Best Doctors® INSURANCE

CONDITIONS OF COVERAGE

BRAZIL

EFFECTIVE MARCH 1, 2026

Contents

Best Doctors® INSURANCE

MEDICAL ELITE™ Pro

PREMIER PLUS™ Pro

GLOBAL CARE™ Pro

MEDICAL SELECT™ Pro

ART. 1 AGREEMENT

Subject to the payment of the premium required, the Insurance Company undertakes to pay up to the benefit indicated in the Table of Benefits per Insured per Policy Year for Covered Expenses and other benefits provided under this Policy.

All benefits are subject to the terms and conditions of this Policy, including any applicable Individual Deductible and/or Coinsurance as defined herein.

ART. 2 POLICY ISSUANCE

2.1 This Policy has been negotiated, issued, and delivered in Bermuda. This Policy is an international health insurance plan and may not provide mandatory coverage required by the authorities and jurisdiction of an Insured's Country of Residence or any other country.

2.2 Ten (10) Day Right to Examine the Policy

The Contracting Party has the right to examine and return the Policy within ten (10) days of receiving it if they are not satisfied with the offered coverage.

The Policy may be returned directly to the Insurance Company or through the Independent Consultant. If returned, the Policy will be considered void as if it was never issued. The Insurance Company will refund the Contracting Party the premium paid minus the amount charged for administrative expenses.

2.3 If it is not returned within the ten (10) day period, any requests for refund of premiums shall be processed as stipulated in the "Refunds of Unearned Premium" article.

2.4 Important Notice About the Health Insurance Application

The Insurance Company issued the Policy based on the information provided by the Primary Insured in the applicable Health Insurance Application. By accepting this Policy, the Primary Insured represents that the statements were provided in good faith on behalf of all Insureds. Regardless of whether or not it is relevant to a claim submitted by an Insured, any inadvertent non-disclosure or any false statement, concealment, deceit, omission of information, or simulation contained in the Health Insurance Application for any Insured that might impact on the underwriting of the risk or results in a possible aggravation of the risk, may be grounds for the cancellation, termination, or modification of the Policy at the discretion of the Insurance Company. The Insurance Company shall only be liable to refund the unearned premium for the remaining time before the expiration of the Policy, starting from its termination, as stipulated in the "Refunds of Unearned Premium" article. If it is determined that any such statement was not made in good faith, was meant to deceive the Insurance Company, or was otherwise fraudulent, the Insurance Company shall not be obligated to return any portion of the unearned premium as stipulated in the "Fraud, False Statement, Omission, or Deception" article.

2.5 In the event of cancellation, termination, or modification of the Policy, the Insurance Company shall be released from any liability for the payment of benefits and obligations stipulated therein from the moment of the effectiveness of such cancellation, termination, or modification.

ART. 3 DURATION OF COVERAGE

Provided that the total applicable premium has been paid, coverage begins at 00:01 hours, Eastern Standard Time (USA) on the Policy Effective Date and ends at 24:00 hours, Eastern Standard Time (USA) on the Policy Renewal Date.

The coverage has a duration period of twelve (12) months and shall be renewed automatically for a similar period of time, provided full payment of the premium due is made, subject to the terms, conditions, provisions, exclusions, and definitions of the Policy, and absent any instances of fraud, misrepresentation, omission, or otherwise any reproachable behavior on the part of the Primary Insured or Insured Dependents, which terms shall renew their effectivity on the Renewal Date. The Policy will also terminate when cancelled in accordance with the "Fraud, False Statement, Omission, or Deception" article. Notwithstanding the foregoing, coverage for an Insured may cease when coverage terminates for such Insured as set forth in the "Eligibility and Coverage Termination" article.

ART. 4 ELIGIBILITY AND COVERAGE TERMINATION

4.1 Primary Insured

The Primary Insured must meet the following requirements at the time of issuance of the Policy:

a. Their Country of Residence must be Brazil.
b. They must be between eighteen (18) and seventy-four (74) years of age.
c. If sixty-four (64) years of age or older, they must provide any medical evidence or documentation reasonably required by the Insurance Company to assess eligibility.

The coverage for the Primary Insured will terminate upon their death or:

a. If they become a Resident of the United States of America as of the next Renewal Date.
b. If the total applicable premium is not paid.
c. If the Policy is cancelled at the Contracting Party's request.
d. In accordance with the stipulations in the "Fraud, False Statement, Omission, or Deception" article.

