GLOBAL **FLEX** VIP STANDARD

INDIVIDUAL AND FAMILY POLICY WORDING

JULY 2023 / JUNE 2024

VUMI®

WELCOME TO **VUMI®**

We are pleased you've chosen VUMI® for you and your family. We know you'll find it to be the most innovative and comprehensive international health insurance coverage. All of our plans come with our exclusive VIP Medical Service®, which includes access to the Second Medical Opinion VIP®.

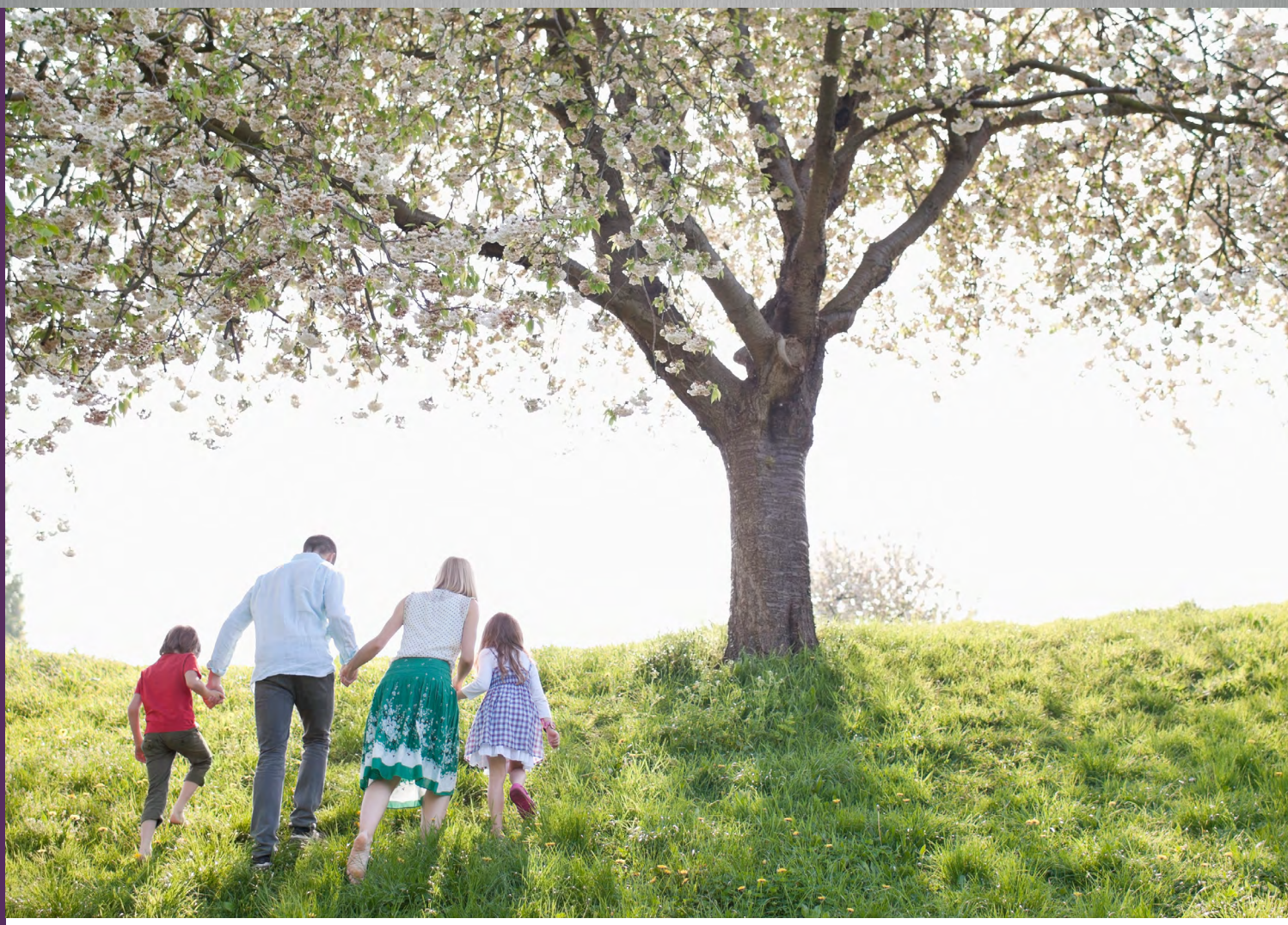
The purpose of this document is to offer you a detailed guide of your coverage. The document is divided into nine sections that define the eligibility requirements and the benefits, their scope and duration, as well as the exclusions of your policy. You will also find general information about the administrative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

With our insurance coverage, you will have the peace of mind, knowing your and your family's health is in the best hands - 24 hours a day, anywhere in the world. Our products are backed by a strong global company with an extensive providers' network and exclusive VIP Medical Service® to guide you when you need it most.

Once again, welcome to VUMI®.

David A. Rendall

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



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VIP Universal Medical Insurance Group, Ltd.
Insurance company registered in Turks & Caicos Islands, a British Overseas Territory
Administration services provided by VUMI Global Services FZ-LLC

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United Arab Emirates. PO Box. 345807
infoglobal@vumigroup.com • www.vumiglobal.com

TABLE OF BENEFITS

Unless otherwise stated, the benefits are offered on a per Insured/per Policy Year basis in which the chosen Deductible or Out-Patient Per Visit Excess and Co-Insurance applies. All amounts are in U.S. Dollars (USD). The benefits are limited to the medical expenses covered under the Policy and are subject to the Usual, Customary and Reasonable expenses (UCR) for the geographic area where the expenses were incurred.

DEDUCTIBLE, OUT-PATIENT PER VISIT EXCESS AND OUT-PATIENT CO-INSURANCE OPTIONS

OPTION I	OPTION II	OPTION III	OPTION IV	OPTION V	OPTION VI	OPTION VII
US$0 Deductible	US$1,000 Deductible	US$2,000 Deductible	US$5,000 Deductible	US$10,000 Deductible	US$15,000 Deductible	US$20,000 Deductible

OPTION VIII	OPTION IX	OPTION X	OPTION XI	OPTION XII
US$15 Out-patient Per Visit Excess	US$30 Out-patient Per Visit Excess	10% Out-patient Co-insurance, up to a maximum out of pocket of US$2,000	20% Out-patient Co-insurance, up to a maximum out of pocket of US$4,000	30% Out-patient Co-insurance, up to a maximum out of pocket of US$6,000

GENERAL PLAN INFORMATION

DESCRIPTION	COVERAGE
Maximum cover per person, per Policy Year	US$3,500,000
Age limit to apply	Up to 74 years
Geographical cover options	The Policyholder can choose geographical area of cover restrictions as follows: *Any treatment received outside the geographic area of coverage is limited to the Emergency non-elective treatment benefit.* **• Worldwide including USA elective treatment** **• Worldwide excluding USA** **• Africa area of cover restriction** For insureds residing in Africa, the area of cover will be restricted to: Africa, India, Pakistan, Sri Lanka, Bangladesh, Jordan, Lebanon, Mainland China and the Philippines. **• Asia area of cover restriction** For insureds residing in Armenia, Azerbaijan, Brunei, Cambodia, Georgia, Indonesia, Kazakhstan, Kyrgyzstan, Laos, Malaysia, Myanmar, Mongolia, the Philippines, Tajikistan, Thailand, Timor-Leste (East Timor), Turkey, Turkmenistan, Uzbekistan and Vietnam, the Asia area of cover restriction will include Singapore but exclude Mainland China, Hong Kong, Japan, and South Korea. **• Indian sub-continent area of cover restriction** For insureds residing in Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka, the Indian sub-continent area of cover restriction will include all named countries and Singapore.

IN-PATIENT BENEFITS

DESCRIPTION	COVERAGE
Adult companion accommodation (related to a covered Hospitalisation of an insured child under age 18)	Up to Policy maximum
Psychiatric treatment	Up to Policy maximum, max. of 30 days
Standard Private Room (room and board)	100% UCR, up to Policy maximum

OUT-PATIENT BENEFITS

DESCRIPTION	COVERAGE
Complementary therapy including physiotherapy, Traditional Chinese Medicine (TCM) and Ayurvedic treatment	Up to Policy maximum, pre-authorisation required after 10 sessions
Day-care Treatment	Up to Policy maximum
General practitioner and specialist fees	Up to Policy maximum
Nursing care at home	Up to Policy maximum, max. of 60 days
Out-patient surgery	Up to Policy maximum
Prescription Drugs	Up to Policy maximum
Psychiatric treatment	Up to US$2,500
Travel vaccinations and preventive medication, e.g. against malaria	Up to US$150

MATERNITY BENEFITS

DESCRIPTION	COVERAGE
Maternity and Birth Complications	Up to Policy maximum
New-born cover	Up to US$75,000

MEDICAL EVACUATION BENEFITS

DESCRIPTION	COVERAGE
Emergency transportation by Air Ambulance & Emergency medical evacuation	Up to Policy maximum
Repatriation of mortal remains	Up to Policy maximum, US$7,500 for burial or cremation costs

GENERAL BENEFITS (The following benefits offer the same cover for both in-patient and out-patient procedures)

DESCRIPTION	COVERAGE
Congenital Conditions after 30 days from birth	Up to US$75,000
Congenital Conditions from birth up to 30 days	Covered under the new-born benefit
Diagnostic study services (laboratory tests, X-rays, CT, PET and MRI scans)	Up to Policy maximum
External prostheses	Up to US$1,500 per Policy Year
HIV-AIDS treatment	Up to US$50,000
Oncology treatments (cancer tests, drugs and treatment)	Up to Policy maximum
Organ Transplant (per organ/tissue, per Lifetime)	Full refund including US$50,000 for donor costs
Prescribed physical therapy and rehabilitation	Up to Policy maximum, max. of 60 days per medical condition
Reconstructive surgery	Up to Policy maximum

GENERAL BENEFITS (The following benefits offer the same cover for both in-patient and out-patient procedures)

DESCRIPTION	COVERAGE
Renal failure and dialysis	Up to Policy maximum
Routine management of Chronic Conditions	Up to Policy maximum
Surgical procedures	Up to Policy maximum
Terminal illness / Palliative care	Up to US$75,000 per Lifetime

OTHER BENEFITS

DESCRIPTION	COVERAGE
Emergency dental treatment	Up to Policy maximum
Emergency non-elective treatment outside the geographical area of coverage	• Up to Policy maximum for Injuries • Up to US$50,000 for Illnesses • Up to US$500 for out-patient hospital visits
Emergency transportation by Ground Ambulance	Up to Policy maximum
Hospital cash benefit	Up to US$300 per night, max. of 30 nights
Passive war and terrorism	Up to Policy maximum
Second Medical Opinion VIP®	Access to the medical opinion of internationally renowned experts from around the world regarding a condition (no Deductible applies)

OPTIONAL ADDITIONAL COVERAGE

DESCRIPTION	COVERAGE
Evacuation to country of choice, country of residence or home country	Up to Policy maximum
Non-Emergency evacuation	Up to US$2,000
USA elective treatment (only available for Insureds who chose the worldwide, including USA elective treatment geographical area of cover)	Up to US$3,000,000
Wellness and optical	• Option I - US$500 • Option II - US$1,000

WAITING PERIODS

DESCRIPTION	COVERAGE
HIV-AIDS	36 months
Maternity and New-born Complications	12 months

Effective from July 1, 2023 or after the annual renewal.

