

GLOBAL FLEX VIP SUPERIOR

INDIVIDUAL AND FAMILY POLICY WORDING



JULY 2026 / JUNE 2027

VUMI®

WELCOME TO VUMI®

We are pleased that you have 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 eight 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 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

VUMI® Group International Insurance

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VUMI® GROUP, I.L.

ORGANISED UNDER CHAPTER 61 OF THE
PUERTO RICO INSURANCE CODE.

NO COVERAGE ISSUED BY THIS INSURER IS PROTECTED BY
ANY GUARANTEE OR INSOLVENCY FUND IN PUERTO RICO.

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Administration services provided by VUMI® Global Services FZ-LLC

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TABLE OF BENEFITS

Unless otherwise stated, the benefits are offered on a per insured/per policy year basis in which the chosen deductible or outpatient per visit excess and coinsurance 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. Benefits are covered up to policy maximum unless specified otherwise in the policy terms and conditions.

DEDUCTIBLE, OUTPATIENT PER VISIT EXCESS AND OUTPATIENT COINSURANCE 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 outpatient per visit excess	US\$30 outpatient per visit excess	10% outpatient coinsurance, up to a maximum out-of-pocket of US\$2,000	20% outpatient coinsurance, up to a maximum out-of-pocket of US\$4,000	30% outpatient coinsurance, up to a maximum out-of-pocket of US\$6,000

GENERAL PLAN INFORMATION

Maximum coverage per person, per policy year	US\$4,000,000
Maximum age to apply for coverage	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 cover is limited to the Emergency non-elective treatment benefit. • Worldwide including USA elective treatment • Worldwide excluding USA



GENERAL PLAN INFORMATION

Geographical cover options (continued)	• 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.
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INPATIENT BENEFITS

BENEFIT	COVERAGE
Adult companion accommodation (related to a covered hospitalisation of an insured child under age 18)	100% UCR
Psychiatric treatment	100% UCR, max. of 30 days
Private Hospital Room (room and associated medical costs)	100% UCR

Inpatient benefits include but are not limited to the following treatments when admitted to hospital: specialists, surgeon and anaesthesiologist fees, drugs, general nursing, intensive care unit, medical appliances and surgical implants, operating theatre, therapies (if prescribed by a specialist as part of the insured's hospital stay but are not the primary treatment for which they are in the hospital to receive).



OUTPATIENT BENEFITS

BENEFIT	COVERAGE
Complementary therapy including physiotherapy, Traditional Chinese Medicine (TCM) and Ayurvedic treatment	100% UCR, pre-authorisation required after 10 sessions
Day-care treatment	100% UCR
General practitioner and specialist fees	100% UCR
Hormone replacement therapy to relieve the symptoms of menopause	Up to US\$250
Nursing care at home	100% UCR, max. of 90 days
Outpatient surgery	100% UCR
Outpatient Prescription Drugs	100% UCR
Psychiatric treatment	Up to US\$5,000
Travel vaccinations and preventive medication, e.g., against malaria	Up to US\$250

MATERNITY BENEFITS

BENEFIT	COVERAGE
Maternity and Birth Complications	100% UCR
Maternity care	Up to US\$12,500
Newborn cover	Up to US\$100,000

MEDICAL EVACUATION BENEFITS

BENEFIT	COVERAGE
Emergency transportation by air ambulance & emergency medical evacuation	100% UCR
Repatriation of mortal remains	100% UCR, US\$10,000 for burial or cremation costs



GENERAL BENEFITS

BENEFIT		COVERAGE
Congenital and/or Hereditary Conditions	From birth up to 30 days	Covered under the newborn benefit
	After 30 days from birth	Up to US\$100,000
Diagnostic study services (laboratory tests, X-rays, CT, PET and MRI scans)		100% UCR
Durable Medical Equipment and external prostheses		Up to US\$2,000 per policy year
HIV-AIDS treatment		Up to US\$50,000
Oncology (tests, drugs and treatments approved by the FDA)		100% UCR
Organ Transplant (per organ/tissue, per Lifetime)		100% UCR, including up to US\$50,000 for donor costs
Prescribed rehabilitation therapies		100% UCR, max. of 90 days per medical condition
Reconstructive surgery		100% UCR
Renal failure and dialysis		100% UCR
Routine management of Chronic Conditions		100% UCR
Surgical procedures		100% UCR
Terminal illness / palliative care		Up to US\$100,000 per Lifetime

OTHER BENEFITS

BENEFIT	COVERAGE
Emergency dental treatment	100% UCR
Emergency non-elective treatment outside the geographical area of cover	• 100% UCR for injuries • Up to US\$50,000 for illnesses • Up to US\$500 for outpatient hospital visits
Emergency transportation by Ground Ambulance	100% UCR
Emergency or Urgent Outpatient Care	100% UCR



OTHER BENEFITS

BENEFIT	COVERAGE
Hospital cash benefit	Up to US\$350 per night, max. of 30 nights
Passive war and terrorism	100% UCR
Second Medical Opinion VIP®	Access to the medical opinion of internationally renowned experts from around the world regarding a condition, no deductible applies
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

OPTIONAL ADDITIONAL COVERAGE*

BENEFIT	COVERAGE
Evacuation to country of choice, country of residence or home country	100% UCR
Non-emergency evacuation	Up to US\$2,000
Wellness and optical	• Option I - US\$500 • Option II - US\$1,000

*Coverage subject to purchase.

WAITING PERIODS

BENEFIT	COVERAGE
HIV-AIDS	36 months
Maternity and Birth Complications	12 months*
Maternity care	12 months*

*Subject to underwriting.

Effective from 1 July 2026, or after the renewal.

All benefits with 100% coverage are up to the Policy limit. Benefits with established coverage will be up to the limits stated in each of them.



SECTION 1. AGREEMENT

VUMI® Group, I.L., hereinafter the “Company,” undertakes to pay to the Policyholder the benefits detailed in this Policy related to the covered expenses incurred by him/her or his/her eligible Insured Dependants, as a result of any treatment, service or medical supply provided 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 Broker 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.

1.2 Important notice about the Application

This Policy is issued based on the statements provided in good faith by the Policyholder, for themselves and their Insured Dependants. If any of the information disclosed in the Application is false, incorrect, inaccurate, incomplete, had the intent of misleading or deceiving, or any information was omitted, resulting in a premium different from that corresponding to the Insured's age or Country of Residence or worsening the risk, the premium and/or coverage of the Policy may be rescinded, modified retroactively or cancelled at the Company's discretion. If coverage is cancelled or terminated, it will have no effect and the Company will not be responsible for any payments of the benefits offered under this Policy. Information found to be omitted, false, incorrect or inaccurate at the time of the application, evaluation of the Application or during the term of the Policy, does not have to be directly related to a claim that could have otherwise been compensable, for the Company to proceed with modification, cancellation or rescission of the coverage that the Company granted without having been able to evaluate all the assumed risks from the Effective Date of the 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, modified, rescinded or cancelled, will have no effect, and the Company will not be responsible for any payment of the 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 to the total payments made for any of the aforementioned causes.

1.3 Entire agreement

The entire agreement between the Insured and the Company (hereinafter, “agreement” or “Policy”) includes:

- A** The Policy Wording (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 Additional Coverage (if acquired) which might include additional coverage.
- H** The underwriting terms for the Policy will form part of the Application.

No changes can be made to the Policy unless approved by the Company. Any change to the coverage must be made through an Amendment issued by the Company’s Underwriting Department.

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 is 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.

Any changes in premiums and in the Policy Wording for the next Policy term will be notified in advance of each Policy Anniversary. By paying the renewal premium, the Policyholder acknowledges and accepts the Policy terms.

SECTION 3. ELIGIBILITY

3.1 Eligibility requirements

This Policy provides coverage to the Policyholder and his/her eligible Insured 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** Policyholder resides in a country other than the United States of America (USA);



- B** Policyholder is not physically located in the United States at the time of application, and until the Policy is approved and issued and delivered in their Country of Residence;
- C** The Policyholder and his/her Spouse or Domestic Partner are at least eighteen (18) years old and under seventy-four (74) years of age, except for minors authorised by one of their parents or a legal guardian;
- D** Dependant children are eligible up to:
 - a** Eighteen (18) years of age if they are single and residing with the Policyholder; or
 - b** Twenty-eight (28) years of age if they are single and full-time students.
- E** Coverage is available for minor children between the ages of 7 to 17 under standalone plans where the Contracting Party is a biological parent, adoptive parent, or legally recognised step-parent of the Applicant. Child-only policies may be subject to any additional requirements.
- F** The Policyholder pays the applicable premium;
- G** Coverage is available for the Policyholder's Insured 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 higher education institution 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 relevant higher education institution confirming the Insured Dependant's enrollment status. Additionally, a premium adjustment will apply if the Insured Dependant remains outside their Country of Residence for a period of more than one hundred and eighty three (183) cumulative days during Policy Year.