4.2 Insured Dependent Spouse or Domestic Partner

The Insured Spouse or Domestic Partner must meet the following requirements when their coverage becomes effective:

a. Their Country of Residence must be Brazil.
b. They must be between eighteen (18) and seventy-four (74) years of age.
c. If sixty-four (64) years of age or older, they must provide any additional medical information required by the Insurance Company.
d. They must provide proof of marriage or other documents that establish their domestic partnership with the Primary Insured.

The coverage for the Insured Spouse or Domestic Partner will terminate upon their death or:

a. If they become a Resident of the United States of America as of the next Renewal Date.
b. If the total applicable premium is not paid.
c. If their relationship with the Primary Insured ends by way of divorce or annulment or if the domestic partnership ends.
d. If the Contracting Party requests to remove them from the Policy.
e. If the Policy is cancelled at the Contracting Party's request.
f. In accordance with the stipulations in the "Fraud, False Statement, Omission, or Deception" article.

4.3 Insured Dependent Child

The Insured Child must meet the following requirements when their coverage becomes effective:

a. Their Country of Residence must be Brazil.
b. They must be younger than eighteen (18) years of age and unmarried, or between eighteen (18) years and twenty-four (24) years of age, unmarried, and full-time student at an Accredited University or School.
c. They must provide birth certificate or other document that establishes their relationship with the Primary Insured.

The coverage for the Insured Child will terminate upon their death or:

a. If they become a Resident of the United States of America as of the next Renewal Date.
b. If the total applicable premium is not paid.
c. If they marry.
d. If they are between eighteen (18) and twenty-four (24) years old and no longer a full-time student at an Accredited University or School by the next Policy Renewal Date.
e. By the next Policy Renewal Date after turning twenty-four (24) years old.
f. If the Contracting Party requests to remove them from the Policy.
g. If the Policy is cancelled at the Contracting Party's request.
h. In accordance with the stipulations in the "Fraud, False Statement, Omission, or Deception" article.

4.4 No maximum age applies for renewal for the Primary Insured, Spouse, or Domestic Partner.

4.5 Coverage Continuity for Insured Dependents

a. A Dependent Child who fails to qualify as an Insured Dependent Child because of their age or marital status, may request their own Policy under a similar plan without being subject to a new underwriting evaluation by completing a Continuous Coverage Request Form and paying the full premium due before the Policy Renewal Date's Grace Period following the corresponding event ends. Under the new individual Policy, the new Primary Insured will be subject to the same terms, conditions, Amendments, exclusions, and restrictions they had as an Insured Dependent Child under the previous Policy.

b. If the Primary Insured becomes ineligible, Insured Dependents may request coverage under one or more new insurance Policies under a similar plan without undergoing a new underwriting evaluation if they are otherwise still eligible for coverage. The new Policy will be subject to the same terms, conditions, Amendments, exclusions, and restrictions the Insured Dependents had under this Policy. They must submit a Continuous Coverage Request Form and full premium due to the Insurance Company before the end of the Renewal Date's Grace Period of the Policy under which they were Insured Dependents.

c. To receive Maternity Care, Complications of Maternity and Birth, and Stem Cells Extraction and Preservation benefits, a female Insured Dependent Child that has been covered more than ten (10) months under her parents' Policy must request coverage under her own individual Policy as Primary Insured or Spouse under a similar plan with the same maternity benefits of her parents' plan. The ten (10) month Benefit Waiting Period to receive such benefits will be waived at the time of issuing her the new Policy only when this is specified in the Table of Benefits.

4.6 Dependent Coverage After Primary Insured's Death

If the Primary Insured dies and the Insured Dependents are eligible for the Primary Insured's Death Benefit, as indicated in the Table of Benefits and in the "Covered Expenses" article, the Contracting Party (or, if the Contracting Party is the same as the Primary Insured, the designated Beneficiary or the legal heirs of the Primary Insured) may choose to maintain the coverage for the eligible Insured Dependents under the Policy and Riders by submitting a Continuous Coverage Request Form without having to pay the corresponding premiums for the period indicated in the Table of Benefits from the next Due Date or Renewal Date of the Policy, whichever occurs first, as long as the cause of the Primary Insured's death is due to an Illness or Accident covered under this Policy. During this period, the Insured Dependents, or if applicable, the Contracting Party or the Legal Representative, shall remain fully responsible for any advance payment for services, Individual and Family Deductibles, and any administrative or other costs not covered under the terms of the Policy. At the end of the waived period indicated in the Table of Benefits, full premium due must be submitted for all eligible Insured to maintain their coverage for the following Policy Year.