SECTION 1. **AGREEMENT**

VIP Universal Medical Insurance Group, Ltd., hereinafter the "Company," undertakes to pay to the Policyholder the benefits detailed in this Policy related to the covered expenses incurred by the him/her or his/her eligible Dependants, as a result of any treatment, service or medical supply anywhere in the world after the Effective Date of the coverage of this Policy, according to the geographical area of cover specified in the Certificate of Insurance.

All benefits are subject to the terms and conditions of the Policy, including the applicable Deductibles, maximum benefits and the limits detailed in the Table of Benefits and the Certificate of Insurance, which are an integral part thereof.

1.1 Right to examine the Policy

The Policyholder understands that this Policy is an international health insurance plan that is not subject to regulations and/or mandatory coverage required by the laws of his/her Country of Residence or other jurisdictions. This insurance Policy is not subject to and does not provide certain benefits required by the United States Patient Protection and Affordable Care Act (PPACA). Therefore, the Policyholder must review the terms of the coverage to verify he/she is in agreement with the coverage offered, or otherwise request the cancellation of this Policy and return it to the Company or the Agent through whom it was purchased within a fifteen (15)-day period after receiving it.

If during that period no claims have been made, the Company will reimburse the total premium paid by the Insured and the Policy will be null and void, as if it was never issued.

Reimbursement of the unearned premium

If the Applicant, the Policyholder or the Company cancels the Policy after the fifteen (15)-day period to examine it, or after it has been reinstated or renewed, the Company will reimburse the unearned portion of the premium, up to a maximum of sixty-five percent (65%) of the total amount of the premium. A thirty-five percent (35%) retention by the Company will not be reimbursed. In case of rescission of the Policy, the Company will apply the premium received to any payment made for a claim against the Policy.

1.2 Important notice about the Application

This Policy is issued based on the statements provided in good faith by the Policyholder. If any of the information disclosed in the Application is false, incorrect, inaccurate, incomplete, had the intent of misleading or deceiving, or was omitted, resulting in worsening the risk, the Policy will be rescinded, will have no effect, and the Company will not be responsible for any payments of the benefits offered under this Policy. Likewise, if a Provider or any other individual or entity who has rendered medical services to the Policyholder and/or to one of the Insureds should submit false statements in collusion with the Policyholder and/or one of the Insureds, with the purpose of claiming payments against this Policy, its articles and/or Amendments, the Policy will be, at the discretion of the Company, rescinded or cancelled, will have no effect, and the Company will not be responsible for any payment of benefits offered under this Policy.

The Policyholder and/or the Insured(s) would have to reimburse the Company on first demand, for any payments it may have made as a result of an omission, incorrect disclosure or Negligence by the Policyholder and/or the Insured(s). In case of cancellation or rescission, the Company will apply the amount of the unearned premium of the total payments made for any of the aforementioned causes.

1.3 Entire contract

The entire contract between the Policyholder and the Company includes:

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

SECTION 2. **POLICY TERM**

The coverage lasts twelve (12) months and will renew automatically for the same period of time upon receipt of payment of the corresponding premium, subject to the eligibility, definitions, conditions and other provisions of the Policy that are in effect at the time of renewal. The coverage starts one (1) minute after midnight (00:01) Eastern Standard Time on the Effective Date of this Policy, and ends at midnight (00:00) three hundred and sixty-five (365) days later.

SECTION 3. **ELIGIBILITY**

3.1 Eligibility requirements

This Policy provides coverage to the Policyholder and his/her eligible Dependants: Spouse, Domestic Partner, biological children, legally adopted children, stepchildren or minors under the age of eighteen (18) for whom the Policyholder has been designated as legal guardian, as long as the following requirements are met at the time of the application:

- A Reside in a country other than the United States of America (USA);
- B The Policyholder and his/her Spouse or Domestic Partner must be at least eighteen (18) years old and up to seventy-four (74) years old, except for minors authorised by one of their parents or a legal guardian;
- C Dependant children are eligible up to:
  - a Eighteen (18) years old if they are single and residing with the Policyholder; or
  - b Twenty-eight (28) years old if they are single and full-time students.
- D Pay the applicable premium.
- E Coverage is available for the Policyholder's Dependant children until the day before they turn eighteen (18) years old if they are single and residing with the Policyholder, or until the day before they turn twenty-eight (28) years old if they are single and full-time students at an accredited college or university at the time the Policy is issued or renewed.

The Company reserves the right to request, at any moment during the term of the Policy, a student certification issued by a representative of the university. Additionally, there will be an adjustment of the premiums if the Dependant remains outside his/her Country of Residence for a period of more than one hundred and eighty (180) days.

When they no longer qualify as Dependants under a Policy, they will be eligible to obtain coverage under their own Policy, without underwriting, by paying the corresponding premium, in a plan with the same or a higher Deductible, under the same conditions and/or restrictions of the previous Policy. The Dependant's Application must be received at the Company before the end of the Grace Period of the Policy under which he/she had coverage with the Company.

3.2 Addition of a New-born under a covered pregnancy

The inclusion as a Dependant of a New-born born from a pregnancy covered by this Policy, will take place without the need for an underwriting evaluation with the exception of children conceived via fertility treatments and/or artificial insemination (IVF) and fostered or adopted children, which will be fully medically underwritten. The Company must receive a copy of the birth certificate or a written notice with the New-born's name, gender and date of birth within the first ninety (90) days after the birth takes place, together with the applicable premium payment. Coverage for the child will become effective from the date of birth without a Waiting Period.

If the New-born is not enrolled within the ninety (90)-day period, an Application will have to be completed and submitted for an underwriting evaluation.

SECTION 4. **OBLIGATIONS OF THE INSURED**

4.1 Deductible and optional co-insurance

Each Insured can voluntarily elect to have an annual Deductible, an Out-patient Co-insurance or an Out-patient Per Visit Excess to reduce the cost of the annual premium.

4.2 Notification of change of Country of Residency

The Policyholder must notify the Company in writing if any Insured changes their Country of Residence within the first thirty (30) days after the change occurs, as this could result in an adjustment to the premium or the Deductible based on the new geographic area where the Insured resides. If the change of Country of Residence is to the United States, this Policy can't be renewed at the next renewal date or anniversary date, whichever occurs first.

The Company reserves the right to request, at any time, additional information to verify the permanent or temporary residence of the Insured.

Failure to notify the Company about the change of Country of Residence of any of the Insureds, as indicated, may result in modification, cancellation or non-renewal of this Policy, at the Company's discretion.

4.3 Notification of legal separation or divorce

In case of legal separation or divorce, the Policyholder must notify the Company within thirty (30) days of the event. The Dependant Spouse or Domestic Partner will have coverage until the end of the Policy Year and subsequently the Company will offer his/her own Policy of the same plan, Deductible, Out-patient Co-insurance or Out-patient Per Visit Excess, and conditions as the previous Policy. The premium of such new Policy must be paid within thirty (30) days of its Effective Date.

4.4 Premium payment

Payment of the premium is the responsibility of the Contracting Party or the Policyholder, whichever may be the case. The premium is payable on the Renewal Date of this Policy, according to the mode of payment selected. Payment of the premium makes the Policy

effective during the period for which the premium has been paid.

Any excess premium paid will be reimbursed without adding any interest and in the same manner as it was paid. Failure to pay the total premium will result in the termination of the Policy. For compliance reasons, the Company reserves the right to accept advance or future payments for insurance premiums. The renewal of this Policy is guaranteed for life according to the terms and conditions of the effective Policy at the time of renewal, as long as the premium is paid and the eligibility requirements of this Policy are maintained.

4.5 Medical notifications

Insureds must notify the Company prior to receiving those medical services that require notification or pre-authorisation, pursuant to Section 8.1 of this Policy, by calling the telephone number or via the e-mail listed on the back of their ID card. If a pre-authorisation is not obtained, treatment is received, and is subsequently proven not to be Medically Necessary, the Company reserves the right to decline the claim. If treatment is Medically Necessary, but the Insured did not obtain a pre-authorisation, the Company will only pay up to Usual, Customary and Reasonable charges.

4.6 Claims and invoices

Claims or invoices related to expenses covered under this Policy must be submitted to the Company within a period of one hundred and eighty (180) days after the date of service for them to be eligible for coverage.

Claims or invoices received after the aforementioned deadline will not have coverage, even if they would have been authorised or the charges would have been payable under this Policy.

4.7 Medical records

The Policyholder, because of the underwriting and/or claims process, must provide the Company with all the medical information required. Additionally, the Policyholder, as well as his/her Dependants, must authorise the Company to obtain any medical report, documentation and/or access to the patient in case deemed necessary to complete the underwriting or claim process, as the case may be. Otherwise, the claim could be denied until the necessary information and authorisations are received.