When they no longer qualify as Insured Dependents under the Policy, they may, at their own discretion, submit an Application for an individual policy and subject to payment of the corresponding premium, obtain coverage with a Deductible equal to or higher than that of the previous Policy, and under the same conditions and/or restrictions as the previous Policy. The Application must be received at the Company before the end of the Grace Period of the Policy under which a dependant had coverage with the Company.

3.2 Addition of a Newborn

A Newborn born from a covered pregnancy (Maternity Care benefit) can be added without the need for underwriting evaluation.

The Company must receive a copy of the birth certificate, along with a Newborn Application, within thirty (30) days after the birth, together with applicable premium. Coverage for the child will become effective from the date of birth.

The Newborn must go through underwriting evaluation in the following cases:

- A** The Newborn is not born from a covered pregnancy, or
- B** The Company received the request for enrollment together with premium after thirty (30) days from birth, or
- C** The Newborn is conceived via fertility treatments and/or artificial insemination (IVF) even if said treatment is covered by this Policy; or fostered, adopted or born to a surrogate.

Where underwriting evaluation is needed the effective date will be the date of acceptance.



SECTION 4. OBLIGATIONS OF THE INSURED AND GENERAL POLICY INFORMATION

4.1 Policy issuance

This Policy is deemed solicited, issued and 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 completed, issued or delivered 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.

Only the Underwriting Department of the Company has the authority to approve, modify, cancel or rescind insurance coverage, through an amendment or an official communication.

Guaranteed renewal

The renewal of this Policy is guaranteed for life, subject to the eligibility requirements and the terms and conditions of the Policy in effect at the time of renewal, provided that the full premium due is paid on time.

Delivery of Policy documents

The Policy, Optional Additional Coverage and payment receipts may be sent to the e-mail address registered with the Company, unless the Policyholder or his/her registered Broker selected another option in the Application or requested it later from the Company. The Policyholder may request a copy of his/her Policy documents directly from the Company, at any time.

Governing contract

The translations of this Policy into other languages are provided as a courtesy for the Insured's convenience. The English version of this Policy is the only valid and binding version. Any included translation exists only to aid interpretation, with any differences in interpretation to be resolved in favor of the English version.

4.2 Notification of change of Country of Residence

The Policyholder must Notify the Company in writing if any Insured changes their Country of Residence in advance or within thirty (30) days after the change occurs, as this could result in an adjustment to the premium based on the new geographic area where the Insured resides.

Once the Notification of change of Country of Residence is received, or the Company has determined the change of Country of Residence occurred, the Company will determine which geographic rate table should be applied retroactively as of the date of which the change of Country of Residence occurred.

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 rescission, cancellation or modification of this Policy, at the Company's discretion.



If for any reason, an Insured remains outside his/her Country of Residence for more than one hundred and eighty-three (183) cumulative days within a Policy Year, be it for work, leisure, studies, etc., the Policyholder must notify the Company within thirty (30) days as this could result in an adjustment to the premium rate established for expatriates, or the rate table of the Region where he/she will spend the majority of the time during the Policy Year. Failure to do so may result in the Policy being modified or cancelled at the Company's discretion.

4.3 Coverage for Pre-existing Conditions

Pre-existing Conditions 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. Pre-existing Conditions that were not declared will not be covered and omission 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 Pre-existing Condition.

4.4 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 Insured Dependants. In no event will the Company modify the rates of an individual Insured based on their claim history.

4.5 Change in Policy Benefits

At Policy Renewal, the Insured can request to change his/her current plan, Deductibles, geographic area of cover, and/ or payment frequency:

- A** If the change is for a plan with lower benefits with the same deductible option, or a higher deductible option available, the change will be automatic without an underwriting evaluation.
- B** If the change is for plan with higher benefits, or the same plan with a lower deductible option, it will be subject to an underwriting evaluation.

As a general rule, any change with an improvement of benefits and/or to a lower deductible option, will be subject to an underwriting evaluation.

If any of the Insureds in the Policy is hospitalised or is undergoing treatment, the underwriting department could postpone the requested change of plan.

Before the Anniversary, the Insured can request to change his/ her current geographic area of cover due to relocation such that the current plan will not cover his new Country of Residence.

If the new plan includes or enhances maternity care benefits, a twelve (12)-month Waiting Period will apply. The benefits that did not exist in the previous plan must meet the corresponding Waiting Periods. During the Waiting Periods, coverage will be provided in accordance with the plan offering the lower level of benefits.

The Company reserves the right to approve or deny the request with changes to the plan, deductibles under conditions and/or restrictions that it considers appropriate.

4.6 Currency

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



4.7 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 or 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. Partial or incomplete payment of the overdue premium shall not result in the renewal of the Policy, and coverage shall remain inactive with no benefits available.

Any premium paid in excess of the amount due will be refunded without interest via the same payment method used for the original payment. 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.

4.8 Payment mode

Premiums can be paid annually, semi-annually, quarterly, monthly or according to the payment mode established by the Company. Changes to payment modes are to be made only on the Anniversary Date of the Policy. If the Insured chooses monthly payment mode, the premium will be collected via automatic Debit Authorisation only.

Renewal notices are issued as a courtesy and the Company does not guarantee their delivery.

If the payment notice has not been received, the Contracting Party/Policyholder must contact the Company or the registered Broker.

4.9 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 Broker or directly with the Policyholder or Contracting Party, 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 or Contracting Party 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 or Contracting Party 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 or Contracting Party to renew this Policy.



4.10 Termination of coverage after the Expiration Date

When this Policy expires, coverage ceases on the termination date and the Company will be responsible only 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.

4.11 Causes for rescission, cancellation or modification of the Policy

By the Company

The Company, in its sole discretion, may cancel, rescind or modify the rates and the Deductible of the Policy, in cases where any of the following conditions is present:

- A** The information disclosed in the Application is false, incomplete or when information has been omitted or when fraud has been committed for any reason, which caused the Company to approve the Policy or a claim when, had the Company been provided with the correct information, the coverage would have been issued under certain restrictions or would have been rejected when it was determined that the Applicant was an uninsurable person under the guidelines of the Company;
- B** The Insured submits a claim or information that the Company considers fraudulent. In the event such fraud occurs, the Policyholder will be liable, both to the Provider and to the Company, and will have to reimburse the Company for the payments made in reference to the fraudulent or non-compensable claim, whether the payment was made in the form of a reimbursement to the Insured or directly to the Provider, or a Guarantee of Payment (GOP) has been issued;
- C** The Insured lives in a country that is under an embargo or has been sanctioned by the United States Office of Foreign Assets Control (OFAC), or if the Insured him/herself appears on any of the lists of persons sanctioned by OFAC, or similar entities in the United Kingdom, the European Union, or other similar lists around the world;
- D** The Insured spends more than one hundred eighty-three (183) days out of a period of three hundred sixty-five (365) days in the United States or any of its territories, without legal justification or a visa for temporary residence in the country, or does not notify of a change of residence within the thirty (30) days established in this Policy;
- E** The Policyholder does not comply with his/her obligation to cooperate with the Company to recover from damage caused by third parties, or to obtain reimbursement of the expenses covered due to the same reason through the subrogation process; or
- F** It is discovered that the eligibility criteria were not met at the time of Application.

At the request of the Policyholder or the Contracting Party:

- G** The Policyholder or Contracting Party (if applicable) requests the cancellation of the coverage in writing or does not pay the total premium before the Grace Period, as stipulated in the provisions of this Policy; or
- H** The Policyholder notifies of his/her divorce or separation (in case of Domestic Partners). The coverage of the Insured Dependant Spouse will terminate at the end of the Policy Year, or when requested by the Policyholder, by notifying the Company within thirty (30) days from the date of the divorce or separation.

Refund of the unearned premium

If the Applicant, the Policyholder or the Company cancels the Policy after the fifteen (15)-day period allocated to examine it, or after it has been reinstated or renewed where there is no utilisation, 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 or refunded.



