Nomad Insurance Complete

This packet includes two separate insurance documents:

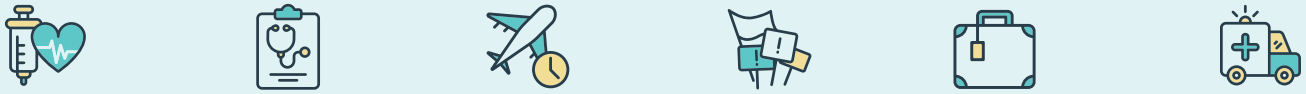
Nomad Travel: A selection of travel benefits underwritten by SafetyWing Insurance I.I., found on page 2.

Nomad Health: An international health insuranceplan underwritten by VUMI Group, I.I. found on page 24.

SafetyWing

SafetyWing (Managing General Agent), Ltd. is acting as producer for both plans. While offered together, these plans remain entirely separate and are independently managed.


Travel
by SafetyWing



What type of insurance is this?

SafetyWing's Insurance I.I's Nomad Insurance Complete travel portion is a global travel insurance, covering a selection of travel related costs. It covers unforeseen travel-related costs while you are outside your primary residence. This description of coverage includes all the information you need to learn exactly what is covered and not covered.

Who can get this insurance?

Most people aged between 18 and 65, from anywhere in the world, can get this insurance. The exception is residents (those living there for more than 6 calendar months out of the year) of Belarus, Canada, Democratic Republic of Congo, Ireland, Palau, Saudi Arabia, United Arab Emirates, and the USA and its territories.

Where can I use this insurance?

You can use this insurance in the vast majority of the world, but there are some exceptions:
→ You are not covered by this insurance in your **primary residence.**
→ You are not covered when traveling to the US, Hong Kong or Singapore unless you buy the optional add-on. If you are a resident of Hong Kong or Singapore, the add-on is required.
→ We will not provide cover and not be liable to pay any claim or provide any benefit under the Policy to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose us to any sanction, prohibition or restriction under United Nations resolutions or any trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America, including Puerto Rico.

What is covered?

Below are all the areas the travel portion of the plan will cover you when the Policy is active (your benefits). Each section is a condition of the Policy with a clear title, a description of what is covered which clearly sets out when we will pay. All your benefits will also be limited by other sections of this description of coverage, especially important is the section called "What is not covered?". This is why we encourage you to read the whole description of coverage.

Overview

❶ Delayed transportation

In the case of a delay of your transportation, you can get a reimbursement for incurred costs such as meals, lounge pass and accommodation.

Important conditions:

- → The delay is at least 3 hours for a $60 reimbursement, or at least 8 hours for a $150-$450 reimbursement ($150 per night after the initial 8 hours).
- → Your scheduled transportation by airplane/bus/train/boat that you had a valid ticket for, was delayed or canceled with no replacement within the time limits, or you were part of a traffic accident while on your way to the place of departure that caused you to miss the original departure incurring a rebooking later than the time limits.
- → Your transportation must have been arranged by a company that has scheduled routes and ticketed passengers (so for example a delayed taxi or rented bus is not covered).
- → For delays from the area of your **primary residence**, you are only covered for the shorter delay ($60).
- → You will need to provide the following documentation:
  - Proof of original booking
  - Proof of delay and replacement booking
  - A police report if the delay was related to a traffic accident that you were a part of

SafetyWing covers: $60 for a 3-8 hour delay or $150 for 8+ hour delays with an additional $150 per night after the initial 8 hours. Up to $450 per trip. Up to $900 per year.

❷ Delayed luggage

You are covered for checked luggage that doesn't show up with your flight or cruise, which is not returned to you within 6 hours after your arrival.

Important conditions:

→ You are not covered for homebound transportation.
→ You must have filed an incident report with the airline/cruise line.
→ You are not covered if customs or other regulatory authorities are holding your luggage.
→ You will need to provide the following documentation:
  - Proof of the booking (ticket or boarding pass)
  - Proof of delay (copy of the incident report)
  - Luggage claim tags

SafetyWing covers: $150 per item. Up to $300 per year.

❸ Lost checked luggage

If your luggage goes missing on your flight or cruise, you can get reimbursed for the bag and what was inside if it's still missing after 10 days.

Important conditions:

→ You must have filed an incident report with the airline/cruise line and completed their instructions and forms to attempt to retrieve your luggage.
→ We will determine the reimbursement value of your belongings based on valuations at the time of loss and market data available at the time of claim decision.
→ We will only pay for expenses after deducting any amounts you have received from the transportation provider.
→ Required documentation:
  - Proof of the booking (ticket or boarding pass)
  - The incident report you filed initially
  - Documentation from the carrier that the bag was checked and is still missing after at least 10 days
  - Proof of the existence of your items before they went missing (for example photos and a receipt of the purchase)

SafetyWing covers: $500 per item. Up to $3,000 per year. Up to $6,000 in your lifetime (**lifetime max**).

❹ Inaccessible or canceled accommodation

If your pre-booked accommodation is inaccessible, you are covered for alternative accommodation and transportation there.

Important conditions:

→ The accommodation was canceled by the vendor, or is inaccessible (for example the self check-in doesn't work or the host doesn't show).
→ You were made aware of your accommodation being inaccessible or uninhabitable at the point of check-in or within 12 hours before your check-in.
→ You will need to provide the following documentation:
  • Proof of original booking and payment (confirmation email, receipts)
  • Confirmation of the cancellation or inaccessibility from the vendor
  • Receipts for alternative accommodation and transportation

SafetyWing covers: Up to $150 per night. Up to $300 per year.

❺ Theft of wallet

If your wallet is stolen, you are covered for a $150 reimbursement.

Important conditions:

→ You took reasonable care for the safety of your wallet.
→ You will need to provide the following documentation:
  • A police report submitted within 24 hours of the theft

SafetyWing covers: $150 per incident.
Up to $450 in your lifetime (**lifetime max**).

❻ You have to cancel your trip (trip cancellation)

You are covered if you need to cancel an upcoming trip for one of the following reasons:

1. An **illness** or **injury**
2. Death of spouse, parent, child, grandchild or sibling
3. A natural disaster, terrorism or outbreak of war at the destination
4. A legal obligation such as jury duty or being called to active military service
5. A mandated **quarantine**
6. Your passport or other necessary travel documents were stolen

Important conditions:

- → The incident that caused your trip to get canceled happened after you booked it.
- → A legal obligation will not be covered if it is related to a crime you have committed or are suspected of having committed.
- → You will need to provide the following documentation:
  - Proof of trip booking and payments such as receipts and booking confirmation
  - A note that advises against travel from your treating **physician** if the reason is an illness or injury
  - Proof of cause of the mandated quarantine
  - Legal documentation if cancellation is due to a legal obligation
  - Proof of death of **family member** if the reason is the death of a **family member**
  - A police report if the cancellation was due to stolen travel documents

SafetyWing covers: $300 per trip. Up to $600 per year.

❼ Burglarized accommodation

If your accommodation is burglarized, you are covered to get your personal items reimbursed.

Important conditions:

- → You are not covered for a burglary resulting from your negligence or carelessness (for example: you left the door unlocked).
- → Electronics are not covered.
- → We will determine the reimbursement value of your belongings based on valuations at the time of loss and market data available at the time of claim decision.
- → You will need to provide the following documentation:
  - A police report submitted within 24 hours of discovering the burglary
  - Proof of ownership and value of the stolen items, such as receipts and photos

SafetyWing covers: $500 per item. Up to $3,000 per incident. Up to $6,000 in your lifetime (**lifetime max**).

❽ Emergency vision test and replacement glasses or contact lenses

If your prescription lenses were lost or broken in an incident covered by this insurance (such as an **accident**, robbery, lost checked luggage), an eye exam in order to obtain a corrective lens prescription is covered, as well as replacement glasses or contact lenses.

Important conditions:

→ The vision test must be performed by a licensed optometrist to establish a proper corrective lens prescription.
→ Lenses were lost or damaged due to an incident covered by this insurance.
→ Required documentation:
  • Proof of a covered cause to the loss or damage
  • Receipts of the vision test and replacement glasses or contact lenses

SafetyWing covers: Up to $300 per year.

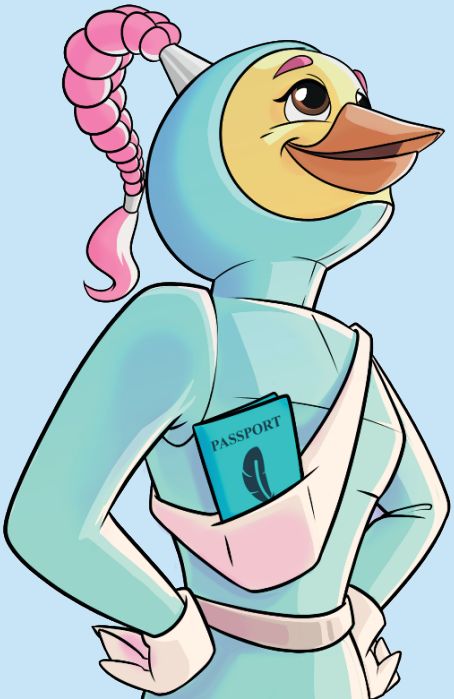
❾ Stolen passport or travel visa

Reimbursement to replace your passport or visa if it was stolen.

Important conditions:

→ You took reasonable care for the safety of your passport/visa.
→ Required documentation:
  • A police report submitted within 24 hours of the theft

SafetyWing covers: $100 per incident.
Up to $300 in your lifetime (**lifetime max**).



❶❼ An unforeseen event which you need to attend (trip interruption)

If an unforeseen event occurs while you're away from your **primary residence**, a one-way economy ticket and reasonable transportation to and from departure or arrival points are covered.

The unforeseen event must be caused by one of the following reasons:

1. Fire or weather destroyed more than 40% of your **primary residence.**
2. If one of the following **family members** died or is on their deathbed: Parent, spouse, sibling, child, grandchild.

Important conditions:

- → A one-way economy ticket is covered for where you need to go, as well as reasonable transportation expenses to and from the place of departure/arrival.
- → If the incident relates to the death of a **family member**, you can get covered to go to either the location of their death or the location of their funeral.
- → Required documentation:
  - Proof of the incident
  - Tickets and receipts for the transportation

SafetyWing covers: Up to $5,000 per year.

⓫ Evacuation from local unrest

If a **travel warning** is issued for the area you are located in, the cost of evacuation transportation by the most economical means possible is covered to either your **primary residence**, a safe country that is nearby, or a location that is otherwise reasonable (for example, you have **family members** located there).