SECTION 5. **GENERAL INFORMATION**

5.1 Coordination of benefits

When the Insured has other insurance coverage, it must be disclosed to the Company at the time of application or when submitting a claim. The coverage under this Policy will act as secondary to any other Policy or healthcare plan inside or outside the Insured's Country of Residence.

The Company will provide benefits after the claims have been submitted to the primary insurance plan first, and only when the benefits payable under the primary Policy have been satisfied. Only the benefits offered by this Policy will be considered for this coordination with other insurers.

The Company shall process a coordination of the benefits in which the amounts paid by the other insurance company will be applied to the Deductible in accordance with the benefits and limitations of this Policy. When filling a claim subject to coordination of benefits, proof of the other insurance coverage must be submitted along with copies of medical records, itemised invoices, Explanation of Benefits (EOB) of the primary insurer, as well as proof of payments made by the other insurance company. The total amount of payments is not to exceed the total of the expenses incurred; the Company shall not pay any amount reimbursed by the other company even though it may exceed the Deductible of this Policy.

5.2 Currency

All currency values shown in this Policy are expressed in U.S. Dollars.

5.3 Non-renewal, rescission or cancellation of the Policy

The Company, in its sole discretion, may modify, cancel, rescind or not renew this Policy, or it may modify the rates and the Deductible, Out-patient Co-insurance or Out-patient Per Visit Excess, in cases where any of the following conditions is present:

- **A** The information disclosed in the Application is false, incomplete or when fraud has been committed, any of which may have caused the Company to approve the Policy when, had the Company been provided with the correct information, it would have issued the Policy under certain conditions or would have deemed that the Applicant was a non-insurable person;
- **B** The Insured and/or his/her Dependants change Country of Residence and fail to notify the Company within a thirty (30)-day period;
- **C** The Policyholder or Contracting Party (if applicable) requests the cancellation of the coverage in writing or doesn't pay the premium as stipulated in this Policy;
- **D** The Insured submits a claim or information deemed fraudulent by the Company. In the event of such fraud, the Policyholder shall be responsible and will have to reimburse the Company for any payments made in reference to the claim in question, whether the payment was made in the form of a reimbursement to the Insured or directly to the Provider;
- **E** The marital status of the Policyholder changes due to divorce, or separation in case of Domestic Partners. The Insured should notify the Company within thirty (30) days of the date of the divorce or separation. Coverage for the Dependant

Spouse will cease at the end of the Policy Year;

- F The Insured lives in a country that is under an embargo or is sanctioned by the Office of Foreign Assets Control (OFAC), or if an Insured is in any of the lists of persons sanctioned by OFAC, or similar entities in the United Kingdom and the European Union; or
- G The Insured spends more than one hundred and eighty (180) days out of a three hundred and sixty-five (365)-day period in the United States or any of its territories.

5.4 Policy issuance

This Policy is deemed solicited, issued or delivered when the Policyholder receives it in his/her Country of Residence.

The Company does not solicit, sell, or accept applications for any insurance policy to be delivered or issued to any person in any state of the United States. If it is determined that the Policy was solicited, sold and/or delivered in the United States or any of its territories, it must be cancelled or rescinded.

The Policy, Optional Benefits and payment receipts may be sent to the e-mail address registered with the Company, unless the Policyholder or his/her registered Agent selected another option in the Application or requested it later from the Company.

5.5 Coverage for routine management of Chronic Conditions

Routine management of Chronic Conditions that are disclosed in the Application may receive coverage, unless they are limited or permanently excluded by this Policy or by the Company through an Amendment included in the Certificate of Insurance.

Chronic Conditions that were not declared will not be covered and ommission of declaration may lead to the modification or cancellation of the Policy.

The Company, at its sole discretion, may modify, rescind, cancel, or not renew the Policy due to the omission of a Chronic Condition.

5.6 Change of Deductible

Before the Anniversary Date, the Insured can request a change to the voluntary Deductible, Out-patient Co-insurance, or Out-patient Per Visit Excess within the same plan. The Company reserves the right to approve or deny the change, or approve it under conditions and/or restrictions that it considers appropriate. If the change is for a higher Deductible, it will be approved under the same conditions of the current plan. If the change is for a lower Deductible, it will be subject to underwriting evaluation.

Once the change is effective, during the first thirty (30) days from the Effective Date, the larger Deductible, Out-patient Co-insurance, or Out-patient Per Visit Excess will be applied to any Illness or Injury not caused by an Illness of Infectious Origin or an Accident that occurred as of the date of the change.

5.7 Change of plan

Before the Anniversary Date, the Insured can request a change to any of the other plans offered by the Company, available in the Insured's geographic Region and subject to underwriting. The Company reserves the right to accept or deny the change for any reason and request that a new insurance Application is completed.

If the change is approved, during the first thirty (30) days following the Effective Date of the new plan, the lesser of the benefits shall be applied to any Illness or Injury not caused by an Illness of Infectious Origin or an Accident that has occurred as of the date of the change. If the new plan includes maternity care benefits, these will be subject to a twelve (12)-month Waiting Period. The benefits that did not exist in the previous plan must meet the corresponding Waiting Periods.

5.8 Payment mode

Premiums can be paid annually, semi-annually, quarterly, monthly or according to the payment mode established by the Company. Payment mode changes will be made only on the Anniversary Date of the Policy.

The premium is payable on the Expiration Date of the Policy. Renewal notices are issued as a courtesy and the Company does not guarantee their delivery.

Payment of the premium is the responsibility of the Applicant or the Policyholder, whichever may be the case, and if the payment notice has not been received, he/she must contact the Company or registered Agent.

5.9 Termination of coverage after the Expiration Date

When a Policy is terminated for any reason, coverage will cease on the termination date and the Company will only be responsible for the treatments covered under the terms of the Policy that took place before its termination date. There will be no coverage for any treatment that occurs after the termination date, regardless of when the Injury or medical condition was first presented or how much additional treatment may be required.

5.10 Grace Period

The Company grants a thirty (30)-day Grace Period to pay the premium corresponding to the Policy, which begins the day after the Expiration Date, according to the selected payment mode. If the full premium is not received by the Company before the Grace Period ends, this Policy shall be deemed expired as of its Expiration Date. During the Grace Period, no benefits or payments will be provided for expenses incurred after the Expiration Date. If the premium is paid during this period, the Policy will be renewed.

The Company may coordinate the payment of the pending premium with the Agent or directly with the Policyholder, at its sole discretion. However, the Company's additional collection

procedures are not equivalent to waiving the right to terminate this Policy due to non-payment of the total premium due on its Expiration Date, as established in this Policy.

It is the absolute responsibility of the Policyholder to pay the premium due on time. The fact that there might be claims or administrative requests pending with the Company does not exempt, stop or extend the term for the payment of the premium on its Expiration Date or the consequent expiration of the Policy.

Failure to pay the total premium due on the Expiration Date shall be understood as the express will of the Policyholder to not renew the Policy. Likewise, the implicit compliance with the registration requirements set by the Company, when applying for insurance coverage again after the renewal deadlines have elapsed, as defined herein, shall be understood as the express will of the Policyholder to renew this Policy.

5.11 Rate Changes

The Company has the right to change the premium rates annually on the Anniversary Date of the Policy, based on the country, geographical area within the same country and/or Region of residence, and/or by age segments and/or depending on the number of children who qualify as Dependants. In no event will the Company modify the rates of an individual Insured based on his/her claim history.

5.12 Policy reinstatement

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

5.13 Policyholder's death

In the event of the death of the Policyholder, the Company will pay the Beneficiary listed in the Application (if applicable), or the heir(s)/heiress(es) or inheriting entity(ies) of the deceased Policyholder, the unearned premium or any reimbursement for benefits that remained unpaid while the Policyholder was alive.

5.14 Tools and resources for the Insured

Insureds have access to MyVUMI™, an online portal offering access to:

- **A** View Policy information, such as Dependants, exclusions, Amendments and upcoming premium payments;
- **B** Download Policy documents such as the Welcome Letter, Certificate of Coverage and ID cards;
- **C** Access the Plan Overview and Policy Wording of the plan;
- **D** Download Claim and Payment Forms;
- **E** Submit a claim or medical notification;
- **F** Contact VUMI®; and
- **G** Obtain the Agent's contact information.

myVUMI

Insureds have access to MyVUMI™ through **www.myvumiportal.com**, or by downloading the app through the Apple® App Store® or Google Play™ for Android.

5.15 Denial of liability

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

5.16 Clerical errors

Any clerical error of the Company will not deny coverage that should have been approved and will not extend coverage that should have been terminated. The Company will amend the error, and this action could entail, among other measures, the adjustment of the corresponding premium and, if necessary, the request for reimbursement of the amounts paid in error.

SECTION 6. **BENEFITS AND PROVISIONS**

Unless stated otherwise, benefits are offered per Insured, per Policy Year, in which the chosen Deductible or Out-patient Per Visit Excess and Co-Insurance applies. All amounts are expressed in U.S. dollars (USD). The benefits are limited to the medical expenses that are covered under the Policy, and are subject to the Usual, Customary and Reasonable (UCR) costs, as defined in this Policy.

6.1 Geographical cover

This plan provides cover with free choice of Hospitals and Doctors, subject to the geographical area of cover chosen at the time of the application and what is specified on the Insured's Certificate of Insurance.

IN-PATIENT BENEFITS

6.2 Adult companion accommodation expenses of a hospitalised Minor Insured

The coverage for adult companion accommodation of a hospitalised Insured Dependant under the age of eighteen (18) is one hundred percent (100%) UCR, up to the Policy maximum.

Charges must be included in the Hospital bill for overnight Hospital accommodation of a hospitalised Insured.

If the room cost includes companion accommodation, this benefit will not apply and will not be transferable to any other expense related to the companion or the Hospitalisation.

6.3 Coverage for Standard Private Hospital Room

The coverage for the Hospitalisation of an Insured in a Standard Private Room (room and board) is one hundred percent (100%) UCR, up to the Policy maximum.