If the Company cancels or rescinds the Policy, any premium already received will be used to cover claims filed against the Policy.

If the premium received does not cover the claims paid, the Company may coordinate with the Broker or directly with the Policyholder or the Contracting Party, at its sole discretion, to recover the outstanding payment paid against the Policy which due to rescission or cancellation becomes an ineligible benefit.

4.12 Notification of divorce or legal separation of the Policyholder

In case of legal separation or divorce, the Policyholder must notify the Company within thirty (30) days of the event. The Insured Dependant Spouse or Domestic Partner may maintain their coverage until the end of the Policy Year, if accepted by the Policyholder. The Company may approve the Insured Dependant Spouse's or Domestic Partner's own Policy under another plan, with Deductibles and conditions identical to the Policy he/she had prior to the divorce/legal separation. The Application and premium for the new Policy must be received within thirty (30) days of being removed from the coverage on which he/she was an Insured Dependant.

4.13 Policy reinstatement

If the Policy is cancelled for non-payment, the Insured may submit a new application to reinstate it. The Company reserves the right to approve or deny such Application.

4.14 Reimbursement of the unearned premium due to the Policyholder's death

In the event of the death of the Policyholder, the Company will pay any pending reimbursement for benefits to the Beneficiary(ies) listed in the Application (if applicable), or the heir(s)/heir(s) or inheriting entity(ies) of the deceased Policyholder.

In the event of the death of an Insured Dependant, the unearned premium will be reimbursed to the Policyholder. In both cases, the Company must receive the corresponding legal documentation.

4.15 Deductible and optional coinsurance

Each Insured can voluntarily elect to have an annual Deductible, an Outpatient Coinsurance or an Outpatient Per Visit Excess to reduce the cost of the annual premium.

The annual Deductible will apply to all eligible services (both inpatient as well as outpatient) which the Insured should pay before the benefits of this Policy becomes payable.

4.16 Tools and resources for the Insured

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

- A** Viewing Policy information, such as Insured Dependents, exclusions, Amendments, and upcoming premium payments;
- B** Downloading Policy documents such as the Welcome Letter, Certificate of Insurance and ID cards;
- C** Accessing the Plan Overview and Policy Wording of their plan;
- D** Downloading Claim form and payment information document;
- E** Submitting a claim; and
- F** Contacting VUMI®.



Insureds may access MyVUMI™ at www.myvumiportal.com, or by downloading the mobile app from the Apple® App Store® or Google Play™ for Android™.

All trademarks belong to their respective registered owners.

4.17 Medical records

The Policyholder, because of the underwriting and/or claims process, must provide the Company, at any time and at the first request, with all the medical information required.

The Policyholder is required to notify the Company of any changes in their medical condition(s) from the time of declaration at application stage, until the Policy inception and the date payment is made. Failure to notify may result in Policy cancellation, rescission, or revision at the sole discretion of the Company.

Additionally, the Policyholder, as well as his/her Insured 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.

4.18 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. 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 filing 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.

Coverage order when other insurance exists

When there is any other insurance Policy, it must cover the expenses as primary while this Policy will act as secondary.

Travel policies

In the event the Insured has a travel policy, it will be considered the primary policy. Once the medical benefits of said travel policy have been exhausted, this individual Policy would cover the claims pending coverage.



Group or corporate policies

Where an Insured holds both an individual policy and a group policy with the Company, the group policy shall serve as the primary policy. Any eligible charges not covered or remaining after the group policy benefits have been exhausted may then be submitted under the individual policy.

4.19 Expiration of claims

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 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.

4.20 Clerical errors and administrative oversights

Administrative or clerical errors made by the Company, its authorised representatives, or network providers during the administration of this Policy including, but not limited to enrollment, eligibility verification, prior coordination, or claims processing, will not invalidate coverage that otherwise should have been approved, nor will extend or validate coverage that should have been denied or terminated under the terms and conditions of this Policy.

Upon discovery of any such error, the Company reserves the right to amend the record, including retroactively adjust corresponding premiums, modify or cancel authorised benefits, or recover any over-payment or amounts paid in error directly from the Contracting Party or the Provider.

SECTION 5. BENEFITS AND PROVISIONS

Unless stated otherwise, benefits are offered per Insured, per Policy Year according to the chosen Deductible. 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.

5.1 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, except those countries sanctioned by the competent authorities.

INPATIENT BENEFITS

5.2 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.

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



5.3 Coverage for Standard Private Hospital Room

The coverage for the Hospitalisation of an Insured in a Private Hospital Room (room and associated medical costs) is one hundred percent (100%) UCR.

OUTPATIENT BENEFITS

5.4 Complementary therapies

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

This benefit covers only consultation and therapy, when prescribed, and must be Pre-authorised by the Company after every ten (10) sessions and is only available on a reimbursement basis. This benefit excludes medicine prescribed by complementary therapists, as well as podiatry and chiropody treatments.

5.5 Day-Care Treatment

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

5.6 Surgeon, Assisting Surgeon and Anaesthesiologist Fees

Surgeon, Assisting Surgeon, and Anaesthesiologist Fees are covered based on the Usual, Customary and Reasonable (UCR) percentages applicable to the surgical team for the particular procedure(s) of the case, or based on special rates that have been established, previously contracted and/or paid by the Company for the geographic area, country or specific Provider where the Insured receives such services.

5.7 Hormone replacement therapy to relieve the symptoms of menopause

Hormone replacement therapy is covered up to two hundred fifty dollars (US\$250) per Policy Year for treatments to relieve the symptoms of menopause, including Prescription Drugs, patches and implants.

5.8 Nurse Care or Therapist Services at home

The coverage for this benefit is one hundred percent (100%) UCR for up to a maximum of ninety (90) 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 Physician. In all cases, the Company must receive the treatment plan, along with the estimated fees, as well as evidence of Medical Necessity of said treatment plan. The Company will evaluate the need and time required for specialised medical care, in order to adjust it in case of prolonged treatment.

Home medical care includes services that can only be provided by certified professionals (Nurses or therapists) and it does not include Custodial Care, as defined in this Policy.

5.9 Outpatient surgery

The coverage for Outpatient surgery is one hundred percent (100%) UCR.



5.10 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 to the Company along with the claim.

The Company will approve or provide the generic Prescription Drugs as the first option when available.

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 Highly Specialised Prescription Drugs, by either receiving treatment with the specific Provider designated by the Company or according to the delivery method available.

This benefit excludes Inpatient or Outpatient 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) or the European Medicines Agency (EMA).

5.11 Travel vaccinations/preventive medication

Travel vaccinations and/or preventive medication are covered up to two hundred fifty dollars (US\$250) per Policy Year for vaccinations, immunisations and preventive medications that are required or recommended for overseas travel.

MATERNITY BENEFITS

5.12 Maternity and Birth Complications

The coverage for Maternity and Birth Complications, as defined in this Policy, is 100% UCR. This benefit is subject to a twelve (12)-month Waiting Period.

There are several indicators used to determine whether a complication exists. These indicators are identified through medical monitoring during pregnancy or labor and provide information regarding the condition of the foetus, the cervix, and the mother.

The Company will provide Maternity and Birth Complications coverage for expenses related to:

- A** Pregnancy termination including, but not limited to, threatened miscarriage, miscarriage, ectopic pregnancy, or premature rupture of membranes, when the severity or progression of the condition requires hospitalisation or surgery.
- B** Medical and surgical care required for the foetus in utero.



- C** Complications arising during a normal delivery or cesarean section, the resolution of which requires extraordinary medical treatment, additional surgeries, and/or admission of the mother, the Newborn, or both to an intensive care unit.

The Maternity Complications benefit ends upon exhaustion of the benefit or the mother's discharge, whichever occurs first. The Birth Complications benefit ends upon exhaustion of the benefit, the Newborn's discharge, or thirty (30) days if the Newborn is not added to the Policy within the required period, whichever occurs first.

This benefit does not apply to conditions that are a result of a fertility treatment or any other type of assisted reproductive procedure, or for pregnancies or births that are not covered by this Policy. Complications as a result of fertility treatments and/or artificial insemination (IVF) will be payable only under the Maternity care benefit limit.