Important conditions:

- → The **start date** of your insurance was before the **travel warning** was issued.
- → There was no **travel warning** in place when you arrived in the area.
- → You have to contact us to have this arranged within 10 days of the **travel warning** being issued.
- → This is arranged in collaboration between us and you, and we decide where you will be evacuated to.
- → Required documentation:
  - Proof of you being located in the area of the **travel warning**
  - Tickets and receipts for the transportation if you paid for this yourself (while collaborating with us when booking)

SafetyWing covers: Up to $10,000 in your lifetime (**lifetime max**).

⓬ Support for your pet if you are hospitalized

If you are traveling with pets but end up **hospitalized** so that your pets are unexpectedly left unattended, a one-way ticket for air or ground transportation to a familial caretaker is covered, or paid pet care in the area that you are.

Important conditions:

- → There is no **family member** on your trip who is over 18 years old that isn't **hospitalized**, other than you.
- → The **hospitalization** is expected to last longer than 36 hours, and is a result of an unforseen **illness** or **injury**.
- → The paid pet care provider cannot be a **family member**.
- → Required documentation:
  - Tickets and receipts for the transportation, or receipts for the pet care

SafetyWing covers: Up to $100 per day for pet care. Up to $1,000 per year.

⓬ Support for your children if you are hospitalized

If you are traveling with children but end up **hospitalized** so that your children are unexpectedly left unattended, a one way ticket for air or ground transportation to a familial caretaker is covered, or paid childcare in the area that you are.

Important conditions:

- → The child is under 18 years old.
- → They are also covered under this insurance.
- → There is no **family member** on your trip who is over 18 years old, other than you.
- → The **hospitalization** is expected to last longer than 36 hours, and is a result of an unforseen **illness** or **injury**.
- → The paid childcare provider cannot be a **family member**.
- → Required documentation:
  - Tickets and receipts for the transportation, or receipts for the childcare

SafetyWing covers: Up to $300 per day for childcare. Up to $5,000 per year.

⓭ Visit from a family member in relation to a serious illness or injury

One economy round-trip ticket, as well as reasonable expenses for transportation, housing and food for up to 15 days are covered for one **family member** to visit the area you are **hospitalized** in (or about to be **hospitalized** in).

Important conditions:

- → You are either confined to an **ICU**, or you have been **hospitalized** in relation to a **life-threatening** covered **illness** or **injury**.

→ The **hospitalization** is expected to last longer than 36 hours, and is a result of an unforseen **illness** or **injury**.
→ Required documentation:
  • Tickets and receipts for the related expenses

SafetyWing covers: Up to $6,000 per year.

14 Robbery

If you are held against your will by the use of force or intimidation, and forced by your captor to give up valuables in order to be released, you are covered for reimbursement of the value of surrendered personal belongings and/or money.

Important conditions:
→ This coverage does not apply if the robbery or abduction first occurs in one of the countries listed as high risk, as follows: Afghanistan, Central African Republic, Democratic Republic of the Congo, Iraq, Libya, Mali, Niger, Nigeria, North Korea, Pakistan, Somalia, Sudan, South Sudan, Syria, Venezuela, Yemen, or any country for which we are prohibited from transaction due to international sanctions.
→ The robbery or abduction must not be a result of dishonest or criminal acts by you.
→ We will determine the reimbursement value of your belongings based on valuations at the time of loss and market data available at the time of claim decision.
→ Electronics are not covered.
→ Required documentation:
  • Proof of the existence of your personal belongings before they were taken from you (for example with a receipt of the purchase). For cash or cash equivalent, you provide evidence of the initial withdrawal of the cash/source of funds
  • A police report submitted within 24 hours of the robbery

SafetyWing covers: Up to $500 per personal belonging, up to $300 for cash or cash equivalent. Up to $10,000 in your lifetime (**lifetime max**).

What is not covered (exclusions)?

This section is important to read, because assuming something is covered, and then realizing after the incident that it is not, is a lot worse than assuming something isn't covered and later realizing it is. If you read this section of what is not covered, you have some idea of what to avoid so that you make sure you take the right precautions and don't put yourself in situations where insurance won't cover you. Everything listed below is relevant to all parts of the coverage.

1. Failure to keep a scheduled appointment.
2. Payable under worker's compensation or employer's liability laws, or by any coverage provided or required by law.
3. Travel or accommodations, except as explicitly described in the covered sections.
4. Anything that happened outside of your **active insurance period**.
5. The incident relates to a crime you committed or are suspected of having committed.
6. The incident was caused by your negligence.
7. The incident happened within your **primary residence**, except as described under the section "An unforeseen event which you need to attend (trip interruption)".
8. Charges exceeding **usual, reasonable and customary**.
9. Claims made more than 60 days after the **end date**.
10. Anything that is not described in the covered sections of this Description of Cover.
11. We do not pay for claims if the expenses have been paid by other insurance or you have received a reimbursement from any other source.

How to file a claim

You need to claim within 60 days of the **end date** of your insurance. Some types of claims require that you notify us in advance, or that we make the arrangements.

You may submit your claim as follows:

1. Pay yourself and submit a claim for reimbursement on the SafetyWing website, or email claims@safetywing.com. Some claims require that you notify us beforehand, or that we arrange for the payment as described below.
2. Reach out to our 24/7 assistance so we can arrange for the payment. This option is not available for all types of claims.

Important:
Every claim will need to be supported by documents that confirm you've met the requirements of the benefit you are claiming for. The 24/7 customer service team is always there to help you if you're unsure about what documentation you need.

For every claim, the total reimbursement we will make will not be more than the actual expenses paid.

When is my insurance active?

When you submit your application, it usually takes up to 10 days to process it. Once approved, your insurance becomes active on the 1st or 15th of the month, whichever comes sooner. The date that your Nomad Complete Policy becomes effective is your Effective Date, after which your coverage begins.

My claim was denied, and I disagree. How do I appeal?

If a travel related benefit claim is denied you will receive a written explanation of why it was denied. If you do not agree with our decision, you can appeal within 6 months (180 days) of the day you received the decision. The appeal can be sent to claims@safetywing.com.

When we receive the appeal we will review it and you'll get a response back in writing. You can appeal a decision two times, but it does not limit your right to make a complaint as described below.

How to make a complaint?
If you're not happy with something related to the **policy** and/or claims, we are here to help. Please follow this process to ensure that your problem or concern is dealt with efficiently.

1. First, if you haven't yet, get in touch with us through one of the following channels:
   a. Our online chat on safetywing.com
   b. To our claims department at claims@safetywing.com
2. If you are not satisfied even after speaking to our Support Team, you can escalate your concerns to management by contacting feedback@safetywing.com. You will be contacted within 5 business days with our proposed solution. If more time is needed to resolve the issue, we will keep you updated at every step on what further information we might need and how much longer it might take. Please be sure to provide:

- Claim or Policy number (if applicable)
- As much information as possible on your dispute or complaint, including any prior responses from us on the issue

3. If, after completing Steps 1 and 2, you are still not satisfied with how we handled things, SafetyWing may propose that your issue be referred to the Centre for Effective Resolution (CEDR), an independent mediation service provider for conflict resolution.
4. Finally, please know that your legal rights are not affected by following the above outlined process. We recommend that you read the information in the "Arbitration" section under "Disclaimers and legal notices".

Definitions

Accident: A sudden, unintentional and unexpected occurrence caused by something external and visible which happens beyond your control and which results in physical injury or death to you.

Active insurance period: The period of time from the start date to the end date as written in your proof of insurance email (maximum 364 days). If you stop paying/extending or if you have been on the plan for 364 consecutive days, you have to start a new active insurance period with a new start date.

Custodial care: A type of care or service that is designed primarily to assist patients in performing activities of daily living. Custodial care also includes medium or long term care for those who are comatose, semi-comatose, paralyzed or mentally incompetent.

Educational or rehabilitative care: Care for restoration (by education or training) of one's ability to function in a normal or near normal manner following an illness or injury. For example: vocational or occupational therapy and speech therapy.

End date: The date your policy is canceled or terminated. The specific time your coverage stops is at the end of the End day at 23:59 (11:59pm) in UTC timezone .

Extended care facility: An institution, or a distinct part of an institution which

- → Is licensed as a hospital, extended care facility or rehabilitation facility in the state or country where it operates
- → Provides 24-hour nursing care under the regular supervision of a physician and the direct supervision of a registered nurse
- → Maintains a daily record on each patient
- → Provides each patient with a planned program of observation prescribed by a physician, and with active treatment of an illness or injury
- → Is not a facility primarily for rest, the aged, substance abuse treatment, custodial care, nursing care or for care of mental health disorders or the mentally incompetent.

Family member: Biological or step parent, biological or step child, current spouse, biological or step siblings, parent in law, children in law, or sibling in law.

Health warning: A health warning is considered to be in place when either of these are true:

1. The **United States Centers for Disease Control & Prevention (CDC)** have issued a Warning Level 3 (Red) for the location/country or worldwide.
2. The **World Health Organization (WHO)** has issued advice against

travel to the area or country.

Country of residence: The country in which you reside for a period of more than one hundred and eighty three (183) days within a year.

Home health care agency: A public or private agency which operates pursuant to law and is regularly engaged in providing home nursing care under the supervision of a registered nurse, and maintains a daily record on each patient, and provides each patient with a planned program of observation and treatment by a physician.

Hospital: An institution which:

- → Legally operates as a hospital and is licensed by the staxte or country where it operates
- → Operates primarily to receive, care for and treat sick or injured people that need to be admitted to a hospital
- → Provides 24-hour nursing service by registered nurses either on duty or on call
- → Has a staff of one or more physicians available at all times
- → Provides organized facilities and equipment for diagnosis and treatment of unexpected medical conditions
- → Is not primarily a rehabilitation facility, long-term care facility, extended care facility, nursing, rest, custodial care or convalescent home, a place for the aged, drug addicts, alcoholics, runaways or similar.

Hospitalization/Hospitalized: Overnight stay in a hospital.

Illness: A sickness, disorder, illness, pathology, abnormality, ailment, disease or any other medical, physical or health condition. Illness does not include learning disabilities, attitudinal disorders or disciplinary problems.

Injury: An unexpected and unforeseen harm to the body caused by an accident that requires medical treatment.

Intensive Care Unit (ICU): A cardiac care unit or other unit or area of a hospital that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Life-threatening: Capable of causing death.

Lifetime max: The maximum amount of money that you can get reimbursed from us in your lifetime.

Master Policy: The Master Policy is a legal contract between the policyholder and SafetyWing Insurance l.l.

Max limit: The maximum amount of money that you can get reimbursed from us on your insurance. Our max limit is $250,000 per active insurance period.