OUT-PATIENT BENEFITS

6.4 Complementary therapy

The coverage for this benefit is one hundred percent (100%) UCR for Out-patient therapy of physiotherapy, chiropractic, homeopathy, dietician, Traditional Chinese Medicine (TCM), ayurvedic, osteopathy and/or acupuncture, provided that therapy is prescribed by a medical practitioner or specialist. The benefit excludes podiatric and chiropody treatments. This benefit must be pre-authorised by the Company after every ten (10) sessions and is only available by reimbursement.

6.5 Day-Care Treatment

The coverage for this benefit is one hundred percent (100%) UCR.

6.6 Surgeon, Assisting Surgeon and Anaesthesiologist Fees

Surgeon, Assisting Surgeon, and Anaesthesiologist Fees are covered based on the Usual, Customary and Reasonable (UCR) charges for the particular procedure(s) of the case, or based on special rates established or contracted in advance by the Company for the geographic area, country or specific Provider in which the Insured receives such services.

6.7 Nurse or Therapist care at home

The coverage for this benefit is one hundred percent (100%) UCR for up to a maximum of sixty (60) days, based on special rates established or contracted in advance by the Company for the geographic area, country or specific Provider with whom the Insured receives such services.

This benefit must be coordinated and approved in advance by the Company and it includes medical home care that has been prescribed by the treating Doctor. The Company will evaluate the need and time required for specialised medical care, in order to adjust it in case of prolonged treatment.

Medical home care includes services from certified professionals (Nurses or therapists) and it does not include Custodial Care, as defined in this Policy.

6.8 Out-patient surgery

The coverage for Out-patient surgery is one hundred percent (100%) UCR.

6.9 Prescription Drugs

The coverage for Prescription Drugs is one hundred percent (100%) UCR.

To request approval, a copy of the prescription written by a physician to treat a condition covered by this Policy must be sent along with the claim.

Highly specialised Prescription Drugs

Highly specialised Prescription Drugs indicated for a specific use will be covered within the limits of the corresponding benefit indicated in the Table of Benefits, as long as they are coordinated and approved in advance by the Company. The Company will coordinate the delivery of such Prescription Drug directly to the Insured with its Providers. The Insured must accept the conditions of the Company for the supply of such specialised Prescription Drugs, by either receiving treatment with the specific Provider designated by the Company or according to the delivery method available. The Company will provide the generic Prescription Drug as a first option when available.

Highly specialised Prescription Drugs include, but are not limited to, Interferon beta-1a, pegylated interferon alfa-2a, interferon beta-1b, etanercept, adalimumab, bevacizumab, ciclosporin A, azathioprine and rituximab.

This benefit excludes In-patient or Out-patient Prescription Drugs that are not scientifically or medically approved for a specific diagnosis or considered as off-label use or Experimental, or the use of combinations that are not generally accepted by the scientific community, even when a particular Doctor prescribes it, as well as over-the-counter medication and/or those not approved for the treatment of the condition of the Insured by the U.S. Food and Drug Administration (FDA).

6.10 Travel vaccinations/preventive medication

Travel vaccinations and/or preventive medication are covered up to one hundred and fifty dollars (US$150) per Policy Year for vaccinations, immunisations and preventive medications that are directly related to overseas travel requirements.

MATERNITY BENEFITS

6.11 Maternity and Birth Complications

After completion of the twelve (12)-month Waiting Period, Maternity and/or Birth Complications are covered up to one hundred percent (100%) UCR.

This benefit ends when the mother is discharged, in case of Maternity Complications, or when the New-born is discharged, in case of Birth Complications, or in ninety (90) days, whichever occurs first, if the New-born is not added to the Policy within the established period.

Bed rest prescribed by a physician which does not require Hospitalisation, as well as any other of the traditional symptoms of a pregnancy, won't be considered as Complications of Maternity.

This benefit does not apply to Dependant daughters. Any primary Insured who has previously been a Dependant daughter under another Policy with the Company, must have maintained her own individual Policy for a minimum of twelve (12) months in order to be eligible under the Maternity and New-born Complications benefit.

6.12 New-born cover

Medical expenses for Injury or Illness of the New-born, such as respiratory distress, prematurity, hypoglycaemia, Congenital and Hereditary disorders, low birth weight and birth trauma, which were diagnosed within the first thirty (30) days of life, will receive coverage up to seventy five thousand dollars (US$75,000) after the corresponding Deductible.

In order for the Company to provide this benefit, the child must have been born from a Maternity Covered under this Policy and must be added to the Policy within the first ninety (90) days of life, and the premium must be paid.

The coverage for expenses additional to the maximum benefit limit of Birth Complications will only be effective if the New-born of a covered Maternity is added in the Policy as a Dependant.

To add a New-born to the Policy, the Insured must send the birth certificate and/or the New-born's personal information to the Company, and the premium must be paid within the ninety (90) day period after the birth. In the event of multiple births covered by the Policy, each New-born will have coverage up to the maximum of this benefit, provided that each New-born is included in the Policy according to Section 3.2 of this Policy.

MEDICAL EVACUATION BENEFITS

6.13 Emergency transportation by Air Ambulance and Emergency medical evacuation

Air Ambulance

The benefit for Emergency transportation by Air Ambulance is covered at one hundred percent (100%) UCR. This benefit applies strictly for Emergencies only. If the transportation by Air Ambulance of a patient may only be convenient or recommended, but does not qualify as an Emergency, as defined in this Policy, it will not be covered under this benefit.

Coverage for return trip

This benefit includes an economy class ticket to return the Insured and one (1) companion to the Insured's Country of Residence or country of nationality, provided the trip is performed within the thirty (30) days of discharge and it is coordinated by the Company. This benefit also includes up to three hundred dollars (US$300) per day for reasonable travel costs to and from the Hospital for the Insured and companion, and non-hospital accommodation, only for immediate pre- and post-hospital admission periods, provided the Insured is under the care of a specialist.

The following requirements must be met for the approval of the Emergency transportation by Air Ambulance benefit:

- **A** The required Emergency treatment is for a condition or an Accident covered by this Policy;
- **B** The Insured's life is in danger, or there is a danger of loss of any of his/her limbs;
- **C** The required treatment cannot be rendered or is not available in any way in the area or place where the Insured is;
- **D** The transportation is provided by an entity licensed for such purposes, with the qualified staff and equipment;
- **E** The transportation will be authorised to the nearest Hospital where the Insured can receive treatment by qualified entities; and
- **F** The Air Ambulance transportation must be pre-authorised and coordinated in advance with the Company.

The Insured, by accepting these services, agrees to hold the Company and its affiliates harmless from any Negligence resulting from such transportation services, as well as for delays or restrictions caused by mechanical problems or by governmental restrictions, in addition to pilot, driver or crew errors, omissions or Negligence, or due to operational, weather, force majeure or any other adverse conditions. This benefit does not cover any air-sea or mountain rescue costs, including costs incurred at non-recognised ski resorts or similar winter sports resorts locations.

6.14 Emergency transportation by Ground Ambulance

The coverage for Emergency transportation by Ground Ambulance is one hundred percent (100%) UCR.

The Insured, by accepting these services, agrees to hold the Company and its affiliates harmless from any Negligence resulting from such transportation services, as well as for delays or restrictions caused by mechanical problems or by governmental restrictions, in addition to driver or crew errors, omissions or Negligence, or due to operational, weather, force majeure or any other adverse conditions.

6.15 Repatriation of mortal remains and cremation services

In the event the Insured dies outside of his/her Country of Residence, the Company will pay one hundred percent (100%) UCR for the repatriation of the remains to his/her Country of Residence provided that the death resulted from a condition covered by this Policy.

This coverage is limited to all basic costs incurred in the repatriation process or the process of cremation of the remains, including a basic container legally approved for transportation, shipping costs and the necessary government authorisations pursuant to the requirements of the pertinent authorities, and it excludes transportation of the remains by Air Ambulance or any private transportation.

Burial or cremation of the remains is covered up to seven thousand five hundred (US$7,500) based on the Usual, Customary and Reasonable charges for the service(s) provided.

This benefit is considered secondary to any other repatriation of mortal remains or cremation benefit that the Insured may be entitled to under another travel coverage or from any other policy, regardless of the benefit offered by this Policy. This benefit must be coordinated and approved in advance by the Company to receive coverage.

6.16 Free coverage in the event of the Policyholder's death

In the event the Policyholder should die, the Dependants covered under the Policy shall have free coverage for a period of two (2) years after the last paid period of the Policy, as long as the cause of death is the result of a condition or Accident covered by this Policy. By electing this benefit, Dependants agree that the deceased Policyholder's unearned premium will not be reimbursed.

GENERAL BENEFITS

The following benefits offer the same coverage for both In-patient and Out-patient procedures, unless otherwise stated.

6.17 Psychiatric treatment

In-patient psychiatric treatment is covered at one hundred percent (100%) UCR, for up to a maximum of thirty (30) days, when it is Medically Necessary and treatment is rendered in a recognised psychiatric unit of a Hospital. All treatments must be administered under the direct control of a licensed psychiatrist.

This benefit also covers up to a maximum of two thousand five hundred dollars (US$2,500) per Insured, per Policy Year for Out-patient psychiatric treatments, only when it is Medically Necessary and provided that it was prescribed by a medical practitioner or specialist and is under the care a licensed psychiatrist. This coverage must be coordinated and approved in advance by the Company.

6.18 Congenital and Hereditary Conditions

The benefit for any Congenital or Hereditary Disorder that manifests after the Insured's first thirty (30) days of birth are covered up to seventy five thousand dollars (US$75,000) per Insured, per Policy Year.

Congenital and Hereditary Disorders that manifest within the first thirty (30) days of birth, are covered under the New-born coverage benefit.

In the event of multiple births covered by this Policy, each New-born will have the right to the maximum of this benefit, provided that each New-born is included in the Policy in accordance with the described provisions.

6.19 Diagnostic study services

Medically Necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET), computerised tomography (CT) scans, X-rays and laboratory services received as an In-patient, Day-patient or Out-patient are covered at one hundred percent (100%) UCR.