Exclusions*

The following are not considered Maternity Complications:

- A** Normal course pregnancies or pregnancies requiring special care;
- B** Bed rests prescribed by a Physician and medical leave which do not require Hospitalisation;
- C** Any typical symptoms of a pregnancy, such as vaginal discharge;
- D** An elective cesarean section, including a repeat cesarean section, with or without medical justification, and where the surgical and postoperative course results in standard medical care;
- E** Care or treatment of a chronic disease not related to the pregnancy, even when special or specific care or treatment is required during the gestation period;
- F** Complications of a pregnancy resulting from fertility treatments; and
- G** Complications of a pregnancy not covered by this Policy.

*This list is not exhaustive. Other situations may need to be considered based on the medical progress of the pregnancy and delivery, and additional testing.

5.13 Maternity care

- A** The benefit for maternity care is up to a maximum of twelve thousand five hundred dollars (US\$12,500) per pregnancy. Any voluntary Deductible, Outpatient Coinsurance or Outpatient Per Visit Excess will apply to this benefit;
- B** The maternity coverage always carries a twelve (12)-month Waiting Period;
- C** In case of Domestic Partners or two married women, only one (1) of them will be entitled to Maternity benefits in the same Policy Year. The Maternity benefit under this Policy is only for Insureds who qualify. It is not available for male Insureds or surrogate mothers;
- D** The maternity benefits do not apply to Insured Dependant daughters. Any primary Insured who has previously been an Insured Dependant daughter under another Policy with the Company or one of its affiliates, must have maintained her own individual Policy for a minimum of twelve (12) months in order to be eligible under the maternity care benefit;
- E** The maternity care benefits include natural deliveries, caesarean deliveries, prenatal care and postnatal care for up to thirty (30) days from the date of discharge including, but not limited to consultations, laboratory tests, ultrasounds, and genetic testing. This benefit will cover only one (1) Insured's pregnancy at a time.



5.14 Newborn cover

Medical expenses for Injury or Illness of the Newborn, such as respiratory distress, prematurity, hypoglycaemia, Congenital and Hereditary Conditions, low birth weight and birth trauma, which were diagnosed within the first thirty (30) days of life, will receive coverage up to one hundred thousand (US\$100,000) 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 thirty (30) days of life, and the premium must be paid. Where underwriting and the Newborn's medical history is required to add the Newborn, restrictions to this benefit may apply.

The coverage for expenses additional to the maximum benefit limit of Birth Complications will only be effective if the Newborn of a covered Maternity is added in the Policy as an Insured Dependant. To add a Newborn to the Policy, the Insured must send the birth certificate and/or the Newborn's personal information to the Company, and the premium must be paid within the thirty (30)-day period after the birth. In the event of multiple births covered by the Policy, each Newborn will have coverage up to the maximum of this benefit, provided that each Newborn is included in the Policy according to Section 3.2 of this Policy.

MEDICAL EVACUATION BENEFITS

5.15 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.

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. No benefit will be provided if the Company does not receive a request for Pre-authorisation and coordination of this Emergency service.

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.

Liability and hold harmless clause

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.

5.16 Emergency transportation by Ground Ambulance

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

Liability and hold harmless clause

The Insured, by accepting these Emergency transportation services by Air or Ground Ambulance, 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.

5.17 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 benefit is not available for a stillborn.

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 ten thousand dollars (US\$10,000) 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, either from 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.



GENERAL BENEFITS

The following benefits offer the same coverage for both Inpatient and Outpatient procedures, unless otherwise stated.

5.18 Psychiatric treatment

Inpatient 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 five thousand dollars (US\$5,000) per Insured, per Policy Year for Outpatient psychiatric treatments, only when it is Medically Necessary and is under the care a licensed psychiatrist. This coverage must be coordinated and approved in advance by the Company.

5.19 Congenital and/or Hereditary Conditions

Any Congenital and/or Hereditary Condition that manifests after the Insured's first thirty (30) days of birth is covered up to one hundred thousand dollars (US\$100,000) per Insured, per Policy Year.

Congenital and/or Hereditary Conditions that manifest within the first thirty (30) days of birth are covered under the Newborn coverage benefit.

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

This benefit includes Gene Therapy required for the treatment of any Congenital and/or Hereditary Condition.

These benefits exclude Insureds who are the product of any type of fertility treatment or procedures for assisted fertility.

5.20 Oncology

The coverage for Inpatient or Outpatient cancer tests, treatment (chemotherapy and/or radiotherapy) and Medication is one hundred percent (100%) UCR.

Gene Therapies for cancer treatment must be coordinated and approved in advance by the Company. To optimise this benefit, the Company highly recommends that such services be rendered through its network of Providers.

5.21 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 Inpatient, Day-patient or Outpatient are covered at one hundred percent (100%) UCR.

5.22 Durable Medical Equipment and external prostheses

When Medically Necessary, Durable Medical Equipment and external prostheses are covered up to a total



combined amount of two thousand dollars (US\$2,000) per Policy Year, as long as the Insured presents a prescription from a Physician or licensed Provider that justifies a therapeutic benefit for the Insured. The allowable rental fee of the equipment must not exceed the purchase price. This coverage must be coordinated and approved in advance by the Company.

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.

Durable Medical Equipment excludes, among others, 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. This list is for illustrative purposes only. To determine if Durable Medical Equipment is covered, the Company should be consulted.

5.23 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 Inpatient 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.

5.24 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. This benefit will not cover treatment for conditions discovered during the evaluation portion of the donation process, nor some post-donation follow-up expenses, transportation, lodging, childcare or lost wages;
- 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 and 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 Additional Coverage 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 receive a Pre-authorisation request as soon as it is determined that an Insured is a candidate for a Transplant in order for the benefit to be managed, coordinated and Pre-authorised by the Company. In order to optimise this benefit for the Insured, the Company will recommend the use of special Transplant Providers.

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.

Coverage is not provided if the procedure is expected to be futile due to co-morbid disease; or if post-transplantation care is expected to significantly worsen co-morbid conditions; or for organs sold rather than donated to a recipient; or for artificial organs; or for a human organ transplant service for which the cost is covered or funded by government, foundation or charitable grants. If the need for a Transplant is related to any of the exclusions of this Policy, coverage cannot be provided.

Coverage is not provided for services and/or expenses related to the donation of an organ, or any treatment required as a result of the donation process when an Insured is the Live Donor.

5.25 Rehabilitation therapies

The coverage for this benefit is one hundred percent (100%) UCR for up to a maximum of ninety (90) 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.

This benefit applies to treatment directly related to and following a hospitalisation covered by this Policy in order to restore bodily function. Treatment must start within thirty (30) days after the hospitalisation.

This benefit covers room and board in a recognised Rehabilitation Centre, and a combination of therapies such as physical, occupational and speech therapy after an event such as a stroke. Room and board is not covered when the treatment being given is solely physiotherapy. Any day in which the Insured receives Inpatient, Day-care, or Outpatient rehabilitation counts as one (1) day.

5.26 Reconstructive surgery and nasal or septum deformity

The reconstructive surgery shall be covered at one hundred percent (100%) UCR if and when it is Medically Necessary and as the result of an Accident, deformity or medical condition that is covered under the terms of this Policy.

Nasal or septum deformity

In 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.

In all cases, the Company may require copy of the reports, tests, films, discs or any other information necessary to evaluate the case.

5.27 Renal failure and dialysis

Renal failure and dialysis is covered up to one hundred percent (100%) UCR for treatments for renal failure.

5.28 Terminal Illnesses / Palliative Care

The coverage for Palliative and Hospice Care is one hundred thousand dollars (US\$100,000) 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 Inpatient, Day-patient or Outpatient 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.

5.29 Routine Management of Chronic Conditions

Routine management of Chronic conditions is covered at one hundred percent (100%) UCR unless such conditions are permanently excluded by this Policy or by the Company during the underwriting process through an Amendment included in the Certificate of Insurance.

5.30 Gene Therapy

This Policy will cover medical treatments that use genes to treat several diseases including, but not limited to somatic Gene Therapy, in vivo Gene Therapy, and ex vivo Gene Therapy (CAR T-cell), among others.



Gene Therapies for cancer treatment will be covered under the oncology benefit of this Policy. Gene Therapies to treat Congenital and/or Hereditary Conditions will be covered under the applicable benefit of this Policy. All other Gene Therapy treatments will be covered according to the limits for the inpatient or outpatient benefits of this Policy.

This benefit must be coordinated and pre-approved by the Company. To optimise this benefit for the Insured, the Company highly recommends that such services be rendered through its network of Providers. Coverage is limited to therapies that have been approved by the U.S. Food and Drug Administration as of July 1, 2026.

OTHER BENEFITS

5.31 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 Inpatient 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.