Medically necessary: Anything involved in the treatment or diagnosis of your illness or injury must be based on generally accepted current medical practice to be covered. Unnecessary extra measures taken which are simply convenient for you or the provider are not covered (for example: a hospital over-treats you by performing procedures or diagnostics or prescribing medicines that you don't need, or makes you stay in the hospital longer than necessary). We determine whether it is medically necessary. If you are unsure if something is medically necessary, please reach out to our 24/7 assistance.

Mental Health Disorder: A mental or emotional disease or disorder which generally denotes a disease of the brain with predominant behavioral symptoms; or a disease of the mind or personality, evidenced by abnormal behavior; or a disorder of conduct evidenced by socially deviant behavior. For example: Psychosis, depression, schizophrenia, bipolar affective disorder.

Outpatient: Medically necessary treatment by a physician for illness or injury that does not require hospitalization.

Physician: A Doctor of Medicine (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DDM), Doctor of Podiatry (DPM), Doctor of Osteopathy (DO), a licensed Physical Therapist or Physiotherapist, and a Doctor of Psychiatry (Psy.D) and a Doctor of Psychology (Ph.D.). Physician also includes a Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetist (CRNA), Nurse Midwife or a Physician Assistant (PA) under the direction of a medical doctor. A physician must be currently licensed by the jurisdiction in which the services are provided, and the services must be within the scope of that license and covered under this insurance.

Policy: The Master Policy document, and any endorsements, riders or amendments that will attach during the Policy period.

Policyholder: The entity shown as the Policyholder in the Master Policy.

Primary residence: Your principal home in your country of residence, where you spend the most time in a year and receive regular mail.

Pre-existing illness or injury: Any illness or injury to which one of the following applies:

1. You received a prior diagnosis or treatment for the illness or injury within 2 years before the start date.
2. You experienced symptoms within 2 years before the start date.*
3. There is reasonable medical certainty (more likely than not) that the illness or injury existed within 2 years before the start date. This means that even without your knowledge it can be considered a pre-existing illness or injury.*

*If you continue to be covered by Nomad Insurance under a new Policy after having reached 364 consecutive days of coverage under a single **active insurance period** conditions 2 and 3 above will not apply to you, except for illness or injury that is untreatable and expected to become worse over time.

Proof of insurance email: The email that is sent to you after purchase that confirms the plan type, the dates of your active insurance period, home country, Policy number, deductible, chosen add-ons, the notable exclusions of this plan and geographical area of cover.

Quarantine: Strict isolation imposed by a physician and government authority to prevent the spread of a disease.

Related third person: Your **family member**, your travel companion, your travel companion's **family member**, and any other person that you are residing with or being hosted by.

Start date: The date your policy becomes effective. Also defined as "Effective Date". Your start date begins at 00:00 (12am) of that date in UTC timezone, or at the time you receive your proof of insurance email, whichever is later.

Substance abuse: Alcohol, drug or chemical abuse, overuse or dependency.

Surgery: An invasive diagnostic procedure or the treatment of illness or injury by manual or instrumental operations performed by a physician while the patient is under general or local anesthesia.

Third person: Any person or legal entity except you or a related third person. travel to the destination.

Travel warning: A travel warning is considered to be in place the first time when either of these are true:

1. The US Department of State issues a level 3 or level 4 travel advisory.
2. The Foreign, Commonwealth & Development Office advises against.

Urgent Care Center: A medical facility in the US separate from a hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an illness or injury presented on an episodic basis.

US/USA: The United States of America

Usual, reasonable and customary: The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. To be determined by us. If you're unsure of whether something meets the criteria, reach out to our 24/7 assistance.

You/Your means the person named in your proof of insurance email.
Your insurance refers to the coverage described
in your proof of insurance email.
We/Us/Our refers to SafetyWing I.I.
$ refers to the United States dollar.

Disclaimers and legal notices

SafetyWing Insurance I.I.

This Description of Coverage is issued to the Eligible Participant pursuant to the Outbound Travel Master Insurance Policy issued by Us to the Policyholder in Puerto Rico.

The travel portion of the benefit plan is underwritten by SafetyWing Insurance I.I. which is a licensed insurance carrier incorporated in Puerto Rico, under the regulatory jurisdiction of the Office of the Commissioner of Insurance of Puerto Rico, company number 52139818. Registered address is 802 Ave. Juan Fernández Juncos, San Juan, Puerto Rico 00907. These details can be checked on the Puerto Rico's Department of State website: https://rcp.estado.pr.gov/en/entity-information?c=496554-411.

Pursuant to the Policy, Eligible Participants are eligible to receive coverage from the Policyholder if they meet the requirements provided in the Classes of Eligible Persons provided in the Policy.

A summary of the coverage provided to you through the Policy is provided above. In the event of any discrepancies between this description of coverage or the Master Policy, the Master Policy will control. You can request a copy of the Master Policy upon request to Us.

Termination

The Insurer, at its sole discretion, may modify, cancel, not renew, or terminate this Policy, or modify the rates thereof, when any of the following conditions are present:

A. The information disclosed in the Application is false, incomplete or when fraud has been committed, any of which may have caused the Company to approve the Policy when, had the Company been provided with the correct information, it would have issued the Policy under certain conditions or would have deemed that the Applicant was a non-insurable person;

B. The Policyholder requests the cancellation of the coverage in writing or doesn't pay the premium as stipulated in this Policy;

C. The Insured submits a claim or information deemed fraudulent by the Company. In the event of such fraud, the Insured shall be responsible and will have to reimburse the Company for any payments made in reference to the claim in question, whether the payment was made in the form of a reimbursement to the Insured or directly to the Provider;

D. The marital status of the Policyholder changes due to divorce or separation in case of Domestic Partners. The Insured should notify the Company within thirty (30) days of the date of the divorce or separation. Coverage for the Dependent Spouse will cease at the end of the Policy year;

E. The Insured lives in a country that is under embargo or sanctioned by the Office of Foreign Assets Control (OFAC) in the United States or similar entities in the European Union and the United Kingdom, or if an Insured is in any of the lists of persons sanctioned by OFAC or similar entities or asset control agencies in other jurisdictions; or

F. The Insured spends more than one hundred and eighty-three (183) days out of a three hundred and sixty-five (365) day period in the United States or any of its territories.

The early cancellation of the Policy shall be without prejudice to the rights of the Insured. The Insurer will only be responsible for the payments of covered expenses under the terms of this Policy, incurred prior to the cancellation date. Any treatment incurred after the cancellation date of the Policy will not be covered regardless of when the Illness or Accident first appeared, or if any additional treatment is required.

Law and Jurisdiction

You cannot take legal action to claim insurance benefits until you provide us with written proof of your claim for at least 60 days. After that, you have up to three years to bring a lawsuit. The laws of Puerto Rico will govern and interpret this agreement.

Arbitration

UNLESS YOU OPT-OUT, ANY DISPUTES BETWEEN YOU AND SAFETYWING INSURANCE I.I. WILL BE RESOLVED THROUGH BINDING ARBITRATION. THIS MEANS YOU CANNOT FILE A LAWSUIT OR PARTICIPATE IN A CLASS ACTION OR SIMILAR LEGAL ACTION.

Arbitration and Class Action Waiver

Except for certain claims, all disputes related to this insurance will be resolved through arbitration based on Puerto Rico's laws. The arbitration will be conducted individually, and both parties waive the right to participate in a class action or similar legal action. The arbitration will take place in Puerto Rico or through alternative means agreed upon, and the American Arbitration Association will administer the process. The arbitrator will make the final decision, and it can be enforced by a court if necessary. Both parties will keep the arbitration process and any awards confidential.

Opting Out of Arbitration

If you do not want to participate in arbitration, you can send a written notice to SafetyWing within 60 days of the end of your active insurance period. This notice should be sent to feedback@safetywing.com, attention to the General Counsel.

Data Protection

Please review SafetyWing's privacy policy on their website at safetywing.com/privacy-policy. We follow strict data protection practices and only allow employees and partners with a need to access your personal information to do so. We will not share your personal information with third parties unless required by law or legal process.

In our business activities, SafetyWing will collect, store, and process your personal data. This privacy policy provides information about how we gather, use, process, and disclose the personal data we collect from you or that you provide to us. Personal data refers to information about a living person that can identify them. We are responsible for protecting your data according to relevant data protection laws, including the European Union General Data Protection Regulation (EU) 2016/679, UK GDPR, as well as other laws related to processing or transferring personal information across different countries. Please read the privacy policy carefully to understand how we use your personal data and your rights.

Rights of Third Parties

You cannot assign insurance benefits to a hospital, physician, or any other provider. They do not have any direct or indirect claims or rights against us.

Important Notice and Disclaimer Concerning the United States Patient Protection and Affordable Care Act

This insurance is not subject to, and does not provide certain insurance benefits required by the United States' Patient Protection and Affordable Care Act ("PPACA"). PPACA requires certain US citizens or US residents to obtain PPACA compliant health insurance, or "minimum essential coverage." PPACA also requires certain employers to offer PPACA compliant insurance coverage to their employees. Tax penalties may be imposed on U.S. residents or citizens who do not maintain minimum essential coverage, and on certain employers who do not offer PPACA compliant insurance coverage to their employees. In some cases, certain individuals may be deemed to have minimum essential coverage under PPACA even if their insurance coverage does not provide all of the benefits required by PPACA. You should consult your attorney or tax professional to determine whether this policy meets any obligations you may have under PPACA.

