving spouse/domestic partner, or for surviving dependents who are not otherwise eligible for coverage under this policy and/or are issued their own separate policy. This extended coverage does not apply to any optional rider. The extended coverage goes into effect as per the next renewal date or anniversary date, whichever comes first, after the death of the policyholder.

RENEWAL

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

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

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

10.4 POLICY CANCELLATION OR NON-RENEWAL: The insurer retains the right to cancel, modify or rescind the policy if statements on the health insurance application are found to be misrepresentations, incomplete, or if fraud has been

committed, leading the insurer to approve an application when, with the correct or complete information, the insurer would have issued a policy with restricted coverage or declined to provide insurance.

If the insured changes country of residence, and the insured's current plan is not available in the insured's new country of residence, the insurer retains the right to cancel or modify a policy in terms of rates, deductibles or benefits, generally and specifically, in order to offer the insured the closest equivalent insurance coverage possible. Submission of a fraudulent claim is also grounds for rescission or cancellation of the policy.

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

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

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 REQUESTED SECOND SURGICAL OPINION: If a surgeon has recommended a non-emergency surgical procedure, the insured should 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.

11.3 DEDUCTIBLE:

(a) All insureds under the policy have an in-country and an out-of-country deductible responsibility per policy year 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 and 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.

(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.

11.4 PROOF OF CLAIM: The insured must provide written proof of loss consisting of original itemized bills, medical records, and a claim form properly completed and signed to USA Medical Services at 18001 Old Cutler Road, Suite 500, Palmetto Bay, Florida 33157, within one hundred eighty (180) days after the treatment or service date. Failure to do so may result in the claim being denied. A completed claim form per incident is required for all claims submitted. 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. Claim forms are provided with the policy or may be obtained by contacting your producer or USA Medical Services at the address shown herein or through our website, www.bupasalud.com. 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 certificate or affidavit from a college or university as evidence that they were full-time students at the time the policy was issued or renewed, AND a written statement signed by the policyholder that the dependent child's marital status is single. In the event that the Insured does not agree with what was determined by the Insurer in relation to any claim (closed) or in the event that the insurer needs additional information, they will have up to 180 days from the date of issuance of the explanation of benefits to present such information.

11.5 PAYMENT OF CLAIMS: It is the insurer's policy to make payments directly to physicians and hospitals worldwide. When this is not possible, the insurer will reimburse the policyholder either the contractual rate given to the insurer by the provider involved or in accordance with the 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 and, solely with respect to the insurer, where otherwise prohibited by the laws in the United Kingdom and/or Denmark. 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 Limited will function as the primary insurer and retains the right to collect any payment from local or other insurers.

The following documentation is required to coordinate benefits: Explanation of Benefits (EOB) and copy of bills covered by the local insurance company containing information about the diagnosis, date of service, type of service, and covered amount.

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

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

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

11.10 **COMPLAINTS:** If we have not met your expectations, we have a simple procedure to ensure your concerns are dealt with as quickly and effectively as possible. If you have any comments or complaints, you can call Bupa's customer service at +1 (305) 398 7400, send an e-mail at bupa@bupalatinamerica.com, or write to us at USA Medical Services, 18001 Old Cutler Road, Suite 500, Palmetto Bay, Florida 33157, USA. If we are not able to resolve the problem and you wish to take your complaint further, please contact the Complaints Manager at +1 (305) 398 7400 or by mail at USA Medical Services, 18001 Old Cutler Road, Suite 500, Palmetto Bay, Florida 33157, USA.

It is very rare that we cannot settle a complaint, but if this does happen, you may be entitled to refer your complaint to an independent organization for review. The organization will depend on the nature of the complaint and the location of the Bupa office where the cause of the complaint occurred. We will provide you with that information when needed. In most cases this will either be the Danish Insurance Complaints Board or the UK Financial Ombudsman Service.

If you would like further information about the Danish Insurance Complaints Board you can write to them at Anker Heegaards Gade 2, DK-1572 Copenhagen V, Denmark, call them at +45 (0) 33 15 89 00, or find details on their website at www.ankeforsikring.dk. If you would like further information about the UK Financial Ombudsman Service you can write to them at South Quay Plaza, 183 Marsh Wall, London E14 9JR, UK, call them at +0845 080 1800 or +44 (0) 20 7964 1000, or find details on their website at www.financial-ombudsman.org.uk. Please let us know if you want a full copy of our complaints procedure. None of these procedures affect your legal rights.

DEFINITIONS

ACCIDENT: An unfortunate incident that occurs unexpectedly and suddenly, provoked by an external cause, always without the insured's intention, which causes injury or bodily trauma and requires immediate ambulatory medical attention and/or patient's hospital admission. The medical information related to the accident will be evaluated by the insurer, and the compensability will be determined under the general policy's provisions.

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

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

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

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

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

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

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

BUPA 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 Bupa provider network is available from USA Medical Services or online at www.bupasalud.com, and may change at any time without prior notice.

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

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

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

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

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

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

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

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

COPAYMENT: 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:

(a) Where the insured resides the majority of any calendar or policy year, or

(b) Where the insured has resided more than one hundred eighty (180) continuous days during any three hundred sixty-five (365) day period while the policy is in effect.

COVERED PREGNANCY: Covered pregnancies are those for which the policy provides pregnancy benefits and the estimate 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 thirty (30) day waiting period for coverage under this policy has been waived.

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

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

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

(a) The policyholder's spouse or domestic partner

(b) Biological children

(c) Legally adopted children

(d) Stepchildren

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

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

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

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

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

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

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

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

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

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

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

i. They have a single dedicated relationship of at least one (1) year
ii. They have joint ownership of a residence
iii. They have at least two (2) of the following:
    - A joint ownership of an automobile
    - A joint checking, bank or investment account
    - A joint credit account
    - A lease for a residence identifying both partners as tenants
    - A will and/or life insurance policy which designates the other as primary beneficiary

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

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

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

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

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

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

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

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 and/or the United Kingdom 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.

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 TRANSPOR-TATION: Emergency transportation to a hospital by ground ambulance.

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.

HOSPICE/TERMINAL CARE: Care that the insured receives following diagnosis of a terminal condition, including physical, psychological, and social care, as well as accommodation in a bed, nursing care, and prescribed drugs. This care must be approved in advance by USA Medical Services.

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 of the body, 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.

INSURER: Bupa Insurance Limited, a company registered in England No. 3956433. Our address is 1 Angel Court, London, EC2R 7HJ, United Kingdom.

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

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

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

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

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

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

(e) It is custodial in nature.

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

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.

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

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

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

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

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

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

PRE-EXISTING CONDITION: A condition:

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

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

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

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

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 policy-holder, 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.

WE/US/OUR: Bupa Insurance Limited or USA Medical Services acting on behalf of Bupa Insurance Limited.

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

Bupa Global is a trading name of Bupa Insurance Limited and Bupa Insurance Limited and Bupa Services Limited Bupa 1 court. London, EC2R 7HJ

Bupa Global is a trading name of Bupa Insurance Limited and Bupa Insurance Services Limited which are registered in England and Wales at Companies House under numbers 3956433 and 3829851 respectively. The offices are 1 Court, London EC2R 7HJ. I-JK. Bupa Insurance Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Bupa Insurance Services Limited is authorised and regulated by the Financial Conduct Authority. The Financial Registration numbers of Bupa Insurance Limited and Bupa Insurance Services Limited are 203332 and 312526 respectively.

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