5.32 Emergency non-elective treatment outside the geographical area of cover

Emergency treatment for Injuries resulting from Accidents, which require Hospitalisation, while outside the geographical area of cover 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 cover of up to thirty (30) days of duration.

Outpatient 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 cover will take precedence.

5.33 Emergency or Urgent Outpatient Care

The coverage for Emergency or Urgent Outpatient Care is one hundred percent (100%) UCR resulting from an Accident or a condition covered under this Policy.

The benefit will cover medical evaluation which includes but not limited to stabilisation, pain management, minor emergency procedure such as wound suture, treatment of lacerations; fractures, dislocated joints, incision, drainage of abscess, emergency diagnostic testing (such as X-rays, ultrasound, EKG/ECG, basic lab testing and diagnostic tests for stabilisation) and emergency medication (emergency infection control, bronchodilators, anti-allergy medications) with/ without short stay observation.

Routine consultation, Chronic condition management, non-urgent diagnostic testing and minor ailments that can be treated on routine outpatient basis, do not constitute Emergency or Urgent Outpatient Care.



5.34 Hospital cash benefit

The coverage for this benefit is up to a maximum of thirty (30) nights, without Deductible, when an Insured person is admitted for Inpatient treatment and is receiving free-of-charge treatment that would have otherwise been eligible for coverage under this Policy.

The benefit will be based on the Usual, Customary and Reasonable, or up to three hundred and fifty dollars (US\$350) per night, whichever is lower.

5.35 Second Medical Opinion VIP®

The VUMI® Second Medical Opinion VIP gives Insureds access to the opinion of world-class medical experts from the comfort of their home. The doctors best suited to the medical condition will evaluate the case based solely on the Insured's medical history and the information that led to the first diagnosis. This service does not provide in-person consultation with any of the doctors providing their opinion.

To opt for this service, the Insured has to complete, sign and submit the form, along with the medical history, diagnosis, tests, copy of his/her passport or ID, and any other documentation relevant to the case to secondopinionvip@vumigroup.com.

IMPORTANT NOTE: The Second Medical Opinion VIP® recommendations do not alter, amend, or override the terms, conditions, or exclusions of this Policy. All claims and coverage determinations are subject to the specific provisions outlined in the Policy Wording.

5.36 U.S. elective treatment

Costs associated with eligible Inpatient, Day-patient and Outpatient 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.

OPTIONAL ADDITIONAL COVERAGE

5.37 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. No benefit will be provided if the Company does not receive a request for Pre-authorisation and coordination of this Emergency service.

5.38 Non-emergency evacuation

This benefit covers costs of an economy class ticket tickets for the round-trip 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 Inpatient 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.

5.39 Wellness and optical

Wellness

Wellness health check-ups and preventative vaccines 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, Outpatient Per Visit Excess or Coinsurance that might be applicable to the plan. These benefits are only available on reimbursement basis.



SECTION 6. GENERAL EXCLUSIONS

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

6.1 Medical care, off-label drugs and experimental treatments exclusions

- A** Non-Medically Necessary treatments and medical care not prescribed or recommended by a Physician: Any service, expense, treatment, Injury or Illness, or charges related to services or supplies that are not Medically Necessary; or provided or prescribed 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.
- B** Investigative or experimental procedures: Treatments not scientifically recognised or still in an Investigative phase or clinical trial, as well as those that have not been approved by the U.S. Food and Drug Administration (FDA) or the European Medicines Agency (EMA).
- C** Non-medically approved Medication: Any medication that is 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, and/or those not approved for the treatment of the specific condition of the Insured by the U.S Food and Drug Administration (FDA) or the European Medicines Agency (EMA).
- D** Experimental medication part of an experimental treatment: A Prescription Medication approved by the U.S Food and Drug Administration (FDA) or the European Medicines Agency (EMA). For the specific condition of the Insured, but that is used as part of an Experimental treatment.
- E** Complications caused by Experimental treatments: Any cost of service or treatment incurred by the Insured due to any complications arising out of, or resulting from, an experimental treatment received, or for any further treatment the Insured may need because of undergoing any experimental treatment, or the use of off-label or cocktail of drugs.
- F** Over the counter medication: Any medication, supplies or medical devices that may be acquired without a Physician's prescription, known as over-the-counter (OTC) medications, even if recommended by a Physician, including, but not limited to analgesics, organic supplements, food supplements; hunger suppressants; vitamins; emollients, moisturisers, gels, and skin-care, herbs; anti-aging; or hair growth medications or products.
- G** Treatments rendered outside the effective period of the Policy: Claims and costs for medical services with dates of service after the Policy Expiration Date that are related to Accidents, Illnesses, or maternities originating during the Policy period, unless the Policy has been renewed before the expiration of the Grace Period. This includes any portion of a covered prescription to be used after the expiration of the current effective period of the Policy.
- H** Treatments for undeclared Pre-existing Conditions: Any Pre-existing Condition not declared in the Application. This also includes any cause, complication and treatment related to any individual condition excluded in this Policy.



- I** Routine exams: 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, Optometry services, eye glasses and contact lenses; prophylactic treatments; hearing loss; and the issuance of medical certificates and physical exams for work or travel, except as specifically provided in Sections 5.11 and 5.39 of this Policy.
- J** Aesthetic or cosmetic treatments: Any type of elective or cosmetic surgery, or treatments whose principal purposes are aesthetic, except when it is necessary due to an Injury, or an Illness that caused a deformity that is affecting a body function, that occurred due to a covered condition and during the effective period of this Policy. This includes, but is not limited to services rendered for cosmetic purposes, including hair transplants; alopecia treatment; any type of body piercing; breast reductions; breast implants; and any treatment for nasal or septum deformities, except as specifically provided in this Policy.
- K** Complications of non-covered services: Complications resulting from non-covered services, as well as the diagnosis or treatment of any condition which arises as a complication of a non-covered service.
- L** Maternity and Birth Complications treatments for a non-covered maternity: Any expense for the treatment of the mother or the Newborn related to a non-covered maternity, including any complication, as well as Maternity and Birth Complication expenses for Insured Dependant daughters.

Any voluntary termination of pregnancy (legal or illegal), unless it is prescribed because the mother's life is in imminent danger, or in the case of a rape legally reported to the corresponding authorities.

- M** Medical expenses for sterilisation, fertilisation treatments: Any portion of a medical expense incurred in male or female sterilisation; sterilisation reversal; birth control; infertility treatments; artificial insemination; in vitro fertilisation services; tests, treatments and/or procedures of any kind including, but not limited to, fertility/infertility drugs, including drugs to regulate the menstrual cycle/ovulation for family planning purposes; artificial inseminations; invitro fertilisation; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); surrogate mother; and all other procedures and services related to fertility and infertility, unless expressly covered by the plan.

Any pregnancy resulting from such treatments, complications of that pregnancy, and postpartum care, unless stated on the Table of Benefits of the Policy. The delivery will be covered up to the maximum maternity care benefit specified on the Table of Benefits, but will not be considered a Covered Maternity for any other benefits of this Policy like Birth Complications services and the automatic inclusion of the Newborn in the Policy.

Any consequences or 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; or psychosexual dysfunctions.

All Genetic Tests including, but not limited to tests to determine paternity or the sex of a child, except Genetic Tests required for the treatment of compensable conditions, as determined and preapproved by the Company.

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 to treat neurogenic or vasculogenic impotence



caused by an Accident or a medical condition that has lasted for more than one (1) year, including, but not limited to a spinal cord Injury/disease, multiple sclerosis, spina bifida, diabetes, radical prostatectomy, rectal surgery, intrapenile arterial disease, status post cavernosal infection, or Peyronie's disease.

- N** Obesity and weight control treatments: Any treatment, expense or service to prevent obesity or for weight control, whether it is weight loss or gain, and any alterations in the body size, including any type of food supplement.
- O** Growth hormones treatments: Treatments with growth hormones or bone growth stimulants, or any treatment related to the growth hormone, regardless of the reason it was prescribed.
- P** Dental or orthodontic treatments: Any expense for dental or orthodontic treatment including, but not limited to abnormalities of the upper maxillary, disorders of the mandible or the mandibular articulation including, but not limited to its anomalies and malformations, 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 linked to said articulations, except as provided in Section 5.31 of this Policy for Accidental treatments.