Medical

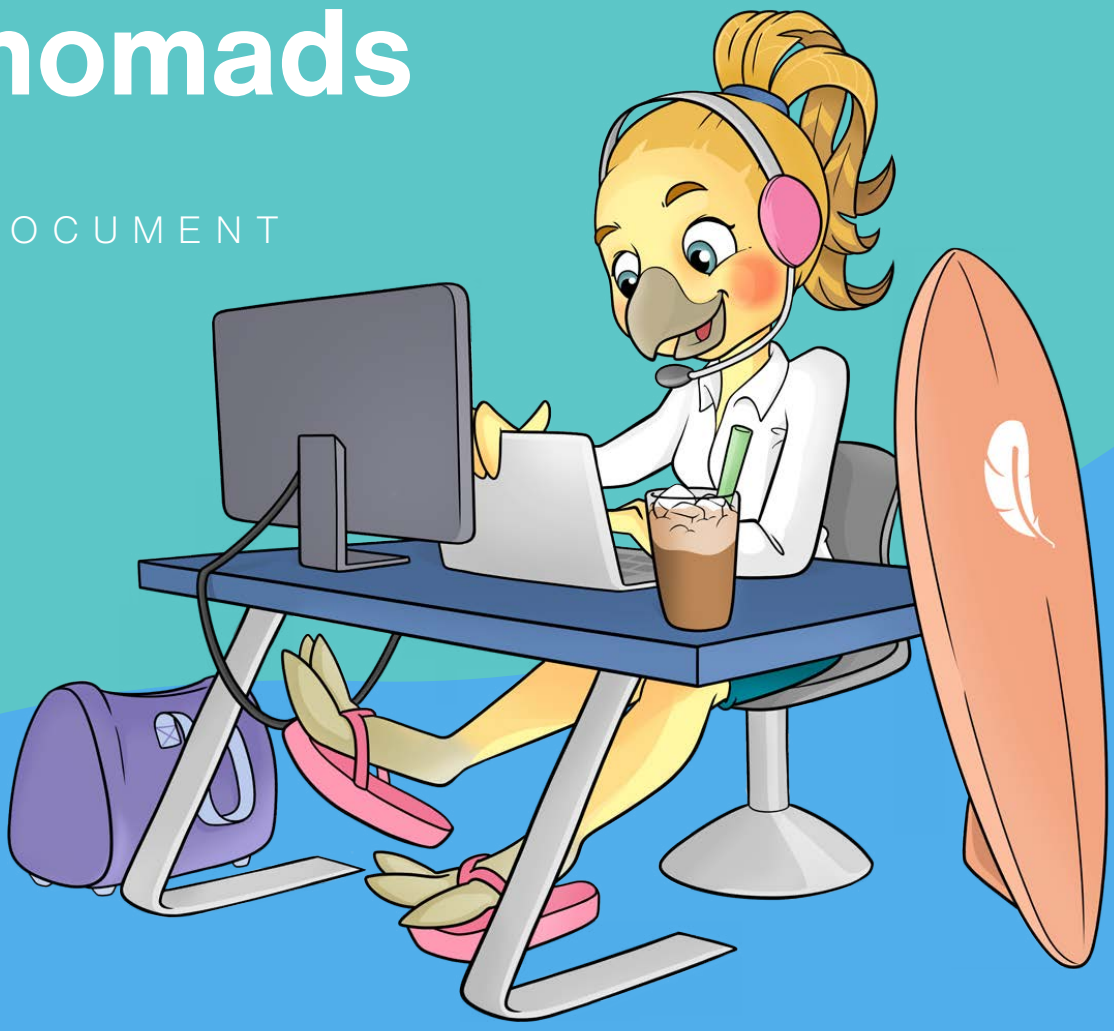
by SafetyWing | VUMI

The health portion of the benefit plan is underwritten by VUMI® Group, I.I. (VUMI®), a Puerto Rico domiciled international insurer, administered by VIP Administration Services LLC, and offered in partnership with SafetyWing.

Nomad Health
by SafetyWing | VUMI

Global health insurance for remote workers and nomads

POLICY DOCUMENT



Nomad Health VIP Standard

IND01

SafetyWing

Premium coverage that works across borders

A fully-equipped health insurance made for remote workers and nomads who spend as much time abroad as they please. Full coverage in your home country, and comprehensive coverage for pandemics.

Buy abroad, stay abroad

You can buy Nomad Health from anywhere in the world and keep moving countries as long as you'd like.

Live and travel anywhere

Nomad Health is fully global, meaning whether you are in your home country, a new country or traveling nonstop, your health needs will always be covered.

Support in every time zone

No matter where in the world you are, know that there is someone ready to help you 24/7. Choose from talking to someone on the phone, or messaging them directly.

One global policy for 175+ countries and everywhere you travel

Full coverage in your home country, and comprehensive coverage for pandemics

VUMI®

VUMI® Group, I.I. (VUMI®) is pleased to have been chosen to offer you and your family the best health care through the most innovative and comprehensive international health insurance coverage. All of our products come with our exclusive VIP medical service and access to the Second Medical Opinion VIP®.

The purpose of this document is to offer you a detailed guide about your Policy. The document is divided into different sections that define the coverage, duration, benefits, exclusions and the eligibility of your Policy. Likewise, you will also find general information, your obligations as an Insured and definitions that will help you better understand the functionality and the benefits of your Policy, as well as information about the importance of notifying medical events, which will allow us to maximize the level of coverage available to you.

In partnership with SafetyWing, with Nomad Health you will have the peace of mind of knowing that your health is in the best hands 24 hours a day, 365 days a year. Our products are backed by a strong global company with an extensive Providers' network and exclusive VIP medical service that will guide you when you need it most.

Nomad Health

SafetyWing | VUMI

Contents

For reimbursement of claims:
rhclaims@safetywing.com

For notifications, pre-authorizations:
rh-preapproval@safetywing.com

General Telephone:
+1 214 276 6376

US Toll Free (from Skype):
+1 855 276 8864

Nomad Health

SafetyWing | VUMI

Table of benefits

Unless otherwise stated, the benefits are offered per Insured/per Policy year. 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.

Plan summary | Standard benefits

General plan information

Maximum cover per Policy year	US$1,500,000
Age limit to apply	Up to 64 years
Geographical cover	Worldwide; or Worldwide excluding US/SG/HK

Base plan coverage

Unless otherwise stated, the following benefits are for inpatient treatments

Standard private room (room & board)	100% UCR
Adult companion accommodation (related to a Hospitalization of a child under age 18)	100% UCR
Intensive care unit	100% UCR
Emergency room care	100% UCR (if admitted immediately as an inpatient)

*Coverage in United States, Singapore, and Hong Kong is only available when traveling there, for up to thirty (30)-days per trip. No restrictions for traveling anywhere else.

Surgery	100% UCR (inpatient) Up to US$500,000 for day patient or outpatient surgery
Surgeon and Anesthesiologist Fees	100% UCR
Prescription Medication	100% UCR (inpatient) 100% UCR pre- and post-operative for up to 15 days before or after inpatient treatment
Inpatient diagnostic study services (laboratory tests, pathology, X-rays, MRI/CT/ PET scans)	100% UCR
Renal failure and dialysis	100% UCR (inpatient or outpatient)
Organ and tissue Transplant	100% UCR
Benefits for Live Donors (included in the organ Transplant benefit)	Up to US$50,000
Oncology: cancer tests, medication and treatment (chemotherapy and/or radiotherapy)	100% UCR (inpatient or outpatient)
Congenital Disorders	Up to US$25,000

Inpatient psychiatric coverage	100% UCR max. of 30 days
HIV-AIDS treatment	Up to US$50,000
Reconstructive surgery after an Accident or Illness	100% UCR
Emergency dental coverage	100% UCR for treatment within the first 180 days of the covered Accident
Rehabilitation and specialized treatments	Up to US$500,000 max. of 30 days per medical condition after a covered Hospitalization
Nurse care at home	100% UCR max. of 60 days
Durable Medical Equipment	Up to US$1,500 per medical condition within 6 months of an eligible medical condition (inpatient or outpatient)
Emergency Ground Ambulance transportation	100% UCR
Evacuation and repatriation including repatriation or cremation of mortal remains	Up to US$100,000

Accident and Emergency non-elective treatment outside the geographical area of coverage United States, Hong Kong and Singapore for up to thirty (30) days	Injuries: 100% UCR Illnesses: Up to US$50,000 Outpatient: Up to US$500
Hospital cash benefit	US$150 per night, max. of 30 nights (by reimbursement only)
Passive war and terrorism	100% UCR
External prosthesis	Up to US$1,000
Palliative Care	Up to US$50,000
Second Medical Opinion VIP®	Access to a second medical opinion of renowned experts from around the world

Outpatient

The maximum allowable amount for all combined outpatient benefit expenses is up to five thousand dollars (US$5,000) per Policy Year.	US$5,000
Emergency room care	100% UCR
Physician and specialist visits	100% UCR
Medications	100% UCR
Physical therapy	100% UCR
Mental health visits	100% UCR up to a max. of 10 visits per Policy Year
Diagnostic study services (Laboratory tests, pathology, X-rays, MRI/CT/ PET scans)	100% UCR
Complementary therapies (Massages, osteopaths, chiropodists and podiatrists, chiropractors, homeopaths, dietitian and acupuncture)	Up to US$60 per visit, up to a max. of 15 visits per Policy Year
Allergy treatments	100% UCR

Screenings & vaccines

Routine health checks including cancer screening, cardiovascular and basic vital signs exams, as well as all basic immunization and booster injections. COVID-19 vaccines are not included.

US$350

Maternity

Covers Medically Necessary costs incurred during pregnancy and childbirth up to US$2,500, including pre and post-natal check-ups for up to 30 days following discharge. This benefit is subject to a ten (10)-month Waiting Period.

Up to US$2,500

Newborn coverage and maternity complications — Up to US$50,000

All benefits in the Plan summary tab with one hundred percent (100%) coverage are up to the Policy limit. Benefits with established coverage will be up to the limits stated in each of them. Capitalized words are defined terms of special relevance and meaning in this document.

Section 1. Agreement

VUMI® Group, I.I. (VUMI®), hereinafter the "Company" or the "Insurer," issues a Policy in the name of the Policyholder listed on the Certificate of Coverage. The benefits detailed in this Policy related to the covered expenses incurred by him/her or his/her eligible Dependents under his/her certificate, as a result of any treatment, service or medical supply anywhere in the world where the plan offers coverage, after the Effective Date of this Policy, while it is in effect.

All benefits are subject to the terms and general and particular conditions of this Policy, including the applicable co-pays, maximum benefits and the limits detailed in the Table of Benefits and the Certificate of Coverage 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, therefore, it may not comply with coverage, underwriting, and other insurance regulatory provisions of the Insured's Country of Residence. 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). The Policyholder must review the terms of the coverage to verify he/she is in agreement with the coverage offered, and otherwise request the cancellation of this Policy and return it to the Company 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 and the Policy will be null and void, as if it was never issued.

Reimbursement of the unearned premium

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

1.2 Important notice about the Application

This Policy is issued based on the statements provided in good faith by the Policyholder and the complete payment of the corresponding premium. The Company reserves the right to accept or reject any Application.

If any of the information disclosed in the Application is false, incorrect, incomplete, had the intent of misleading or deceiving, or was omitted, resulting in worsening the risk, the Policy will be rescinded, will have no effect, and the Company will not be responsible for any payments of the benefits offered under this Policy, releasing the Company of any responsibility for the payment of benefits stipulated hereunder, as the case may be.

Likewise, it is understood that it will result in the same aforementioned effect if a Provider or any other individual or entity who has rendered medical services to the Policyholder or any of the Insureds, should submit false statements in collusion with the Policyholder and/or any of the Insureds with the purpose of claiming payments against this Policy, its sections and/or Amendments, the Policy would be at the discretion of the Company, rescinded or cancelled, will have no effect and the Company will not be responsible for any payments of the benefits offered under this Policy.