6.20 Durable Medical Equipment and external prostheses

When Medically Necessary, Durable Medical Equipment will be covered at one hundred percent (100%) UCR, as long as the Insured presents a prescription from a Physician or licensed Provider that justifies a therapeutic benefit for the Insured. This coverage must be coordinated and approved in advance by the Company.

This benefit includes, but is not limited to, prosthetic limbs, wheelchairs, canes, crutches, respirators, pressure mattresses and walkers, provided that such equipment is prescribed by a Physician and it is customarily useful to a patient for the Illness or Injury. External prosthetic limbs are covered up to one thousand five hundred dollars (US$1,500) per Policy Year. The allowable rental fee of the equipment must not exceed the purchase price.

Durable Medical Equipment excludes motor-driven wheelchairs or beds, robotic devices (prosthetic or not), comfort items such as telephone accessories and over the bed tables, items used to modify air quality or temperature, such as air conditioners, humidifiers, dehumidifiers and purifiers (air cleaners), disposable supplies, exercycles, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment and/or similar items, or the cost of instructions

for the use and care of any medical device. Adaptations of Durable Medical Equipment to any residence or vehicle are also excluded.

6.21 Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)

The coverage for this benefit is up to fifty thousand dollars (US$50,000) per Insured, per Policy Year. This coverage is subject to the fact that the Human Immunodeficiency Virus's antibodies or the AIDS virus had not been detected before the Effective Date of the Policy, nor in the first thirty-six (36) months from the Effective Date of this Policy, and/or when is a result of a proven occupational Accident (such as being a member of an Emergency services, medical or dental practitioner where the Insured may have contracted the infection accidentally while carrying out normal duties) or a blood transfusion when received as In-patient as part of a Medically Necessary treatment. The benefit includes pre- and post-diagnosis consultations, routine check-ups for this condition, drugs and dressings (except experimental or those unproven), Hospital accommodations and nursing fees. This benefit must be coordinated and approved in advance by the Company.

6.22 Organ and tissue Transplant

The coverage for this benefit is one hundred percent (100%) UCR*, including:

- **A** The benefit of up to fifty thousand dollars (US$50,000) for medical expenses related to the Live Donor;
- **B** All pre-Transplant care, which includes those services directly related to the evaluation that established the need for the Transplant, the evaluation of the Insured to receive the Transplant procedure, and the preparation and stabilisation of the Insured for said procedure;
- **C** Every pre-surgery exam, including laboratory exams, X-rays, CT scans, MRIs, ultrasounds, biopsies, Prescription Drugs and supplies;
- **D** The cost of obtaining the organ and tissues, their harvesting and transportation, and the medical expenses of the Donor;
- **E** The procedure to transplant the organ;
- **F** The coverage of an artificial heart, or mono or bi-ventricular devices to allow the patient to be viable until he/she receives the final Transplant;
- **G** All post-Transplant care directly related to the Transplant including, but not limited to, any follow up, Medically Necessary treatment resulting from the Transplant, and complication that may arise after the Transplant, whether it may be a direct or indirect consequence of the procedure; and
- **H** Any drugs or therapeutic measure used to ensure the viability and permanence of the transplanted organ.

**The Lifetime limit for this benefit includes any other amount previously paid under another plan or Optional Benefit of the Company or any of its affiliated companies.*

The following requirements are necessary for this Transplant coverage:

- **A** It is Medically Necessary;
- **B** It is not considered elective, Experimental or Investigative;
- **C** No other optional procedures and/or treatments are available that will lead to the same level of results and care to treat the medical condition or Illness that has caused the need for the Transplant;
- **D** It is not originated by or as a result of a Transplant in which the receiver obtains a mechanical artefact or artificial equipment aimed to replace human organs, or when the organ to be transplanted is an animal's; and
- **E** It is not performed due to an initial failed Transplant carried out prior to the Effective Date of this Policy, or a non-approved Transplant that was carried out after the Effective Date of this Policy.

The Company must be notified as soon as it is determined that an Insured is a candidate for a Transplant in order for the benefit to be coordinated and pre-authorised by the Company. To claim this benefit, the Insured must authorise the Company to submit all medical documentation related to the Transplant for a Second Medical Opinion VIP® to determine the Medical Necessity and relevance of the procedure.

6.23 Physical therapy and rehabilitation

The coverage for this benefit is one hundred percent (100%) UCR for up to a maximum of sixty (60) days per Insured, per medical condition, per Policy Year when Medically Necessary and based on the Usual, Customary and Reasonable charges for the particular therapy(ies) of the case, or based on special rates established or contracted in advance by the Company for the geographic area, country or specific Provider with whom the Insured receives such services. In all cases, the Company must receive the treatment plan, together with the estimated fees, as well as evidence of Medical Necessity for said treatment plan. Coverage for this care or treatment must be authorised in advance by the Company. The Company would evaluate the extension of the treatment if it is Medically Necessary.

6.24 Reconstructive surgery and nasal or septum deformity

Reconstructive surgery is covered at one hundred percent (100%) UCR, up to the Policy maximum, only when it is Medically Necessary and required to restore natural function or appearance following an Accident or a surgical procedure as a result of a medical condition covered by this Policy which occurred after its Effective Date. In the case of treatment provided for nasal malformations or of the septum, coverage will be provided if caused by trauma received during an Accident covered by the Policy or due to the treatment of nasal cancer. Copy of films and reports of the radiological exams or CT scans performed will be required.

6.25 Renal failure and dialysis

Renal failure and dialysis is covered up to one hundred percent

(100%) UCR for treatments for renal failure.

6.26 Terminal Illnesses / Palliative Care

The coverage for Palliative and Hospice Care is seventy five thousand dollars (US$75,000) per Lifetime for palliative services to Insureds with a terminal Illness covered by this Policy, with a medical diagnosis certifying that it is a terminal Illness with a life expectancy of the Insured of one hundred and eighty (180) days or less. This benefit includes any In-patient, Day-patient or Out-Patient treatment given on the advice of a medical practitioner or specialist for the purpose of offering temporary relief of symptoms, and charges for Hospital or Hospice accommodation, nursing care by a qualified nurse and Prescription Drugs and dressings. This service must be provided by a medically supervised team of professionals. This benefit must be coordinated and approved in advance by the Company.

OTHER BENEFITS

6.27 Emergency dental treatment

The coverage for Emergency dental treatment is one hundred percent (100%) UCR for Injuries resulting from a covered Accident. The treatment must be rendered within the first thirty (30) days after the date of the Accident, as an In-patient only with a Hospital admission of a minimum of one (1) night. This benefit is limited to the treatment necessary to restore or replace sound natural teeth that have been damaged and/or lost in a covered Accident.

6.28 Emergency non-elective treatment outside the geographical area of coverage

Emergency treatment for Injuries resulting from Accidents, which require Hospitalisation, while outside the geographical area of coverage is covered at one hundred percent (100%) UCR.

This benefit also covers up to fifty thousand dollars (US$50,000) for Emergencies due to sudden Illnesses which require Hospitalisation, manifested during planned trips outside the geographical area of coverage of up to thirty (30) days of duration.

Out-patient Emergency room Hospital visits as a result of an Accident are covered up to five hundred dollars (US$500) per Insured, per Policy Year. If the optional USA elective treatment benefit is chosen, its coverage will take precedence.

6.29 Hospital cash benefit

The coverage for this benefit is up to three hundred dollars (US$300) per night, for up to a maximum of thirty (30) nights, without Deductible, when an Insured person is admitted for In-patient treatment and is receiving free-of-charge treatment that would have otherwise been eligible for coverage under this Policy.

OPTIONAL BENEFITS

6.30 Emergency air evacuation and repatriation to country of choice

The coverage for Emergency transportation by Air Ambulance is one hundred percent (100%) UCR.

Coverage for return trip

This benefit includes an economy class ticket to return the Insured and one (1) companion to the Insured's Country of Residence, country of nationality or the Insured's country of choice, provided that the trip is performed within the thirty (30) days of discharge and it is coordinated by the Company.

This benefit also includes up to three hundred dollars (US$300) per day for reasonable travel costs to and from the Hospital for the Insured and companion, and non-Hospital accommodation, only for immediate pre- and post-Hospital admission periods provided the Insured is under the care of a specialist.

The following requirements must be met for the approval of the Emergency transportation by Air Ambulance benefit:

- **A** The required Emergency treatment is for a condition or an Accident covered by the Policy;
- **B** This Insured's life or the loss of any of his/her limbs is in danger;
- **C** The required treatment cannot be rendered or is not available in any way in the area or place where the Insured is;
- **D** The transportation is provided by an entity licensed for such purposes, with the qualified staff and equipment; and
- **E** The Air Ambulance transportation must be pre-authorised and coordinated in advance with the Company.

6.31 Non-Emergency evacuation

This benefit covers costs of an economy class ticket for the return of the Insured and one (1) companion to the Insured's Country of Residence, up to two thousand dollars (US$2,000) in aggregate for both, provided that the medical condition (not an Emergency) is covered by this Policy, is being treated on an In-patient basis, and the treatment required cannot be provided, or is not available in any manner in the area or place where the Insured finds himself/herself at that moment.

6.32 U.S. elective treatment

Costs associated with eligible In-patient, Day-patient and Out-Patient treatment in the U.S. will be covered up to three million dollars (US$3,000,000). This benefit only applies for Insureds with the worldwide including U.S. elective treatment geographical area of cover.

6.33 Wellness and optical

Wellness

Wellness health check-ups are covered up to five hundred dollars (US$500) for option I and up to one thousand dollars (US$1,000) for option II, based on the Usual, Customary and Reasonable charges for the particular service.

This benefit is payable towards the cost of routine health checks including cancer screening, BRCA I & II tests, bone densitometry, cardiovascular examination, neurological examinations, vital signs (e.g., blood pressure, body mass index, urinalysis, cholesterol) and well child tests (up to five (5) years of age).