6.2 Patient services exclusions

- A** 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 Outpatient medical Services, unless said admission was approved by the Company.
- B** 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.
- C** Excessive expenses over UCR: 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 if the benefit is covered at one hundred percent (100%), it will be subject to these limitations and any excess will be the responsibility of the Insured.
- D** Extended care: Treatments in mental health centres or psychiatric institutions; nursing homes for the elderly; home care services beyond the reasonable time to cure or heal a condition; assisted living facilities; hospices; Long-Term Care Facilities; hydro-clinics; health spas and memberships to gymnasiums except as provided in Sections 5.18 and 5.28 of this Policy.
- E** Counseling services: Any expense related to recreational or educational therapy; marriage relationship counseling; services of adoption agencies; pastoral counseling; family, social, occupational, religious, or other social maladjustment counseling; chronic behaviour disorders; codependency; impulse control disorders; organic disorders; learning disabilities; hyperkinetic syndrome. This includes any Prescription Medication for treatment associated with any of the above conditions.



- F** Mental health treatments: Services for mental and nervous disorders and related Prescription Medication except if they are required to treat a covered Psychiatric Illness, as defined in the terms and limits of this Policy, and except as provided specifically in Section 5.18 of this Policy.
- G** Custodial Care: Assistance with household chores or for personal hygiene; any other personal services offered for comfort including, but not limited to beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, and travel expenses, other than Medically Necessary Emergency Ambulance services that are specifically provided in this Policy.
- H** Charges for treatments provided by immediate relatives: Charges for Physicians' services imposed by an immediate relative or member of the Insured's household, even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation.

This exclusion also precludes an Insured who is also a Physician from treating himself/herself and submitting claims for such coverage. For the purpose of this exclusion, immediate relative means any of the following: husband or wife; natural or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law, mother in-law, son in-law, daughter-in-law, brother-in-law or sister-in-law; grandparent or grandchild; spouse of grandparent or grandchild.

The Company reserves the right to authorise the treatment provided by the family member or the use of the Provider's facilities.

- I** Foetal 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.
- J** Hazardous activities and Professional Sports: Any 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. Any additional flying as a pilot in a non-commercial and/or light aircraft activities that the Company may deem to be a hazardous sport such as winter sports, or when required and appropriate safety equipment recommended is not adhered to.

Any treatment for Injuries or Illnesses related to the Insured's participation in any sports show, race, or competition, including any training; base jumping; paragliding; hand gliding; flying as a pilot in a non-commercial and/or light aircraft; scuba diving below twenty (20) meters; mountaineering and/or trekking that requires specialised equipment and/or that occurs above eleven thousand five hundred feet (11,500 ft.) or three thousand five hundred meters (3,500 m.); sailing or operating boats outside of territorial waters; skiing/snowboarding off piste, or any other winter sport off piste; and any expeditions in Mount Everest, K2, Kilimanjaro, the Arctic, Antarctica, the North Pole or Greenland.

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



- M** 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.
- N** Administration / registration fees: Administration and/or registration fees in relation to received medical treatments, unless the Company at its reasonable discretion agrees that such fees are proper and usual accepted practice in the relevant country.
- O** Allergy tests: Any expenses incurred for allergy testing even when prescribed by a medical practitioner.
- P** Maternity exclusions: a) Home births, maternity preparation classes, and lactation consultants; b) all Maternity benefits for Insured Dependant daughters.
- Q** Expenses when the Insured travels against doctor's orders: Any medical expenses when the Insured has travelled against any healthcare professional's medical advice.
- R** 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.
- S** Treatment outside the selected area: Any treatment received outside the geographical scope selected.

6.3. Medical Equipment and supplies exclusions

- A** Podiatric care: routine foot care, as well as any service or supply in connection with medical care, including but not limited to the treatment of flat feet, fallen arches, and chronic foot strain; removal of warts, corns or calluses; special shoes; any type of orthopedic inserts; pedicures or trimming of toenails.
- B** Artificial kidney equipment: Any portable or home-use artificial kidney equipment.
- C** Artificial or animal organs, cryopreservation, and storage of tissues and Stem Cells:
Any expense related to:
 - The acquisition and implantation of artificial organs (e.g., artificial heart) or organs obtained from animal sources;
 - The cryopreservation; or
 - Storage of bone marrow, tissues, Stem Cells, or umbilical cord blood beyond twenty-four (24) hours, except when Medically Necessary for diagnostic testing.
- D** Duplicate Durable Medical Equipment:
Any expense related to:
 - Duplicate equipment serving the same medical function as an existing covered device;
 - The loss, repair, or replacement of Durable Medical Equipment, unless the equipment has reached the end of its manufacturer-defined useful life and the original equipment was covered under this Policy; or
 - General-use consumer items which do not meet the primary criteria for Durable Medical Equipment, even



if prescribed by a Physician or useful for a patient's comfort or reduction of physical strain including, but not limited to ergonomic mice and keyboards.

6.4. Exceptional risks exclusions

- A** Reckless Behaviour: Services, care and treatment, without limitations, incurred in connection with Injuries that occurred from Negligent, Gross Negligent or Reckless Behaviour or Willful Misconduct of the Insured, as determined by the Company.
- B** Wild animal encounters: Injuries or expenses resulting or arising from encounters with wild animals where an Insured:
 - Voluntarily provoked, handled, or disturbed such animals;
 - Was engaged in the professional or recreational handling of wild or dangerous animals; or
 - Acted Negligently or engaged in Reckless Behavior in circumstances where a reasonable person would have foreseen the risk of such encounter and taken reasonable precautions to avoid it.
- C** Disorderly conduct: Injuries or expenses for participating in fights, including when members of his/her family take part in it, unless the Insured is acting legitimately, in self-defense, as determined by a court of law.
- D** Criminal acts: Injuries and/or Illnesses resulting or arising from or occurring during the commission or perpetration of a violation of the law by an Insured.
- E** Self-exposure to Injuries: 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, or disregard for the rights and safety of himself/herself or others, except in an endeavor to save human life.
- F** Self-inflicted Illness or Injury: Treatment for any conditions as a result of self-inflicted Illnesses or Injuries, suicide or attempted suicide, while sane or insane, or Emergency air services for the same.
- G** Substance Abuse and Related Conditions: Treatment, services, supplies, rehabilitation, or complications arising from or related to alcohol abuse, drug use, substance dependency, chemical dependency, or the non-medical use of prescription medications or controlled substances. This includes any illness, injury, accident, or medical condition resulting from intoxication by alcohol or under the influence; use of illegal drugs or narcotics; or misuse of prescription medication or controlled substances.

The application of this exclusion shall not require a police report, criminal charge, criminal conviction, arrest, citation, or legal determination of intoxication. It shall apply whenever the available evidence, as defined in this Policy, reasonably demonstrates that such use, abuse, misuse, or impairment was a direct cause of, or material contributing factor to, the condition for which benefits are claimed.

- H** Expenses covered by third parties: Healthcare services resulting from accidental bodily Injuries arising out of a motor vehicle, watercraft or aircraft Accident, or any other type of Accident, whether in public or private transportation, business, residence, etc. where the incident that injures the Insured is covered under any type of insurance, private or public, regardless of whether the Insured sues a third party for liability. Care and treatment



for any Injury, Illness, or condition for which the Insured is paid benefits under any workers' compensation law, employer's liability policy, or any similar policy.

- I** Expenses for services or medical treatment for a declared Epidemic or Pandemic: 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), the United States Centers for Disease Control and Prevention (CDC), or any other government, governmental agency or governing body of the country where the Epidemic occurred. In addition, such coverage is also excluded if there has been an official warning issued against travel to the area by the State Department or similar office, the embassies of the affected countries, the airline, or another government agency, before traveling to the affected country, except when the exposure occurs accidentally or unknowingly while traveling to or from undeclared risk areas, or because of visiting the area prior to the declaration of an Epidemic or Pandemic.
- J** Injuries as a result of active duty, war or participation in 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 and provided that the Insured had not, at the time of the incident, put themselves in danger by entering or remaining in any country, region, or area against which a government authority in the Insured's country of residence, or the country of travel, had issued an official travel advisory or warning recommending against all travel or all but essential travel, prior to or at the time of such entry.

*"Indirect" participation activities which merely support any of the parties in conflict. Such indirect activities include, but are not limited to selling goods to one or more of the armed parties. Injuries caused by indirect participation in war or conflict include any support of a party involved in a conflict without directly engaging in combat, such as providing financial aid, supplying weapons, propaganda, or intelligence, essentially contributing to the war effort without actively fighting on the battlefield.
- K** 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.
- L** Expenses incurred 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, the United Kingdom, the European Union, or any of its entities or asset control agencies.