Any payments made unduly by the Company as a result of an omission, incorrect disclosure or negligence by the Policyholder, any Insured, or due

to an administrative error of the Company, shall be reimbursed to the Company at the first request.

Section 2. Coverage duration

The coverage has a duration period of twelve (12) months and could be renewed for the same period of time, as long as the Policyholder fulfills his/her payment commitment of the established premium, subject to the Applicants meeting the eligibility requirements, and subject to the terms, conditions and other provisions of the Policy that are in effect at the time of renewal.

Start of coverage

The coverage starts one (1) minute after midnight (00:01) Eastern Standard Time on the Effective Date of this Policy, and ends at midnight (00:00) three hundred and sixty-five (365) days later.

Section 3. Eligibility

3.1 Eligibility requirements

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

A. Reside in a country other than the United States of America (USA);

B. The Policyholder and his/her Spouse or Domestic Partner must be at least eighteen (18) years old and up to sixty-four (64) years old, except for minors authorized by one of their parents or a legal guardian;

C. Dependent children are eligible up to:

- **a.** Nineteen (19) years old if they are single; or
- **b.** Twenty-four (24) years old if they are single and full-time students.

D. Pay the corresponding premium.

3.2 Effective coverage for eligible Dependents of the Policyholder

Coverage is available for the Policyholder's Dependent children until the day before they turn nineteen (19) years old if they are single, or until the day before they turn twenty-four (24) if they are single and full-time students at an accredited college or university at the time the Policy is issued or renewed.

The Company reserves the right to request, at any moment during the term of the Policy, a student certification issued by a representative of the university. Additionally, there will be an adjustment of the premiums if any of the Dependents remains outside his/her Country of Residence for a period of more than one hundred and eighty-three (183) days during a calendar year.

If a Dependent child gets married, or ceases to be a full-time student, or if a Dependent Spouse is no longer married to the Policyholder due to divorce or annulment of the marriage, coverage for such Dependents will end on the Expiration Date of the Policy following the corresponding event.

3.3 Addition of a Newborn

To include a Newborn as an Insured Dependent in the Policy, the Company must receive a copy of the birth certificate within the first ninety (90) days of the birth.

If the Newborn is not enrolled within the ninety (90)-day period, an insurance Application will have to be completed. The Insurer reserves the right to request additional information and/ or modify the conditions of coverage of the Applicant.

3.4 Addition of a Newborn

Newborns from a non-covered maternity or those resulting from fertility treatment do not qualify for automatic inclusion or coverage continuity. Therefore, a Request must be completed, and it will undergo by full medical underwriting.

Section 4. General information

4.1 Issuance of the Policy

The Policy is deemed solicited, issued and delivered when the Policyholder receives his/her Certificate of Coverage.

The Company does not solicit, sell, or accept Applications for any insurance policies to be delivered or issued to any person in any state of the United States.

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

Any translations of this Policy into other languages are provided as a courtesy for the Insured's convenience. However, the English version will prevail and will be the controlling contract in case of any doubt or dispute regarding any provision of this Policy.

4.2 Authority

No Agent or agency has the authority to change the Policy or exonerate any of its provisions. After being issued, no change in the Policy will be valid, unless there is written approval by an authorized official of the Insurer and such approval is endorsed by an Amendment to the Policy. Any errors in the documents that constitute the contract does not bind the Insurer and may be corrected once detected, through an Amendment to the Certificate of Coverage.

4.3 Administrative errors

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

4.4 Entire contract

Once the premium has been paid on its due date, the following documents constitute the complete contract between the parties: the insurance Application, the Policy Document, the Certificate of Coverage and Add-ons or Amendments, if any.

4.5 Currency

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

4.6 Coverage start

Subject to the provisions of this Policy, benefits begin on the Effective Date of the coverage, as indicated in the Certificate of Coverage.

4.7 Delivery of medical information to the registered Agent

The Policyholder, by accepting the coverage that this plan offers, expressly states that all Insureds in the Policy understand and accept that the registered Agent may access all confidential and private medical information (past, present and future) submitted to the Insurer, any of its affiliates or subcontractors, as well as the private medical information issued by the Insurer.

The Policyholder, therefore, accepts that the Insurer makes this information available to the Agent in order to facilitate the transfer of information on his/her behalf between the Insured and the Insurer during the claims process and/or provision of medical treatments that the Policyholder and any other Dependents covered under this Policy may receive. The Policyholder, therefore, grants his/her consent to the Insurer, Agent and/or administrator to access this information, acknowledging that the Insurer has no obligation to request his/her consent. On the contrary, the Insured, knowingly and voluntarily, requests granting such access to the information for the Agent and/or administrator in any manner that the Insurer chooses, at its sole discretion.

4.8 Notification of legal separation or divorce

In case of legal separation or divorce, the Policyholder must notify the Company within thirty (30) days of the event. The Dependent Spouse or Domestic Partner will have coverage until the end of the Policy year and subsequently the Company will offer his/her own Policy of the same plan and conditions as the previous Policy. The premium of the new Policy must be paid within thirty (30) days of its Effective Date.

4.9 Medical notifications

The Insured must notify the Company prior to receiving those medical services that require notification or pre-authorization, pursuant to Section 9.1 of this Policy, by calling the telephone number or through the e-mail listed on the back of their ID card. If the Policyholder and/or Insured fail to notify the Company accordingly, they will be responsible for thirty percent (30%) of all covered costs. This penalty will only apply for claims above US$500.

4.10 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 for them to be eligible for coverage.

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

4.11 Medical records

The Policyholder, because of the underwriting and/or claims process, must provide the Company with all the medical information required. Additionally, the Policyholder, as well as his/her Dependents, must authorize 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 authorizations are received.

4.12 Coverage under another insurance/coordination of benefits

If another health insurance has been contracted, including government-sponsored programs, these should be declared at the time of purchase or when the original Application is completed. In the event of a claim, a verification of coverage and a copy of the itemized invoices must be submitted, along with the settlement of the expenses paid by the other insurer (Explanation of Benefits).

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 benefits payable under the primary Policy have been satisfied. When filing a claim subject to coordination of benefits, proof of the other insurance coverage must be submitted along with copies of the medical records, the itemized invoices, Explanation of Benefits (EOB) of the primary insurer, as well as proof of the 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.

4.13 Cancellation or non-renewal of the Policy

The Insurer, at its sole discretion, may modify, cancel, not renew, or terminate this Policy, or modify the rates thereof, when any of the following conditions are present:

A. The information disclosed in the Application is false, incomplete or when fraud has been committed, any of which may have caused the Company to approve the Policy when, had the Company been provided with the correct information, it would have issued the Policy under certain conditions or would have deemed that the Applicant was a non-insurable person;

B. The Policyholder requests the cancellation of the coverage in writing or doesn't pay the premium as stipulated in this Policy;

C. The Insured submits a claim or information deemed fraudulent by the Company. In the event of such fraud, the Insured shall be responsible and will have to reimburse the Company for any payments made in reference to the claim in question, whether the payment was made in the form of a reimbursement to the Insured or directly to the Provider;

D. The marital status of the Policyholder changes due to divorce or separation in case of Domestic Partners. The Insured should notify the Company within thirty (30) days of the date of the divorce or separation. Coverage for the Dependent Spouse will cease at the end of the Policy year;

E. The Insured lives in a country that is under embargo or sanctioned by the Office of Foreign Assets Control (OFAC) in the United States or similar entities in the European Union and the United Kingdom, or if an Insured is in any of the lists of persons sanctioned by OFAC or similar entities or asset control agencies in other jurisdictions; or

F. The Insured spends more than one hundred and eighty-three (183) days out of a three hundred and sixty-five (365) day period in the United States or any of its territories.

The early cancellation of the Policy shall be without prejudice to the rights of the Insured. The Insurer will only be responsible for the payments of covered expenses under the terms of this Policy, incurred prior to the cancellation date. Any treatment incurred after the cancellation date of the Policy will not be covered regardless of when the Illness or Accident first appeared, or if any additional treatment is required.

A Contracting Party may request the cancellation of a Member's Certificate of Coverage in writing with at least 15 days' notice. The Insurer reserves the right to request documentation verifying the reason for termination, which may include but is not limited to:

- The Member is no longer employed by the Contracting Party or no longer meets the Community Plan and Associated Persons definitions.
- The Member relocates to a country where they can no longer use the plan.

4.14 Fraud

If, in case of fraud or deceit, any of the Insureds try to or obtain benefits for him or herself or for another person that otherwise would not have been paid, the Policy will be automatically cancelled by the Insurer. In this sense, the existence of fraud will result in the Policyholder and his/her Dependents to automatically lose all rights of coverage under this Policy. Additionally, in the event of fraud, the Policyholder will be immediately liable to the Insurer for all payments made improperly by the Company to the Insured or directly to the Provider of any benefits under this Policy. In these cases, there will be no right of reimbursement of the unearned premium of the Policy.

4.15. Change of plan

Before the Anniversary Date, the Insured can request to change his/her current plan to any other plan, available in the Insured's geographic Region.

To be eligible to a mid-term change you cannot have submitted claims in the current plan.

For changes within core plans* (Standard, Premium and Premium Plus) the following rules applies:

A. If the change is for a plan with lower benefits , the change will be automatic.

B. If the change is for a plan with higher benefits, it will be subject to a waiting period.

As a general rule, any change with an improvement of benefits, will be subject to a waiting period.

If the new plan includes maternity care benefits, a ten (10)-month Waiting Period will apply.

The benefits that did not exist in the previous plan must meet the corresponding Waiting Periods.

The Company reserves the right to accept or deny the change of plan for any reason.

4.16 Coverage for Pre-existing Conditions

The Pre-existing medical Conditions disclosed in the Application may receive coverage, unless they are limited or permanently excluded by the Company through an Amendment included in the Certificate of Coverage.

Pre-existing Conditions that were not declared will not be covered, and omission of declaration may lead to the modification, rescission or cancelation 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.

4.17 Medical underwriting at policy renewal

Upon renewal, the insurer reserves the right to offer a medical underwriting to review the full exclusion and or only excludes specific conditions.

The insured must complete an application and submit up to date medical records within the last thirty (30) days before the end of the annual policy term. Submitting this medical application to the insurer does not guarantee that the coverage will be modified, or exclusions will be removed, as it depends on the insurer's evaluation of the application.

Section 5. Rates and premium payments

5.1 Premium payment mode

This Policy is considered an annual Policy. The premium can be paid annually or monthly (with a ten percent (10%) increase). Changes in payment

mode will be made only on the Policy Anniversary Date.

5.2 Grace Period

The Company grants a thirty (30)-day Grace Period to pay the annual renewal premium of the Policy, which begins the day after the Expiration Date of the Policy, according to the selected payment mode. If the premium is not paid within the Grace Period, the Insurer will terminate the Policy at 23:59 on the last day for which the premium had been paid. 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.