Optical

This benefit includes a contribution towards optician charges of up to three hundred dollars (US$300) for option I and six hundred dollars (US$600) for option II based on the Usual, Customary and Reasonable charges for the particular service.

This benefit covers an annual eye test carried out by an ophthalmic optician, prescribed spectacles including frames and lenses and/or contact lenses when the Insured's prescription has changed.

This benefit excludes prescription sunglasses or transition lenses, and is not subject to any Deductible, Out-patient Per Visit Excess or Co-Insurance that might be applicable to the plan.

SECTION 7. **EXCLUSIONS**

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

7.1 Not Medically Necessary, Alternative, Investigative, or unapproved treatments

Any treatment, Injury or Illness, or charges related to services or supplies that are not Medically Necessary, or provided to an Insured who is not under the care of a physician or medical professional who is legally qualified in the area or country in which he/she practices; or has not been prescribed by a physician or medical professional.

Medications that are not scientifically or medically approved for a specific diagnosis or considered as off-label use or Experimental, or the use of combinations that is not generally accepted by the scientific community, even when a particular Doctor prescribes it, as well as over-the-counter medication and/or that not approved for the treatment of the condition of the Insured by the FDA. Treatments or protocols that are not scientifically recognised; or are still in an Investigative phase or clinical trial, as well as those that have not been approved by the FDA or the equivalent governmental entities in the Insured's Home Country or Country of Residence.

7.2 Substance abuse, self-inflicted Illness or Injury, or criminal acts

Self-inflicted Illnesses or Injuries, whether the individual is sane or insane; suicide; failed suicide; addictive conditions of any kind; alcoholism, alcohol abuse (when the Insured's blood alcohol level is considered in excess of the legal limit, in the place where the incident occurred); treatment for any Injuries caused by, contributed to or resulting from drug use or abuse; use of Illicit substances or illicit use of controlled substances or any drugs or medicines that are not taken in the dosage or for the purposes prescribed by the Insured's doctor; encounters with wild animals in any circumstances; participating in fights, including when members of his/her family take part in it, unless the Insured is acting, legitimately, in self-defence, as determined by a court of law; Injuries and/or Illnesses resulting or arising from or occurring during the attempt or perpetration of a crime or a violation of law by an Insured; as well as any incident or Accident resulting from or related to any of the criteria previously mentioned. The services, care or treatment are excluded whether or not the Insured is charged with or convicted of any criminal offences.

Treatment for any loss or expense of any nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily injury, disregard for the rights and safety of himself/herself or others, except in an endeavour to save human life. Care and treatment, without limitations, incurred in connection with Injuries that occurred from a Negligent, Gross Negligent or Reckless Behaviour, or Wilful Misconduct of the Insured, as determined by the Company.

7.3 Routine examinations

Any routine exam conducted as part of a preventive study not specified in the Table of Benefits; routine examinations of the ear and eyes, cochlear implants or any other surgical implant for hearing, eye glasses and contact lenses, procedures to correct eye refraction disorders including radial keratotomy; prophylactic treatments; and the issuance of medical certificates and exams for work or travel, except as specifically provided in Sections 6.10, and 6.33 of this Policy.

7.4 Aesthetic treatments

Any type of elective or cosmetic surgery, or treatments whose principal purposes are aesthetic, except when it is necessary due to an Injury, deformity or Illness occurred during the effective period of this Policy. This includes any treatment for nasal or septum deformities, except as specifically provided in Section 6.24 of this Policy.

7.5 Podiatric care, orthopaedic devices and alopecia

Podiatric care, including special shoes, pedicures and orthopaedic inserts of any type or form; any treatment for alopecia.

7.6 Undeclared Chronic Conditions

Any Condition not declared in the Application. This also includes any cause, complication and treatment related to any individual condition excluded in this Policy. Any complications due to the lack of treatment.

7.7 Treatment covered by third parties

Any treatment received or expense incurred within a private or governmental establishment where the Insured has the right to receive free care; or when a third party is responsible for the medical expenses of the Insured, be it because of contractual obligations or due to civil responsibility, including the treatment of declared Epidemics, as well as workers' compensation or car insurance, among others.

7.8 Epidemics or Pandemics

Any medical treatment subject to the management of public authorities, including treatment and services related to infectious diseases declared as an Epidemic or public emergency by the World Health Organisation (WHO), Centers for Disease Control and Prevention (CDC), or any other government or governmental agency or governing body of the country where the Epidemic occurred.

In addition, such coverage is also excluded if it has been an official warning issued against travel to the area, by the State Department or similar office, the Embassy(s) of the affected country(s), the airline or another government agency, before traveling to the affected country.

This exclusion will not apply if the exposure occurs accidentally or unknowingly while traveling to or from undeclared risk areas, or if the exposure occurs as a result of visiting the area prior to the declaration of an Epidemic or Pandemic.

7.9 Procedures or treatments for Alzheimer's and mental health

Any medical expenses related to the treatment of Alzheimer's disease, mental procedures or treatments due to psychiatric Illnesses and conduct or growth-related disorders, except if they are required to treat a complication of a covered condition, as defined in the terms and limits of this Policy, and except as provided specifically in Section 6.17 of this Policy.

7.10 Excessive expenses

Any portion of a medical expense that exceeds the Usual, Customary and Reasonable (UCR) expenses or the amounts negotiated by the Company with specific Providers. Even when the benefit is covered at one hundred percent (100%), it will be subject to these limitations.

7.11 Sterilisation, fertilisation treatments and sexual reassignment

Any portion of a medical expense incurred in male or female sterilisation; sterilisation reversal; birth control; infertility treatments; artificial insemination; in vitro fertilisation (unless expressly covered by the plan); any condition suffered by the mother or the Newborn as a result of any type of fertilisation treatment; sexual reassignment, reproduction or modification services, including hormone therapy, intersex surgery, sexual deviations and disorders; psychosexual dysfunctions; genetic tests to determine paternity or the sex of a child; treatments or protheses used to improve or restore potency or other sexual deficiencies; testicular prosthesis and/or the insertion of a penile prosthesis, except when necessary for the treatment of neurogenic or vasculogenic impotence resulting from a medical condition greater than one (1)-year duration including, but not limited to spinal cord injury/disease, multiple sclerosis, spina bifida, diabetes, radical prostatectomy, rectal surgery, fractured pelvis, intrapenile arterial disease, status post cavernosal infection, Peyronie's disease, penile contusion, or penile fracture.

7.12 Obesity and weight control treatments

Any treatment, expense or service to prevent obesity or for weight control, whether it is weight reduction or gain, and any alterations in the body size, including any type of food supplement, except as provided in Section 6.4 of this Policy.

7.13 Growth hormones and hormone replacement therapy

Treatments with growth hormones or bone growth stimulants, any treatment related to the growth hormone, or hormone replacement therapy, regardless of the reason why it was prescribed.

7.14 Dental or orthodontic treatment

Any expense for dental or orthodontic treatment, except as provided in Sections 6.27 of this Policy. The following treatments are excluded even if dental coverage is provided under the policy, but are not limited to: maxillofacial treatments and/or surgery, abnormalities of the upper maxillary, disorders of the mandible or the mandibular articulation including, but not limited to its anomalies and malformations, the Temporomandibular Joint Syndrome (TMJ), craniomandibular disorders or any other mandibular condition, or any condition of the articulations that join the mandible and the cranium, as well as other tissues that are related to said articulations.

7.15 Active duty, war, and disturbances

The treatment of Injuries that may result when an individual is an active member of the police force, the army or other military force of any country, or is directly or indirectly participating in a war or military conflict, disturbance, civil or military coup d'état, hostility, civil war, riot, rebellion, martial law, act of terrorism or any illegal activity, including the possible arrest and incarceration resulting

from said participation, except for cases in which the Insured is a simple spectator or civilian innocent of these actions.

7.16 Hospital pre-admission for more than twenty-three (23) hours

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

7.17 Treatments provided by immediate relatives

Any treatment provided by a direct family member of an Insured, or in the facilities of a Provider owned by him/herself, or that is under the supervision of a direct family member or another Insured. For the purpose of this exclusion, a direct family member is the Spouse, parents, siblings, children or another person who regularly resides in the Insured's home. The Company reserves the right to authorise the treatment provided by the family member or the use of the Provider's facilities.

7.18 Non-prescription drugs

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

7.19 Artificial kidney equipment

Any portable or home-use artificial kidney equipment.

7.20 Artificial or animal organs, cryopreservation, and storage of tissues and Stem Cells

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

7.21 Injuries or Illnesses caused by radiation

The treatment of Injuries or Illnesses caused by any loss arising from ionising radiation, pollution or radioactive contamination of any nuclear residue from the combustion of nuclear fuel and from radioactive, explosive or toxic radioactive property or other hazardous component, as well as receiving X-ray therapy or radiotherapy without a prescription or medical supervision.

7.22 Duplicate functions and Medical Equipment repairs

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

7.23 Additional medical assistants

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

7.24 Miscellaneous therapies and homelike care

Any expense related to recreational or educational therapy; Custodial Care or assistance with household chores or for personal hygiene; Long-Term Care Facilities, assisted living, and services or supplies commonly used in a home.

7.25 Extended care and fitness memberships

Treatments in mental health centres or psychiatric institutions, nursing homes for the elderly, assisted living facilities, hospices, long-term care facilities, hydro-clinics, health spas and memberships to gymnasiums, except as provided in Section 6.26 of this Policy.

7.26 Expenses in sanctioned countries

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

7.27 Expenses for completing medical forms or obtaining medical records

Any expenses incurred by a medical or dental practitioner for completing claim forms or providing medical records. This also includes charges relating to police reports, if required. Any costs relating to shipping (including customs duty) for transporting medicine.

7.28 Allergy tests

Any expenses incurred for allergy testing even when prescribed by a medical practitioner.

7.29 Fetal surgery

Any expenses incurred in relation to a surgery performed on a baby while still in the mother's womb, except as part of the covered maternity care benefit.

7.30 Genetic testing

Any expenses incurred in relation to genetic testing in order to establish the Insured's genetic predisposition to the development of certain medical conditions.