SECTION 7. MANAGEMENT OF THE POLICY

7.1 Medical Notifications and/ or Pre-authorisations

To better serve our Insureds, it is strongly recommended that the Insureds notify the Company when receiving or planning to receive medical treatment, be it in a Hospital or as an outpatient. See the mandatory Pre-authorisation Section 7.2 for those services that require Pre-authorisation.

These Notifications give the Company an opportunity to verify the terms and conditions in which the treatment will be covered, as well as make suggestions about the best places for the Insured's care, provide logistical support and, whenever possible, make arrangements to establish direct payment to the Hospital or Doctor of choice, thereby reducing the possibility the Insured will have to incur an unexpected or excessive out-of-pocket expense.

Please note a Notification is not the same as a Pre-authorisation.

7.2 Benefits requiring Pre-authorisation

Insureds must notify the Company seventy-two (72) hours prior to receiving those medical services that require Notification or Pre-authorisation, pursuant to Section 7.1 of this Policy. Pre-authorisation requests for elective services must be sent to the Company at least three (3) business days prior to the date of the service. 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.

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** U.S. elective treatment
- B** All Hospital admissions;
- C** All Hospital or outpatient surgeries;
- D** Complementary therapies after ten (10) sessions;
- E** Any major procedure, such as MRIs, CT scans, PET scans, gastroscopies, colonoscopies, biopsies, etc.;
- F** Physical and rehabilitative therapy, home health care or Private Nurse or Therapist;
- G** Reconstructive surgery;
- H** Refractive eye surgery;
- I** Emergency transportation by Air Ambulance;
- J** Durable Medical Equipment or any special medical device;
- K** Repatriation or cremation of mortal remains, whereby a Pre-authorisation must be made on behalf of the Insured;
- L** Any medical service or purchase of specialised drugs, such as those related to the Human Immunodeficiency Virus (HIV) or the Acquired Immune Deficiency Syndrome (AIDS);
- M** Organ and tissue transplants; bone marrow, stem cell Transplants, and any other similar procedure;
- N** Oncologic treatment; and
- O** Extended care / inpatient rehabilitation;



- P** Dialysis
- Q** Psychiatric treatment;
- R** Terminal illness / Palliative Care; and
- S** Gene Therapies.

ALL PRE-AUTHORISATIONS MUST HAVE A WRITTEN RESPONSE FROM THE COMPANY.

To request a Pre-authorisation, the Insured can send an email to **notifyglobal@vumigroup.com/**
customerserviceglobal@vumigroup.com.

This is the only acceptable method to request mandatory Pre-authorisation.

It is the Insured's responsibility to obtain a Pre-authorisation from the Company.

To request a Pre-authorisation, the Insured must send the following required documentation to the Company:

- A** Policy number and full name of the Insured receiving medical services;
- B** Name of the Provider (i.e. hospital, facility, Physician, therapist)
- C** Place where treatment will be performed (city and country)
- D** Service date;
- E** Medical records signed and sealed by the treating/ordering Physician, including:
 - Past medical and surgical history (with dates of onset)
 - History if present illness/diagnosis (with dates of onset)
 - Treatment/services planned
- F** Estimate costs.

Medical Emergency authorisations must be requested within forty-eight (48) hours of the admission or procedure. In instances of medical Emergency, the Insured should go to the nearest Hospital or Provider for assistance, even if that Hospital or Provider is not part of the network. If treatment would not have been approved by the Pre-authorisation process, all related claims will be denied.

7.3 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 appropriate security guarantees.

It is understood that the Insured has given his/her consent in the insurance Application 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 Broker or when required by law or the procurement or administration of justice. The Insured may revoke this authorisation to share their private health information with their insurance Broker at any time by notifying the Company in writing.

7.4 Limited liability

The Company will not be responsible for any loss, damage or Illness 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 complaint directly to the medical service Provider or the person who has offered the service.

7.5 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 obliged 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.

Bank transfers fees

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.

Information required to submit a claim

The Company shall receive all medical and non-medical information required in order for the claims process to begin. The Insured must send the following documentation to the Company:

- 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, any other information available from any other third parties involved in the matter, be it an individual or a company, including their personal or company information, available insurance information (pertaining to the case), and any other information that is useful to establish civil and criminal liability (if applicable) and a possible coordination of benefits; and
- 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 letter 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 Pre-existing 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.

7.6 Appeals

Initial appeal

In the event the Insured disputes or disagrees with the Company's administrative disposition or decision regarding any claim submitted by the Insured under the Policy, and before the Insured commences a legal proceeding against the Company, the Insured shall be required to submit an appeal of the Company's disposition or decision by letter to the Company's Appeals Committee. The Insured's appeal must be submitted to appeals@vumigroup.com within thirty (30) days of the Company's disposition or decision of the claim. The Insured's letter must include all information and documentation relevant to the Insured's appeal.

The Company's Appeals Committee shall review any information and documentation provided by the Insured and shall notify the Insured of its decision in writing within thirty (30) days of receipt of the Insured's letter. The Company's Appeals Committee shall have the right to request additional information or documentation from the Insured or the Insured's Providers, third parties or entities, if deemed necessary by the Company, to evaluate the Insured's appeal. The Company shall have the right to extend the deadline to respond to the Insured's appeal by thirty (30) days in order to receive and review any additional information or documentation provided.

Second appeal

Once the Company's Appeals Committee has notified the Insured of its decision concerning the Insured's appeal, the Insured may, but is not required to, submit an objection to the Company's Appeals Committee within ten (10) days from the date of the notification. If the Insured has new information or documentation that the Insured would like the Company to consider, the Insured may submit it, along with a second letter, to the Company. The Company shall respond to the Insured's second appeal within fifteen (15) business days. The Company's decision with regard to the Insured's second appeal shall be final and not subject to further appeal.

As a mandatory condition precedent to the filing of a claim in any legal proceeding, the Insured and the Company shall attempt, in good faith, to resolve any dispute, controversy or claim through informal settlement discussions for a period of thirty (30) days.



7.7 Governing law

This Agreement and the transactions contemplated herein shall be governed by, construed, and interpreted in accordance with the laws of the State of Florida, without regard to Florida's choice of law or conflicts of law rules. Notwithstanding the foregoing, this Policy is not subject to regulatory oversight by the State of Florida and does not provide any benefits or coverages mandated by Florida law or U.S. federal law.

Jurisdiction and venue

The parties agree that the exclusive jurisdiction and venue over any claims, disputes, lawsuits, actions, litigation or legal proceedings arising out of, relating to, or concerning the agreement of the Policy shall be vested exclusively in the state or federal courts located in Miami Dade County, Florida, and the parties hereby expressly consent to the jurisdiction of such courts and expressly waive any objections based on improper venue, lack of personal jurisdiction, lack of long-arm jurisdiction, or forum non convenient.

WAIVER OF JURY TRIAL

THE PARTIES TO THE AGREEMENT AND POLICY AND ALL INSUREDS UNDER THE POLICY HEREBY KNOWINGLY, INTENTIONALLY, VOLUNTARILY, AND IRREVOCABLY WAIVE ANY AND ALL RIGHTS TO A TRIAL BY JURY AFFORDED BY U.S. OR FLORIDA LAW IN ANY LEGAL OR OTHER PROCEEDING RELATING IN ANY WAY TO, CONCERNING, OR ARISING OUT OF, DIRECTLY OR INDIRECTLY, THE AGREEMENT BETWEEN THE POLICYHOLDER AND THE COMPANY, THE POLICY, THE CERTIFICATE OF COVERAGE, THE CONDITIONS OF COVERAGE, ANY AMENDMENTS OR RIDERS TO THE POLICY, THE APPLICATION SUBMITTED BY THE PARTIES OR INSUREDS, THE FORMATION, INTERPRETATION, BREACH OR TERMINATION OF THE POLICY, OR THE TRANSACTIONS CONTEMPLATED HEREIN. THIS WAIVER OF JURY TRIAL EXTENDS TO ALL DISPUTES, CONTROVERSIES OR CLAIMS WHETHER BASED IN CONTRACT, TORT, COMMON LAW, OR STATUTE.

7.8 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 8. 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.