5.3 Premium payment

The on-time payment of the premium is the responsibility of the Policyholder. The premium is payable on the Renewal Date of the Policy. Payment of the premium keeps the Policy current for the time such payment corresponds. The premium paid in excess will not grant additional responsibility for such excess, but only and exclusively to the refund of such premium paid in excess, without interest. The difference will be refunded by the Insurer in the same form of payment in which it was received.

Failure to pay the premium within the agreed period, or at the time when it becomes due, will entitle the Insurer to unilaterally and fully void this Policy as hereby established.

5.4 Payment notices

The premium is payable on the Expiration Date of the Policy. Renewal notices are issued as a courtesy and the Company does not guarantee delivery. If the Policyholder does not receive a payment notice thirty (30) days before the Expiration Date, and the Policyholder does not know the premium amount, he/she must contact the Agent or the Insurer. The collection efforts of the premium made by the Insurer does not imply the resignation of the Company of its right to terminate this Policy for lack of payment.

Failure to pay the renewal premium on or before the Expiration Date will be interpreted as the expressed will of the Policyholder to not renew this Policy.

5.5 Rate changes

The Insurer reserves the right to change the premium rates on the date of each anniversary of this Policy, according to the inflation of medical costs.

5.6 Premium reimbursement

If the Insurer cancels or rescinds the Policy, the Insurer will reimburse the unearned portion of the corresponding premium to said Insured, following provision 1.1.

If the Policyholder requests the cancellation of the Policy to the Insurer, or the latter cancels the Policy for any reason other than fraud, the Insurer will reimburse the unearned portion of the premium to the Policyholder, up to a maximum of sixty-five (65%) of the premium.

Section 6. Benefits and provisions

Unless stated otherwise, benefits are offered per Insured, per Policy year. All amounts are expressed in US 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 for the geographical area where the expenses were incurred.

6.1 Geographical coverage

This plan provides coverage with free choice of Hospitals and Doctors worldwide (require US/HK/SG Add-on); or worldwide, excluding the United States of America, Hong Kong and Singapore (default coverage), subject to the geographical area of coverage chosen at the time of the application and what is specified on the Insured's Certificate of Coverage.

6.2 Standard Private Hospital Room

The coverage for room and board during the Hospitalization of an Insured in a Private Standard Room is one hundred percent (100%) UCR.

6.3 Intensive care unit

The coverage for the treatment of an Insured in an intensive care unit is one hundred percent (100%) UCR.

6.4 Surgeon, Assisting Surgeon and Anesthesiologist Fees

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

6.5 Organ and tissue Transplant

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

A. The benefit of up to fifty thousand dollars (US$50,000) for medical expenses related to the Live Donor;

B. Every 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 stabilization of the Insured for said procedure;

C. Every pre-surgery exam, including laboratory exams, X-rays, CT scans, MRIs, ultrasounds, biopsies, Prescription Medication and supplies;

D. The cost of obtaining the organ and tissues, its 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. Every post-Transplant care directly related to the Transplant including, but not limited to any follow up, any Medically Necessary treatment resulting from the Transplant, and any complication that may arise after the Transplant, whether it may be a direct or indirect consequence of the procedure; and

H. Any Medication or therapeutic measure used to ensure the viability and permanence of the Transplanted organ.

The following requirements are indispensable for this Transplant coverage:

A. It is Medically Necessary;

B. It is not considered elective, Experimental or Investigative;

C. No other 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 caused the need for the Transplant;

D. It is not originated as a result of a Transplant where the receiver obtains a mechanical artifact or artificial equipment aimed to replace human organs, or when the organ to

be Transplanted is an animal's; and

E. It is not performed due to an initial failed Transplant carried out prior to the Effective Date of this Policy or a non-approved Transplant that was carried out after the Effective Date of this Policy.

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

6.6 Congenital Disorders

The benefit for any Congenital Disorder is up to a maximum of twenty-five thousand dollars (US$25,000).

This benefit excludes coverage if the diagnostic was prior to the effective date, and conditions and/or consequences resulting from any type of fertility treatment or procedures for assisted fertility that manifest at any age.

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

The coverage for this benefit is up to a maximum of 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 has 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 (for teams under 5 people), 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. This benefit includes pre and post diagnosis consultations, routine check-ups for this condition, Medication and dressings (except experimental or those unproven), Hospital accommodations and nursing fees. This benefit must be coordinated and approved in advance by the Company.

6.8 Adult companion accommodation expenses of a Hospitalized Insured

The coverage for adult companion accommodation of a Hospitalized Insured Dependent under the age of eighteen (18) is one hundred percent (100%) UCR.

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

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

6.9 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 a medical condition covered by this Policy. In the case of treatment provided for nasal malformations or of the septum, coverage will be provided if caused by trauma received during an Accident covered by the Policy or due to the treatment of nasal cancer. The Company may require copy of the reports, tests, films, discs or any other information necessary to evaluate the case.

6.10 Day patient or outpatient surgery

The coverage for surgery as a day patient or outpatient in a Hospital, Clinic or medical office is up to five hundred thousand dollars (US$500,000).

6.11 Inpatient Emergency dental treatment

The coverage for this benefit is one hundred percent (100%) UCR for Injuries resulting from a covered Accident. This benefit is limited to a necessary treatment to restore or replace sound natural teeth that have been damaged and/or lost in a covered Accident.

6.12 Rehabilitation and specialized treatments

The coverage for this benefit is up to a maximum of five hundred thousand dollars (US$500,000), or up to thirty (30) days per medical condition, for Medically Necessary physical therapy, speech therapy or occupational therapy, all therapies combined, after a covered Hospitalization.

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 authorized in advance by the Company. The Company would evaluate the extension of the treatment if it is Medically Necessary.

6.13 Nurse care at home

The coverage for this benefit is one hundred percent (100%) UCR, for up to sixty (60) days, and based on the Usual, Customary and Reasonable charges for the particular care 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.

This benefit must be coordinated and approved in advance by the Company and it includes medical home care that has been prescribed by the treating Doctor.

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

6.14 Emergency transportation

Ground Ambulance

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

The Insured, by accepting this service, agrees to hold the Company and any of 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 driver errors, omissions or negligence, or due to operational, weather, force majeure or any other adverse conditions.

6.15 Evacuation and repatriation

The benefit for evacuation, repatriation and repatriation of mortal remains or cremation is up to a maximum of one hundred thousand dollars (US$100,000).

Air Ambulance Emergency evacuation

The evacuation 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 the Policy;

B. The 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;

E. The transportation will be authorized to the nearest Hospital where the Insured can receive treatment by qualified entities; and

F. The Air Ambulance transportation must be pre-authorized and coordinated in advance with the Company.

The Insured, by accepting this service, agrees to hold the Company and any of 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.

Repatriation

This benefit includes for the Insured and one (1) companion a return ticket in a commercial airline flight, economy class cabin to the place from which the Insured was evacuated, provided that the trip is performed within the ninety (90) days of discharge and it is coordinated by the Company.

Repatriation or cremation of mortal remains

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 authorizations pursuant to the requirements of the pertinent authorities, and it excludes transportation of the remains by Air Ambulance or any private transportation.

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

6.16 Accident and Emergency non-elective treatment outside the geographical area of coverage

The coverage for Accident and Emergency non-elective treatment when traveling to the United States, Hong Kong or Singapore is one hundred percent (100%) UCR for Injuries, up to a maximum of fifty thousand dollars (US$50,000) for Illnesses, and up to a maximum of five hundred dollars (US$500) for Outpatient services. This coverage is limited to up to thirty (30) days per planned trip.

6.17 Hospital cash benefit

The coverage for this benefit is up to one hundred and fifty dollars (US$150) per night, up to a maximum of thirty (30) nights, 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. This benefit is only available by reimbursement.

6.18 Passive war and terrorism

The coverage for Injuries sustained as a bystander passive subject during war or terrorism is one hundred percent (100%) UCR when the Insured is a simple spectator or civilian innocent of any actions.

6.19 Terminal Illness / Palliative Care

The coverage for this benefit is up to a maximum of fifty thousand dollars (US$50,000) for palliative services to patients 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 service must be provided by a medically supervised team of professionals, and it must be rendered in an accredited hospice. This benefit must be coordinated and approved in advance by the Company.

6.20 Prescription Medication

The coverage for Medication during a Hospitalization is one hundred percent (100%) UCR. The coverage for pre- and post-operative Medication is one hundred percent (100%) UCR, for up to fifteen (15) days before or after inpatient treatment.

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

Highly specialized Medications

Highly specialized Medications 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 Medication directly to the Insured with its Providers. The Insured must accept the conditions of the Company for the supply of such specialized Medications, by either receiving treatment with the specific Provider designated by the Company or according to the delivery method available. The Company will provide the generic Medication as a first option when available.

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

This benefit excludes inpatient or outpatient Medications that are not scientifically or medically approved for a specific diagnosis or considered as off-label use or Experimental, or the use of combinations, 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). If a prescribed medication is approved by the FDA for the specific condition of the Insured, but it is part of an Experimental treatment, that drug it is also excluded of coverage.

6.21 Durable Medical Equipment

When Medically Necessary, Durable Medical Equipment will be covered up to a maximum of one thousand five hundred dollars (US$1,500) per medical condition, within six (6) months of the eligible medical condition, as long as the Insured presents a prescription from a Physician or licensed Provider that justifies a therapeutic benefit for the Insured. This coverage must be coordinated and approved in advance by the Company.

This benefit includes, but is not limited to prosthetic limbs, wheelchairs, canes, crutches, respirators, pressure mattresses, and walkers, provided that such equipment is prescribed by a Physician and it is customarily useful to a patient for the Illness or Injury. The allowable rental fee of the equipment must not exceed the purchase price.

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

6.22 Inpatient psychiatric coverage

The coverage for this benefit is one hundred percent (100%) UCR, for up to thirty (30) days of inpatient psychiatric care.

6.23 Health screenings and vaccines

The coverage for this benefit is up to a maximum of three hundred and fifty dollars (US$350).This benefit includes coverage for health screenings and vaccinations. This benefit excludes COVID-19 vaccinations.

6.24 Maternity care

A. The benefit for maternity care for natural and Medically Necessary cesarean deliveries is up to a maximum of two thousand five hundred dollars (US$2,500) per pregnancy, including pre- and postnatal expenses.

B. In case of a cesarean considered a Maternity Complication, it will receive coverage as stipulated in the Maternity Complications benefit.

C. For same-sex Domestic Partners, only one of them has the right to maternity care benefits.

D. The maternity benefits do not apply to Dependent daughters.

E. The maternity care benefits include natural deliveries, cesarean deliveries, prenatal care, postnatal care for up to thirty (30) days from the date of discharge.