7.31 Hazardous activities and Professional Sports

Treatments for Injuries or Illnesses related to the participation by the Insured in the practice of hazardous activities, Professional Sports or during the practice of sports for which he/she may receive monetary compensation for conducting such activity professionally.

7.32 Sleep conditions
Any expenses for treatments related to snoring, insomnia, jet-lag, fatigue or sleep apnoea, including sleep studies or corrective surgery for any of these conditions.

7.33 Claims filed outside the allowable time
Claims for medical services not received within one hundred and eighty (180) days from the date of service.

7.34 Termination of pregnancy
Any voluntary termination of pregnancy, unless the mother's life might have been in imminent danger.

7.35 Home births and Maternity
Home births, maternity preparation classes, lactation consultants and maternity care benefits.

7.36 Expenses when the Insured travels against doctor's orders
Any medical expenses when the Insured has travelled against any healthcare professional's medical advice.

7.37 Developmental and behavioural conditions
Any expenses related to the treatment of developmental, behavioural or learning problems such as autism, attention deficit hyperactivity syndrome, speech disorders or dyslexia and physical developmental problems.

SECTION 8. **MANAGEME**

8.1 Notifications and/or pre-authorisations
It is recommended that the Insured notifies the Company when receiving medical treatment. This will give the Company an opportunity to verify the terms and conditions in which the treatment will be covered, as well as improve and maximise the level of coverage available to the Insured, make suggestions about the best places for his/her care, provide logistical support and, whenever possible, make arrangements to establish direct payment to the Hospital or Doctor of choice, thereby reducing the possibility that the Insured will have to incur an unexpected or excessive out-of-pocket expense.

In order to guarantee direct payment and the coordination of benefits, notification is required. Therefore, the Insured must notify the Company in advance and obtain the necessary authorisations for any of the following benefits:

- **A** All Hospital admissions;
- **B** All Hospital or Out-patient surgeries;
- **C** Any major procedures, such as MRIs, CT scans, PET scans, gastroscopies, colonoscopies, biopsies, etc.;
- **D** Physical and rehabilitative therapy, home health care or Private Nurse or Therapist;
- **E** Nasal or reconstructive surgery;
- **F** Emergency transportation by Air Ambulance;
- **G** Durable Medical Equipment or any special medical device;
- **H** Physiotherapy or complementary therapy after ten (10) sessions;
- **I** Repatriation or cremation of mortal remains, whereby a notification must be made on behalf of the Insured;
- **J** Any medical service or purchase of drugs related to the Human Immunodeficiency Virus (HIV) or the Acquired Immune Deficiency Syndrome (AIDS); and
- **K** USA elective treatment.

The Insured must notify the Company at least seventy-two (72) hours prior to receiving those medical services that require notification or pre-authorisation. The Company must also be given notice of all medical Emergencies that require notification within seventy-two (72) hours after the event that caused the Emergency. If pre-authorisation is not obtained and treatment is received and is subsequently proven not to be Medically Necessary, the Company reserves the right to decline the claim. If treatment is Medically Necessary, but the Insured did not obtain pre-authorisation, the Company will only pay up to Usual, Customary and Reasonable charges.

To notify the company, the Insured may send an e-mail to **notifyglobal@vumigroup.com**, or fill out the medical notification form on MyVUMI™ at **www.myvumiportal.com** or by downloading the mobile app, or on our website **www.vumiglobal.com**.

8.2 Medical information privacy notice
The Company handles the privacy and confidentiality of the personal information of its Insureds with strict adherence to the laws and regulations in force on the matter. All confidential information will be protected in the offices and by the available electronic means, which have all the security guarantees.

It is understood that the Insured has given his/her consent for the transfer of said information when necessary, in order to comply with any contract or agreement for the provision of services, including to his/her registered insurance agent or when required by law or the procurement or administration of justice.

8.3 Limited liability
The Company will not be responsible for any loss, damage, or Illness that the Insured may suffer which was caused by the provision of services for covered expenses by a medical service Provider or any person who provides such services. In this case, the Insured will have to present his/her complaint directly to the medical service Provider or the person who has offered the service.

8.4 Claims
The Company, in most cases, will make payments directly to

physicians and Hospitals worldwide in legal currency for covered expenses, pursuant to the terms and conditions of the Policy. When this is not possible, the Company will reimburse the covered costs to the Insured in accordance with the applicable Usual, Customary and Reasonable (UCR) fees or the contracted rates between the Company and the Provider.

In no case will the compensation amount exceed the amount billed. If the Insured receives compensation that exceeds the invoice amount by mistake, the Insured will be obligated to immediately return the excess amount to the Company, or the Company will deduct the outstanding balance from any other amount pending to settle with the Insured.

The Company shall receive all medical and non-medical information required. In order for the claims process to begin, the Company must receive the proof of claim, which must consist of the following information:

- **A** Claim Form duly completed;
- **B** All itemised bills from the Provider detailing the services rendered, along with proof of payment;
- **C** A recent medical history or any other medical information that the Company may consider pertinent;
- **D** For pharmacy expenses, a copy of the medical prescription;
- **E** In the event of an Accident, the Insured must submit all information related to said Accident, as well as the circumstances surrounding it, pursuant to what is required by the Company. This includes, but is not limited to Accident reports, police reports or others, when issued by the pertinent authorities or any other information available from any other third parties involved in the matter;
- **F** Declare any other medical insurance coverage the Insured may have when submitting a claim.

When simultaneously submitting multiple claims for reimbursement from different Insureds, the expenses for each Insured, Accident, Illness and/or Provider must be divided into each separate Insured and events. Once the claim process has been initiated, the Insured must send all the information requested by the Company to complete the process in a period of no longer than ninety (90) days from the first request by the Company. Once this period has elapsed without receiving the requested information, the claim will not proceed and the Company will be relieved of any obligation.

Should the information provided be considered inadequate or is incomplete, it may create a delay in the payment or reimbursement process, or it may cause the claim to be temporarily closed until the necessary information is received within the stipulated time limit.

The Company reserves the right to request the original receipts, medical records and/or any other relevant documentation in order to process the claim. The Company will not return original documentation received to process a claim; however, it may offer a copy of such documentation when requested.

In the event that a claim that should have been denied because coverage was excluded from the Policy or was not compensable for any other reason, has been paid in error, the Company will not be obligated to continue paying for the expenses of treatments or services related to such claim from the date of the identification of the error, and may request the reimbursement of the amounts unduly paid.

Guarantee of Payment (GOP) letter

The Company, upon receiving a notification from the Insured or a Provider, may issue, in good faith, a Guarantee of Payment so the Insured begins to receive the required care. If during the treatment or Hospitalisation of the Insured, the Company receives information that the care or claims are not compensable due to undeclared Chronic Conditions, Policy exclusions or any other reason that invalidates the coverage, the guarantee issued will be withdrawn and the Insured must assume the total responsibility for the non-compensable expenses towards the Provider.

The Company will not be responsible for any fees charged by the receiving bank, such as commissions for currency exchange or for incoming wire transfers. These charges will be the responsibility of the recipient of the payment.

8.5 Appeals

In the event of any disagreement between the Insured and the Company regarding a claim or administrative decision, before any other action is taken, the Insured must begin an appeal about the claim or decision to the Company's Appeals Department for review and analysis. The appeal must be submitted within a period of no more than thirty (30) days from the date the administrative decision on a claim was made.

The Insured must submit a letter appealing the claim to: **appealsglobal@vumigroup.com**. Said letter must include all relevant information, as well as copies of all documents considered necessary to re-evaluate the decision made.

The Company's Appeals Department will review in detail the arguments and information provided and will notify its decision to the Insured in writing within thirty (30) days following receipt of the appeal letter along with all pertinent information and/or documentation. During the process, the Company's Claims Department will have the right to request additional information or documentation from the Insured or the Providers, third parties or entities, if deemed necessary, to accurately evaluate the arguments of the appeal.

Second instance of appeal

Once the Claims Department has notified the Insured of its decision, the Insured will have the opportunity to express his/her

opposition to that decision within ten (10) days from the date of the notification. If the Insured has new documentation, he/she may request a second and final review of the case. The Company must respond to this second request within the next fifteen (15) business days. The decision in this last instance will be final and not subject to appeal.

8.6 Arbitration and legal actions

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

The arbitration shall be confidential pursuant to the Commercial Arbitration Rules of the American Arbitration Association. Any decision or compensation as a result of such arbitration shall be presented in writing and provide an explanation of the findings, by law and evidence, that has been reached, and include assessment of costs, expenses, and reasonable attorneys' fees. Such arbitration shall be conducted by an arbitrator who is experienced in the subject matter that pertains to the issue between the parties in question and its written record shall include the minutes of the arbitration hearing. The parties reserve the right to object to the intervention of any individual employed by or affiliated to a competing organisation or entity. If the arbitration were to result in the receipt of compensation by either party, it may be subject to confirmation by a court of competent jurisdiction.

Governing Law

The parties agree to grant to the State District Courts of Dallas County, Texas (or if there is exclusive federal jurisdiction, then the United States District Court for the Northern District of Texas, Dallas Division) exclusive jurisdiction and venue over any disputes arising out of or in connection with this contract involving the parties, and the parties hereby consent to the jurisdiction of such courts.

The Insured and the Company hereby agree that the resolution of legal disputes, which may arise from this Group Policy, shall be resolved by a non-jury trial. Each party also agrees to cover the costs and fees of their respective representatives.

8.7 Subrogation of third parties and indemnity

The Company has the right of subrogation or reimbursement of payments made if the Insured has recovered all or part of said payments from a third party. The Company will subrogate up to the amount paid, under all its rights and actions, against third parties that, due to the damage suffered, the Insured is entitled to. The Policyholder shall have the obligation to cooperate with the Company to recover from the damage caused by third parties or to obtain reimbursement of the expenses covered by it.

Failure to comply with this obligation entitles the Company to consider cancelling this Policy. The required cooperation includes, but is not limited to providing all relevant documentation or testimonial evidence and undergoing medical examinations, if necessary. The Company may make any claim on his/her behalf, before or after having made payments for expenses covered under this Policy.