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 Broker

The individual or company authorised by the Company to distribute its products and provide administrative services to the Insureds. The Broker shall have access to the Insured's health and medical information, which can be sent to the Company or any of its affiliates. No Agency or Broker has the authority to modify the Policy or exonerate the Insured from 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 Insured Dependants. This form is used by the Company to determine the insurability of the Applicant and his/her Insured 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, such as routine patient care, surveillance, monitoring of signs, periodic turning and positioning in bed and administration of medications that may be self-administered or administered orally and by non-medically trained persons, as well as preventive or routine care; or care under standard conditions, including assistance in daily activities, for example: washing, bathing, feeding or dressing of an Insured, providing assistance for moving or mobilisation, making the bed and any other essential activities related to daily living, 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.

Available Evidence

Any information, documentation, record, statement, report, finding, or other material that is reasonably obtainable by the Company and that the Company would reasonably rely upon in evaluating a claim or determining the applicability of any Policy provision, limitation, exclusion, condition, or benefit.

Available Evidence may include, without limitation:

- A** Medical records, hospital records, physician notes, consultation reports, nursing notes, discharge summaries, and clinical assessments;
- B** Laboratory results, pathology reports, toxicology reports, diagnostic imaging, and other diagnostic or clinical findings;
- C** Emergency medical services records, ambulance reports, accident reports, incident reports, and records maintained by healthcare facilities;
- D** Statements, declarations, admissions, or representations made by the Insured, beneficiaries, family members, witnesses, treating providers, employers, agents, or other persons with relevant knowledge;
- E** Pharmacy records, prescription histories, medication administration records, and prescription monitoring data where legally available;
- F** Governmental, regulatory, law enforcement, immigration, customs, or public authority records to the extent legally obtainable;
- G** Travel records, employment records, attendance records, and other records relevant to the circumstances of a claim;
- H** Photographs, videos, audio recordings, electronic communications, social media content, or other digital evidence to the extent legally obtainable and relevant to the claim; and
- I** Any other credible and relevant information reasonably related to the claim or the application of any Policy provision.

The Company shall evaluate Available Evidence based upon the totality of the information obtained and may make claim determinations where the Available Evidence reasonably demonstrates that a Policy exclusion, limitation, condition, or other provision applies.

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.



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.

Clinically Significant

Practical, real-world impact of a medical treatment, intervention, or research finding on a patient's daily life, health, or prognosis. It measures whether a change is meaningful, rather than just statistically possible, focusing on whether a treatment genuinely improves health outcomes.

Company

The insurer, VUMI® Group, I.I.

Chronic Condition

A medical condition which has two or more of the following characteristics:

- A** It has no known recognised cure;
- B** It continues indefinitely;
- C** It has come back;
- D** It is permanent;
- E** Requires palliative treatment;
- F** Requires long-term monitoring, consultations, check-ups, examinations or tests;
- G** You need to be rehabilitated or specially trained to cope with it.

Congenital Conditions

Any condition, organic disorder, malformation, embryopathy, persistency of embryonic or foetal tissue or structure, which has been acquired during the development of the foetus 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 Insured 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 and receive the unearned premium. When applicable, 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 spends or intends to spend more than one hundred and eighty-three (183) days within a calendar year or Policy Year, or the majority of the time during a Policy Year.

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. In addition to the plan's annual Deductibles, the Company may impose, in the Certificate of Insurance, additional Deductibles: per Policy Year and/or for the life of the Policy.

Doctor

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

Domestic Partner

Person 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.

Emergency or Urgent Outpatient Care

Prompt medical treatment for acute illnesses or injuries that require immediate attention but do not necessitate a formal hospital admission. These services are provided in emergency departments, urgent care centres, or equivalent facilities, where patients are evaluated and treated without requiring formal hospital admission.

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 U.S. Food and Drug Administration (FDA) or the European Medicines Agency (EMA) 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.

Gene Therapy

Medical technology that aims to produce a therapeutic effect through the manipulation of gene expression or through altering the biological properties of living cells.

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 Condition

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.

Highly Specialised Prescription Drugs

Prescription Drugs that require specialised handling, administration, monitoring, storage, or clinical management due to their complexity, cost, limited distribution, or the nature of the medical condition being treated. These drugs are typically prescribed for chronic, rare, or complex medical conditions and may require ongoing supervision by a healthcare professional.

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 Inpatient 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.

Inpatient

Insured who receives 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 Insured 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 and Birth Complications

Morbid conditions, acute and unexpected events that occur during pregnancy, childbirth, or the postpartum period (after delivery), for which care exceeds the maternity care coverage, and, which may affect the mother, the baby, or both, resulting from the abnormal course of pregnancy and/or delivery. Some examples of complications include*, but are not limited to toxemia; eclampsia; ectopic pregnancy; hydatidiform mole;



ante- and post-partum hemorrhage; retained placenta membrane; stillbirths; miscarriage; placental abruption; placenta previa; failure of foetal descent; amniotic fluid embolism; prematurity; tight cord injury; foetal distress; perinatal asphyxia; umbilical cord problems; or shoulder dystocia.

*This list is not exhaustive. Other situations may need to be considered based on the medical progress of the delivery and additional testing.

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 Private Hospital 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.

Newborn

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

Notification

A communication to the Company about a procedure or treatment, requesting assistance with appointments or advice about specialists, providers, etc. A Notification doesn't count as a request of a mandatory Pre-authorisation for a service that requires more information about the use of one of the benefits of the Policy.

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.

Ophthalmology

Medical specialty that focuses on the eyes, including their anatomy, physiology, and treatment of complex eye diseases. Ophthalmologists diagnose, treat, and manage eye disorders, and they can perform surgery when necessary.

Optometry

Primary eye care providers who perform routine eye exams, prescribe eyeglasses and contact lenses, and manage common eye conditions.



Optional Additional Coverage

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.

Outpatient

Insured who receives any services or treatments that do not require a Hospital admission or Hospital stay for more than twenty-three (23) hours.

Outpatient Coinsurance

Uninsured percentage of the costs, which the Policyholder must pay towards the cost of a claim.

Outpatient Direct Billing Network

List of Hospitals and medical providers contracted by the Company for direct billing.

Outpatient Per Visit Excess

Uninsured amount payable by the Insured (per Outpatient consultation) when eligible Outpatient treatment is received.

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.

Pandemic

An occurrence in which a disease spreads very quickly and affects a large number of people over a wide area or throughout the world, which has been declared as such by the World Health Organisation (WHO), the Centers for Disease Control and Prevention (CDC) or an equivalent organisation.

Physician

Physician is a licensed healthcare professional who has earned a medical degree (M.D. or D.O.) and is qualified to practice medicine in a specific territory. They diagnose illnesses, treat injuries, and prescribe medications.

Physician Assistant

Physician Assistant, also known as a physician associate, is a licensed medical professional who practices medicine in collaboration or consultation with a Physician.

Policy

The set of documents describing the general and specific conditions agreed upon between the Company and the Insured, and which govern the insurance contract. For the purposes of this Policy, the terms “Agreement” and “Contract” shall have the same meaning and may be used interchangeably.

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.

Pre-authorisation

Request made by the Insured in order to obtain an authorisation from the Company to use one of the benefits of the Policy that requires this mandatory request about a treatment or procedure.

Pre-existing Condition

A condition which was diagnosed by a Physician prior to the Effective Date of this Policy or its reinstatement; or for which medical advice or treatment was 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.

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.

Private Hospital Room

Hospital room equipped to accommodate only one (1) patient, and does not include higher-tier accommodations and luxury rooms such as suites, VIP rooms, or deluxe rooms and the associated medical costs.

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.

Psychiatric Illness

A mental or nervous disorder that is associated with present distress, or substantial impairment of the Insured person's ability to function in a major life activity. The condition must be Clinically Significant and diagnosed and not merely an expected response to a particular event such as bereavement, relationship, or academic problems.

Reckless Behaviour

The conscious disregard of a substantial and unjustifiable risk.

Region

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

Rehabilitation Centre

A legally licensed facility that operates under the supervision of qualified medical professionals, primarily providing rehabilitative services such as physical, occupational, and speech therapy to restore function after



illness, injury, or surgery. This facility may be independent or part of a hospital but is distinct in its purpose and services.

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 as required by the standard protocol of care for treatment and services needed urgently, 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.

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 and its territories.

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.



VUMI® GROUP

ORGANISED UNDER CHAPTER 61 OF THE PUERTO RICO INSURANCE CODE.
NO COVERAGE ISSUED BY THIS INSURER IS PROTECTED BY ANY
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