F. Outpatient treatment of an eligible medical condition that was a direct result of a pregnancy complication including:

- Ectopic pregnancy
- Hydatidiform mole
- Retained placenta
- Placenta previa
- Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
- Post-partum hemorrhage
- Miscarriage requiring immediate surgical treatment

Coverage is not provided for conditions that are a result of a fertility treatment or any other type of assisted fertility procedure, or for a pregnancy not covered by this Policy.

This benefit is subject to a ten (10)-month Waiting Period and is waived only in cases of miscarriage requiring immediate surgical treatment.

6.25 Newborn coverage and Maternity Complications

The maximum benefit for Newborn coverage and Maternity Complications is up to fifty thousand dollars (US$50,000).

This benefit includes medical expenses for Injury or Illness of the Newborn, such as respiratory distress, prematurity, hypoglycemia, low birth weight and birth trauma, which were diagnosed within the first thirty (30) days of life. This benefit excludes expenses related to Congenital or Hereditary Conditions. In order for the Company to provide this benefit, the newborn must have been born from a Maternity Covered under this Policy.

The coverage of expenses related to Birth Complications, will be available only if the Newborn of a covered Maternity is added to the Policy as a Dependent.

To add a Newborn to the Policy, the Insured must send the birth certificate to the Company and the corresponding premium must be paid.

This benefit ends when the Newborn is discharged or in ninety (90) days if the Newborn is not added to the Policy within the established period, whichever occurs first.

Coverage is not provided for conditions that are a result of a fertility treatment or any other type of Assisted fertility procedure, or for a pregnancy not covered by this Policy.

Bed rests prescribed by a physician which don't require Hospitalization, as well as any other of the traditional symptoms of pregnancy, won't be considered as Complications of Maternity.

The Maternity Complications benefit does not apply to Dependent daughters. Any primary Insured who has previously been a Dependent daughter under another Policy with the Company, must have maintained her own individual Policy

for a minimum of ten (10) months in order to be eligible under this benefit.

6.26 Allergy treatments

The coverage for this benefit is one hundred percent (100%) UCR and it includes diagnostic exams.

Outpatient benefits

The maximum allowable amount for all combined outpatient benefit expenses is up to five thousand dollars (US$5,000).

6.27 Emergency room care

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

6.28 Physician and specialist visits

The coverage for outpatient physician and specialist visits is one hundred percent (100%) UCR.

6.29 Prescription Medications

The coverage for outpatient Medication, not prescribed during a Hospitalization, is one hundred percent (100%) UCR.

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

Highly specialized Medications

Highly specialized Medications 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 Medication directly to the Insured with its Providers. The Insured must accept the conditions of the Company for the supply of such specialized Medications, by either receiving treatment with the specific Provider designated by the Company or according to the delivery method available. The Company will provide the generic Medication as a first option when available.

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

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

6.30 Physical therapy and rehabilitation

The coverage for outpatient physical therapy and rehabilitation is one hundred percent (100%) UCR. 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 authorized by the Company in advance.

6.31 Mental health visits

This benefit includes coverage for mental health Prescription Medication and outpatient services from a psychiatrist, psychologist, and/or speech, vocational or occupational therapist, provided they are licensed professionals and are supported by a treatment plan. Services must be rendered in the Provider's office, clinic, or via virtual medical consultation.

Covered services include treatment for bulimia,

anorexia, bereavement, non-medical causes of insomnia, Attention Deficit Disorder (ADD), and Attention Deficit Hyperactivity Disorder (ADHD).

This benefit excludes aptitude testing, educational testing, services for conditions not determined to be an emotional or a personality Illness, services extending past the necessary time for evaluating and diagnosing a mental health issue, services for mental disorders or Illnesses that cannot be improved or treated effectively, and marriage and family counseling.

In all cases, the Company must receive the physician's treatment plan, supported by evidence of services being Medically Necessary. This coverage must be coordinated and approved in advance by the Company. Pre-authorization by the Company is mandatory for every ten (10) visits, excluding the first consultation.

6.32 Diagnostic test services

The coverage for outpatient diagnostic test services, including but not limited to pathology, X-rays or MRI/CT/PET scans is one hundred percent (100%) UCR.

6.33 Complementary therapies

The coverage for this benefit is up to sixty dollars (US$60) per visit, for up to a maximum of fifteen (15) visits per Policy Year for massages, osteopathy, chiropodist, podiatrist, chiropractic, homeopathy, dietitian and acupuncture therapies. Any treatments must be carried out by qualified and authorized therapists.

Section 7. Exclusions

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

7.1 Active duty, war and disturbances

The treatment of Injuries that may result when an individual is an active member of the police force, the army or other military force of any country, or is directly or indirectly participating in a war or military conflict, disturbance, civil or military coup d'état, hostility, civil war, riot, rebellion, martial law, act of terrorism or any illegal activity, including the possible arrest and incarceration resulting from said participation, except for cases in which the Insured is a simple spectator or civilian innocent of these actions.

7.2 Additional medical assistants

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

7.3 Administrative and non-medical fees

A. Any fees related to filing a claim form or to retrieve medical records from a medical or dental Provider.

B. Any fees related to filing or retrieving police records.

C. Any costs associated for delivering or transporting medications including customs duties.

7.4 Aesthetic treatments

Any type of elective or cosmetic surgery, or treatments whose principal purposes are aesthetic, except when it is necessary due to an Injury, deformity or Illness occurred during the effective period of this Policy. Complications resulting from non-covered services, including the diagnosis or treatment of any condition which arises as a complication of a non-covered service including, but not limited to services rendered for cosmetic

purposes including hair Transplant, any alopecia treatment, ear or any other body piercing, breast reductions and breast implants.

This includes any treatment for nasal or septum deformities, except as specifically provided in Section 6.9 of this Policy.

7.5 Undeclared Chronic Conditions

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

7.6 Artificial kidney equipment

Any portable or home-use artificial kidney equipment.

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

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

7.8 Dental or orthodontic treatment

Any expense for dental or orthodontic treatment not specified in the Table of Benefits, 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.

7.9 Duplicate Durable Medical Equipment

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

7.10 Epidemics or Pandemics

Any medical treatment subject to the management of public authorities, including treatment and services related to infectious diseases declared as an Epidemic or public Emergency by the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), or any other government or governmental Agency or governing body of the country where the Epidemic occurred. In addition, such coverage is also excluded if 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 as a result of visiting the area prior to the declaration of an Epidemic or Pandemic.

7.11 Excessive expenses

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

7.12 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 on public transportation where the Insured is covered under any type of insurance, private or public, regardless of whether or not 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.

7.13 Expenses incurred in sanctioned countries

Any expense or claim incurred for the treatment, services or supplies rendered in countries, or 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 European Union, the United Kingdom, or any of its entities or asset control agencies.

7.14 Extended and Custodial Care; counseling services

Treatments in nursing homes for the elderly, assisted living facilities, hospices, long-term care facilities, hydro-Clinics, health spas and memberships to gymnasiums.

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 behavior 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.

Custodial Care or assistance with household chores or for personal hygiene; any other personal services for comfort including, but not limited to beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, travel expenses other than Medically Necessary Emergency ambulance services that are specifically provided in this Policy.

7.15 Fetal surgery

Any surgery or treatment of a child while in the mother's womb.

7.16 Growth hormones

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

7.17 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.

7.18 Injuries or Illnesses caused by radiation

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

7.19 Maternity or Newborn Complications under 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 Complication expenses for Dependent daughters. Any voluntary termination of a 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.

7.20 Medical care not prescribed and recommended by a physician, Non-Medically Necessary, Alternative, Investigative or Experimental procedures

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

alternative care; or is not scientifically recognized or is 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).

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, as well as over-the-counter Medication and/or those not approved for the treatment of the specific condition of the Insured by the U.S. Food and Drug Administration (FDA).

A prescribed Medication that is approved by the FDA for the specific condition of the Insured, but that is part of an Experimental treatment, it's also excluded from coverage.

7.21 Obesity and weight control treatments

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

7.22 Over the counter Medication

Any Medication that may be acquired without a physician's prescription including, but not limited to food supplements needed as a result of digestive intolerance, hunger suppressants, vitamins, anti-aging or hair growth Medications or products.

7.23 Podiatric care and orthopedic devices

Routine foot care, as well as any service or supply in connection with foot care including, but not limited to treatment of bunions, flat feet, fallen arches, and chronic foot strain; removal of warts, corns, or calluses; special shoes; pedicures or trimming of toenails; and orthopedic inserts of any type or form, except as specifically provided in Complementary therapies of this policy.

7.24 Professional Sports

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

7.25 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; hearing aids; eye glasses and contact lenses; prophylactic treatments, and the issuance of medical certificates and physical exams for work or travel, except as specifically provided in Section 6.23 of this Policy.

7.26 Self-inflicted Illness or Injury or criminal acts

Any care or treatment for self-inflicted Illnesses or Injuries, whether the individual is sane or insane; suicide; failed suicide; addictive conditions of any type; alcohol abuse; drug use or abuse; use of Illicit Substances or illicit use of controlled substances or Medication; being under the influence of alcohol or drugs; encounters with wild animals; and participating in fights or criminal acts in which the Insured or members of his/her family take part in a negligent manner, unless he/she/they are acting, legitimately, in self-defense; as well as any incident or Accident resulting from any of the criteria previously mentioned.

Care and treatment incurred in connection with Injuries which occurred during a crime committed by an Insured or which the Insured tries to commit including, without limitation, treatment and care for any Injuries sustained when the Insured's blood alcohol content is in excess of the legal limit in the place where the incident occurred, whether or not the Insured is charged with or convicted of any criminal offenses.

7.27 Sleep disorders, Alzheimer's and autism

The treatment or services related to any of the following conditions: sleep disorders, Alzheimer's and autism.

7.28 Sterilization, fertilization treatments; sexual reassignment

Any portion of a medical expense incurred in male or female sterilization; sterilization reversal; birth control; infertility treatments; artificial insemination; in vitro fertilization; conditions suffered by the mother or the Newborn as a result of any type of fertilization treatment; treatments or prostheses used to improve or restore potency, or other sexual deficiencies, even if the treatments or prostheses are secondary to a condition covered by this Policy. Sexual Reassignment, reproduction or modification services; including hormone therapy, intersex surgery, sexual deviations and disorders, psychosexual dysfunctions, genetic tests to determine paternity or sex of a child; disorders related to the Human Papilloma Virus (HPV) and genital herpes.

7.29 Treatment for mental health

Services for mental and nervous disorders and related Prescription Medication; neuro-developmental disorders, are not covered, except if they are required to treat a complication of a covered condition, as defined in the terms and limits of this Policy, and except as specifically provided in Sections 6.22 and 6.31 of this Policy.