The Policyholder must refrain from taking any action, reconciling or accepting agreements that may adversely affect the Company's subrogation rights in accordance with the provisions of this article. Any claim action initiated by the Insured in relation to damages that were covered by this Policy must be notified immediately to the Company, in order to assert its subrogation rights on any payment related to the expenses covered by the incident that originates the claims.

SECTION 9. **DEFINITIONS**

Accident

A violent, sudden, unforeseen and unintentional event, produced exclusively by external causes that result, independently of other causes, in bodily Injuries to the Insured.

Additional Coverage Options (Optional Benefits)

A document attached to the Policy by the Company when it is acquired and paid by the Policyholder and which provides additional optional coverage.

Administrative Error

Involuntary physical mistake such as a spelling or numerical error, mistakes in mathematical calculations that are easily verifiable, or failure to review the available information to make a decision on the approval of coverage or the payment of claims. The Company can correct the physical or administrative error at any time.

Agency or Agent / Broker

Individual or company authorised by the Company to distribute its products and provide administrative services to the Insureds. The Agent shall have access to the Insured's health and medical information, which can be sent to the Company or any of its affiliates. No Agent or Broker has the authority to modify the Policy or to remove any of its terms and conditions.

Air Ambulance
Aircraft staffed with licensed medical personnel and that is equipped with the supplies necessary to provide medical care during air transportation. This service is provided by a licensed and authorised entity for said purpose.

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

Anaesthesiologist Fees
Fees charged by an anaesthesiologist for the administration of anaesthesia and/or pain control.

Anniversary Date
Day on which the Policy meets a twelve (12)-month effective period.

Applicant
Natural person applying for an insurance Policy. The Applicant is usually the intended Policy owner or Policyholder after a Policy is issued.

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

Assisted or Custodial Care
Services that include, but are not limited to, personal assistance that does not require professional or training skills, for example: washing, feeding or dressing of an Insured, providing assistance for moving or mobilisation, making the bed and other activities related to daily life, with the purpose of preventing Accidents and providing accompaniment, among others.

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

Beneficiary
Person designated by the Policyholder to receive the amount of the unearned premium or the payment of reimbursements of pending claims in case of death.

Birth Complications
Any disorder related to a New-born that is not caused by genetic factors and that occurs during the first thirty (30) days of life.

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

Company
The insurer, VIP Universal Medical Insurance Group, Ltd.

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

Congenital Disorders
Any condition, organic disorder, malformation, embryopathy, persistency of embryonic or fetal tissue or structure, which has been acquired during the development of the fetus in utero or during birth, regardless of whether it is evident before birth, at the time of birth or manifests itself later.

Contracting Party
Natural or legal person who pays the premium of the Policyholder and/or his/her Dependants, due to a work relationship or family affinity. The Contracting Party is not an Insured and therefore does not enjoy the benefits under the Policy, however, he/she has the power to request the cancellation of the Policy paid for the Policyholder and receive the unearned premium. The Policyholder may pay the corresponding premium to maintain the current coverage when the Contracting Party requests the cancellation and refund of the unearned premium.

Country of Nationality
The country for which the Insured holds a passport.

Country of Residence
The country in which the Insured resides no less than one hundred and eighty (180) days within a year while this Policy is in effect.

Covered Maternity
A pregnancy ending by natural or caesarean delivery after the Waiting Period of twelve (12) months after the Effective Date of the mother's coverage.

Custodial Care
Services rendered which include, but are not limited to personal assistance that does not require professional or training skills, for example: washing, feeding, and dressing an individual, among others.

Day-Care Treatment
Day-patient services or treatments that require a Hospital

admission or Hospital stay where there is a period of medically supervised recovery, but the patient does not occupy a bed overnight.

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

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

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

Durable Medical Equipment
Equipment that provides therapeutic benefits to the patient and allows him/her to perform tasks that otherwise, and due to medical conditions or Illnesses, he/she could not perform. The Medical Equipment must be durable for continuous use, used for a medical purpose, approved for home use, and able to be transported, such as wheelchairs, crutches, and Hospital beds.

Effective Date
Start date of the term of the Policy.

Emergency
A sudden, serious and acute medical condition, which requires immediate medical assistance due to the danger it represents to the life or physical integrity of the Insured if medical attention is not provided within the next twenty-four (24) hours.

Epidemic
Incidence of more cases than expected of a certain Illness or health condition in a specific area or within a group of people during a particular period, and which has been declared as such by the World Health Organisation (WHO), the Centers for Disease Control and Prevention (CDC) or an equivalent organisation in a local government.

Experimental or Investigative
Any treatment, procedure, equipment, drug, combination of drugs, device, supply or Hospitalisation which, at the time the service or supply is provided, does not meet the approved norms for the specific indication or application to the condition by the FDA or other applicable federal or government agency of the U.S., and whose approval is required regardless of the location where the medical expenses are incurred.

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

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

Gross Negligence or Gross Negligent
Lack of care that demonstrates reckless disregard for the safety or live of others, which is so great it appears to be a conscious violation of other people's rights to safety.

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

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

Hereditary Disorder
Genetic disease or disorder whose main characteristic is its survival from generation to generation through defective genes transmitted from parents to children, and so on.

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

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

Hospitalisation
Admission to an In-patient medical centre for a period of twenty-four (24) hours or more to receive medical or surgical care. The severity of the medical condition justifies the need for a Hospital admission. The medical care limited to an emergency room or urgent care is not considered a Hospitalisation for the purposes of this Policy.

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

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

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

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

In-patient Treatment
Any service or treatment received at a Hospital, clinic or any other medical facility requiring admission or stay for more than twenty-three (23) hours.

Insured
Refers to both the Policyholder and the covered Dependants.

Insured Dependants
Spouse or Domestic Partner of the Policyholder, his/her biological children, legally-adopted children, stepchildren or children under eighteen (18) years for whom the Policyholder has been named legal guardian by a court of competent jurisdiction.

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

Live Donor
A live person who donates an organ, tissue or cells to be transplanted into the body of another person or recipient.

Long-Term Care Facility
Assisted living institution.

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

Medical Necessity or Medically Necessary
Treatment, medical service or medical supply prescribed by the treating Physician and approved by the Company as deemed necessary to diagnose and/or treat an Illness or Injury.

It is not Medically Necessary if the service:

- **A** Is provided as a matter of convenience to the Insured, his/her family or the Hospital/Physician;
- **B** Is not appropriate for the diagnosis or treatment of the specific condition;
- **C** Exceeds the level of care required for the diagnosis or treatment of a specific condition;
- **D** Is outside the scope of the standard practices established for Doctors or other health professionals and Hospitals; or
- **E** Is a substitution of a Standard or Private Room for a Suite, if the Policy doesn't offer this benefit.

Negligence or Negligent
Failure to behave with the level of care that someone of ordinary prudence would have exercised under the same circumstances. The behaviour usually consists of actions, but can also consist of omissions when there is some duty to act or rules or care to follow.

New-born
Infant from the moment of birth up to the first thirty (30) days of life.

Nurse or Therapist
An individual legally licensed according to the regulations where he/she provides services and who offers patient care services according to the indications of a physician.

Optional Benefits
Document which is issued by the Company, is attached to the Policy when it is acquired, paid by the Contracting Party or the Policyholder, and which provides additional coverage.

Out-patient Co-insurance
Uninsured percentage of the costs, which the Policyholder must pay towards the cost of a claim.

Out-patient Direct Billing Network
List of Hospitals and medical providers contracted by the Company for direct billing.

Out-patient Per Visit Excess
Uninsured amount payable by the Insured (per Out-patient consultation) when eligible Out-patient treatment is received.

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

Palliative Care
Treatment provided to patients with advanced, progressive and incurable Illnesses with a prognosis of less than one hundred and eighty (180) days of life.

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

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

Policyholder
Individual who signs the insurance Application, is the main Insured under the Policy, has the authority to request changes in the Policy, and receives the reimbursements for payments of medical services covered under this Policy, as well as any reimbursement of the unearned premium.

Prescription Drugs
Drugs prescribed by a physician that would not be available without such prescription. Certain treatments and drugs such as vitamins, herbs, aspirin, cold remedies and drugs, and Experimental or Investigative drugs or supplies, even when recommended by a physician, do not qualify as Prescription Drugs.

Professional Sports
Training and practice of sports for which a person receives compensation.

Provider
Hospitals, Clinics, physicians, diagnostic centres, pharmacies and other entities or individuals legally authorised to provide medical services.

Reckless Behaviour
The conscious disregard of a substantial and unjustifiable risk.

Region
Group of countries and/or a geographical area within one country.

Renewal Date
Due date for the payment of the Policy. Depending on the payment mode, the Renewal Date may also be the Anniversary Date.

Routine or Preventive Health Check-ups
Preventive medical examinations conducted by a certified physician and/or an institution providing medical services.

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

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

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

Stem Cells
Adult Stem Cells (hematopoietic Cells) obtained from blood of the umbilical cord at the time of delivery and are stored by cryopreservation.

Suite
Hospital room of a Hospital or Clinic classified by the same as a Suite, usually of a larger size than that of a Private Room and which may have a reception area. This includes rooms referred to as "Junior" or "Presidential."

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

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

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

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

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

The Usual, Customary and Reasonable amount for a service, treatment, or provisions will be determined by the Company based on special rates established or contracted in advance by the Company for the geographic area, country or specific Provider with whom the Insured receives such services. In some cases, the UCR amount will be determined by direct contracts between the Providers and the Company.

Benefits covered at one hundred percent (100%) are subject to Usual, Customary and Reasonable costs. It should not be understood that they will be covered for the total amount of the invoice submitted.

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

Wilful Misconduct
Deliberate act or omission which is contrary to or goes beyond the conduct to be expected of a party, where such party knows that or is reckless to the fact that such act or omission is contrary to or goes beyond the conduct to be expected of them.

VIP Universal Medical Insurance Group, Ltd.
Insurance company registered in Turks & Caicos Islands, a British Overseas Territory
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