7.30 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, are excluded from coverage. This exclusion also precludes an Insured who is also a physician from treating him/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 authorize the treatment provided by the family member or the use of the Provider's facilities.

7.31 Claims filed outside the allowable time

Claims for medical services not received within one hundred and eighty (180) days from the date of ser vice.

7.32 Expenses when the Insured travels against doctor's orders

Any medical expenses when the Insured has travelled against any healthcare professional's medical advice.

7.33 Pre-existing conditions

This health insurance policy does not provide coverage for any pre-existing condition, as defined in this Policy, except as specifically provided in Sections 6.23 and 6.32 of this Policy.

In case of accident or emergency not related or caused directly or indirectly due to a pre-existing condition, coverage will extend to treatments necessary to the management and stabilization of injuries or conditions resulting solely from such an incident.

Section 8. Definitions

Accident
A violent, sudden, unforeseen and unintentional event provoked, exclusively by external causes resulting, independently of other causes, in bodily Injuries to the Insured.

Add-on
Document attached to the Policy by the Company when it is acquired and paid by the Policyholder and which provides additional optional coverage.

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

Agency or Agent
The individual or company authorized by the Company for the distribution of this Policy document. The Agent shall have access to the Insured's health and medical information which may be delivered to the Company or any one of its affiliates. No Agent has the authority to modify the Policy or to remove any of its terms and conditions.

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

Amendment
A declaration added to the Policy by an authorized 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.

Anesthesiologist Fees
Fees charged by an anesthesiologist for the administration of anesthesia and/or pain control.

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

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 Dependents. This form is used by the Company to determine the insurability of the Applicant and his/ her Dependents. Any information or questionnaires submitted to the Company with the Application is considered part of the Application.

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

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

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

Birth Complications
Any disorder related to a Newborn not caused by genetic factors and which manifests during the first thirty (30) days of life.

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

Company
The Insurer or VUMI® Group, I.I.

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

Country of Residence
The country in which the insured habitually resides (usually for a period of more than 6 months) within a year while this policy is in effect.

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

Domestic Partner
Person with whom the Insured 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
The date when the Policy becomes effective.

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

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

Experimental or Investigative
Any treatment, procedure, equipment, Medication, combination of Medication, device, supply or Hospitalization which, at the time the service or supply is provided, does not meet the generally approved norms for the specific indication or Application to the condition by the FDA or other applicable federal Agency of the government of the USA, 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.

FDA approved
https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm.

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

Ground Ambulance
Ground transportation equipped with medical equipment and medically trained personnel to

transport individuals who are injured or ill.

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

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

Hospitalization
Admission to an inpatient medical center 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 Hospitalization for the purposes of this Policy.

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

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 that 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.

Insured
It refers to both the Policyholder and the covered Dependents.

Insured Dependents
Spouse or Domestic Partner of the Policyholder, his/her biological children, legally-adopted children, stepchildren or children under eighteen (18) years old 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 cell to be Transplanted into the body of another person or recipient.

Long-Term Care Facility
Assisted living institution.

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

Medical Necessity or Medically Necessary
Treatment, medical service or medical supply deemed necessary by the Company, in mutual agreement with the Insured's physician, 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 or 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 and Hospitals; or

E. Is a substitution of a Standard or Private Room for a Suite, if the Policy doesn't offer this benefit.

Member
An individual named under the Policy at any given time.

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

Non-covered maternity
A pregnancy resulting from fertility treatment or assisted fertility procedures or a delivery that occurs before the waiting period of ten (10) months.

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.

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

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

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 Organization (WHO), the Centers for Disease Control and Prevention (CDC) or an equivalent organization.

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

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

Policyholder or Applicant
The 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-existing Condition
Any illness or injury for which you received treatment or diagnosis in your life, and any illness or injury you have experienced symptoms in the last two (2) years.

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

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

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

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

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

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

Second Medical Opinion VIP®
VUMI® service that provides Insureds access to a second medical opinion of renowned experts from around the world.

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 Hospitalization of twenty-four (24) hours or more.

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

Standard Hospital Room
Hospital room equipped to accommodate one (1) or more than one patient.

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

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

Suite
Hospital room of a Hospital or Clinic classified by said Hospital or Clinic 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 reimplant it in the same person.

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

United States, US, USA
The united States of America and 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 provides 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.

Section 9. Management of the Policy

9.1 Notifications and/or pre-authorizations

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

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

A. All Hospital admissions;

B. All Hospital or outpatient surgeries;

C. Any major procedures, such as MRIs, CT scans, PET scans, gastroscopies, colonoscopies, biopsies, etc.;

D. Physical and rehabilitative therapy, home health care or Private Nurse or Therapist;

E. Nasal or reconstructive surgery;

F. Emergency transportation by Air Ambulance;

G. Durable Medical Equipment or any special medical device;

H. Physiotherapy or complementary therapy after ten (10) sessions;

I. Repatriation or cremation of mortal remains, whereby a notification must be made on behalf of the Insured;

J. Any medical service or purchase of drugs related to the Human Immunodeficiency Virus (HIV) or the Acquired Immune Deficiency Syndrome (AIDS); and

K. USA elective treatment.

The Insured must notify the Company at least seventy-two (72) hours prior to receiving those medical services that require notification or pre-authorization. The Company must also be given notice of all medical Emergencies that require notification within seventy-two (72) hours after the event that caused the Emergency. If the Policyholder and/or the Insureds fail to notify the Company accordingly, they shall then be responsible for thirty percent (30%) of all covered costs.

All notices and other necessary communication between the parties will be sent in writing by mail or electronic means of communication and will be considered valid with the receipt confirmation of the information by the recipient. In case of notifications sent by other means of communication, a confirmation receipt of the information sent via email will be required indicating the date of reception.

In case of Emergency or any questions related to the provision of the services, the Company has the following contact information available for its Insured:

- Email address: rhpreapproval@safetywing.com
- Phone number: +1.214.276.6376

9.2 Claims

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

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

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

A. Claim Form duly completed;

B. All itemized bills from the Provider detailing the services rendered, along with proof of payment;

C. A recent medical history or any other medical information that the Company may consider pertinent;

D. For pharmacy expenses, a copy of the medical prescription;

E. In the event of an Accident, the Insured must submit all information related to said Accident, as well as the circumstances surrounding it, pursuant to what is required by the Company. This includes, but is not limited to Accident reports, police reports or others, when issued by the pertinent authorities or any other information available from any other third parties involved in the matter;

F. Declare any other medical insurance coverage the Insured may have when submitting a claim.

When simultaneously submitting multiple claims for reimbursement from different Insureds, the expenses for each Insured, Accident, Illness and/or Provider must be divided into single Insureds 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.

Once the complete information is submitted, the turnaround time for reimbursement to the Insured will be fifteen (15) business days.

If the information provided should 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 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.

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.

9.3 Claims appeals

In the event of any disagreement between the Insured and the Company regarding a claim or administrative decision, before any other action is taken, the Insured must begin an appeal about the claim or decision to the Company's Appeals Department for review and analysis. The appeal must be submitted within a period of no more than ninety (90) days from the date the administrative decision on a claim was made.

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

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

Second instance of appeal

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

9.4 Arbitration and legal actions

Any dispute, controversy or claim arising out of or relating to this insurance Policy, including the formation, interpretation, breach or termination thereof, and including whether the claims asserted are arbitrable, will be referred to and finally determined by arbitration in accordance with the JAMS International Arbitration Rules. The parties reserve the right to object to the intervention of any individual employed by or affiliated to a competing organization or entity.

The seat of the arbitration will be New York City, NY. The language to be used in the arbitral proceedings will be English. Judgment upon the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. In any arbitration arising out of or related to this insurance Policy, the arbitrator may not award any incidental, indirect or consequential damages, including damages for lost profits.

The parties shall maintain the confidential nature of the arbitration proceeding and the award, including the privacy of the hearing, except as may be necessary to prepare for or conduct the arbitration hearing on the merits, or except as may be necessary in connection with a court application for a preliminary remedy, a judicial challenge to an award or its enforcement, or unless otherwise required by law or judicial decision.

In any arbitration arising out of or related to this insurance Policy, the arbitrator shall award to the prevailing party, if any, the reasonable costs for legal representation incurred by the prevailing party in connection with the arbitration. If the arbitrator determines a party to be the prevailing party under the circumstances where the prevailing party won on some, but not all of its claims and counterclaims, the arbitrator may award the prevailing party an appropriate percentage of the reasonable costs for legal representation incurred by the prevailing party in connection with the arbitration.

Governing Law

The parties agree to grant to the State and Federal courts located in the borough of Manhattan, County of New York, State of New York (or if there is exclusive federal jurisdiction), exclusive

jurisdiction and venue over any disputes, action or proceedings arising out of or in connection with this insurance Policy involving the parties, and the parties hereby consent to the jurisdiction of such courts.

9.5 Subrogation 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 10. Language

English is the prevailing language in case of any discrepancy with the provisions of this Policy. Other languages may be used at the request of the Insured in all communications, reports, correspondence, specifications and calculations of the Company, as well as in the invoices presented to the Insured.

Section 11. Agreement

This contract constitutes and encompasses a complete agreement regarding matters or concerns regulated herein, and will prevail or revoke any previous agreements between the parties related to the service, either verbal or written, implied or explicit.

Section 12. Amendments

In the event of any conflict between this contract, its appendices and/or addenda, the provisions contained in the corresponding appendix and/or addendum will prevail, as long as they are not inconsistent with the provisions contained in this contract in terms of liability.

Data Protection:

1. Data Collection and Use
   We are committed to protecting the privacy

of all individuals whose personal data we collect, use, and process during our business activities. We collect personal data only to the extent necessary for the specific purpose for which it is processed, and we ensure that such data is accurate, up-to-date, and relevant.

2. Confidentiality and Security
We maintain appropriate technical and organizational measures to protect the confidentiality, integrity, and availability of personal data we collect, use, and process. We limit access to personal data to authorized personnel who have a legitimate business need to access it. We ensure that our third-party service providers who process personal data on our behalf also have appropriate technical and organizational measures in place.

3. Data Transfers
We ensure that personal data is only transferred to third parties who provide an adequate level of protection for such data, in accordance with applicable data protection laws and regulations.

4. Monitoring and Review
We regularly monitor and review our data protection practices to ensure that they remain up-to-date and effective. We provide training and education to our employees on data protection matters to ensure that they are aware of their responsibilities and obligations.

Contact us

remotehealth@safetywing.com

Website

safetywing.com/nomad-health

VUMI® GROUP, I.I.
ORGANIZED 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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