4.7 Addition of Newborns

a. A newborn child resulting from a Covered Maternity that is not a result of Assisted Reproductive Technology may be added to the Policy as an Insured Dependent Child without being subject to medical underwriting if the child qualifies as a Dependent Child, the Insurance Company is notified within sixty (60) days of the newborn's date of birth and receives a copy of the birth certificate, and the applicable additional premium amount to insure the Dependent Child is received. For newborn children not added within sixty (60) days of their date of birth, a Health Insurance Application must be submitted, and they will have to go through an underwriting evaluation.

b. A newborn Dependent Child that does not result from a Covered Maternity or that results from an Assisted Reproductive Technology shall become an Insured Dependent Child under this Policy upon the submission of a Health Insurance Application, acceptance by the Insurance Company, and the receipt of the applicable additional premium amount to insure the Dependent Child.

ART. 5 COST SHARING

5.1 Deductible

The Policy contains a Deductible provision that must be met prior to Covered Expenses being payable under this Policy. Individual and Family Deductibles are subject to any waivers or other conditions contained hereunder. Your Deductible is specified in your Certificate of Coverage.

5.1.1 Any Covered Expenses incurred by the Insured during the last three (3) months of the Policy Year that are used to satisfy that Policy Year's Individual Deductible will be carried over and applied towards the Insured's Individual for the following Policy Year.

5.1.2 In case of a Serious Accident, as defined in this Policy, the Individual Deductible will be waived for the first Medically Necessary Hospitalization immediately following said Serious Accident. Any subsequent treatment will incur the Individual Deductible.

5.1.3 The Individual Deductible will be waived up to a maximum amount of five thousand dollars (US$5,000) per event in the case of an Emergency as defined herein that occurs while the Insured is traveling for business or tourism outside their Country of Residence but within their Area of Coverage defined herein. The Insured must present proof of travel like passport with the corresponding entry/departure dates or copy of a business/tourist (non-immigrant) visa. This benefit covers Medically Necessary treatments incurred or received in a Hospital, emergency room, urgent care centers, outpatient clinics, and private medical practices, and is subject to the following considerations:

a. Events related to chronic medical conditions, such as arterial hypertension, diabetes mellitus, etc. would only qualify for this benefit if the patient has been stable and without changes in the treatment of the condition in question for at least the last six (6) months prior to the Emergency.

b. The Individual Deductible will be waived only for Medically Necessary expenses incurred or indicated during the care of said Emergency. An immediate Medically Necessary follow-up within fifteen (15) days related to the same event would also be exempt from Individual Deductible. For any other medical events or further treatment, including but not limited to physical and rehabilitation therapies and Prescription Medication, the corresponding Individual Deductible will apply.

5.1.4 The Individual Deductible will be reduced by fifty percent (50%) for the Insured that has not filed claims for three (3) consecutive Policy Years when indicated in the Table of Benefits. This benefit does not apply in the case of Family Deductibles. Once a claim has been filed, a new period of three (3) policy years begins at the next Renewal Date to qualify for this benefit again. A change to another Individual Deductible or plan that also offers this benefit does not interrupt the three (3) Policy Year period without submitting claims, but the lower of the benefits will apply until a new period of three (3) Policy Years begins. This benefit applies only to Individual Deductibles equal to or less than five thousand dollars (US$5,000). Routine Health Checkups and claims where the Insurance Company does not issue payments to a Provider or to the Primary Insured will not be taken into account to qualify for this discount.

5.2 Coinsurance

Coinsurance is the percentage of the Covered Expenses for medical costs that the Insured is responsible for after meeting their Individual Deductible.

If your plan is subject to Coinsurance, it will be specified in your Table of Benefits and Certificate of Coverage.

ART. 6 PROVIDER ACCESS

Your provider access within the selected Area of Coverage is indicated in the Table of Benefits.

6.1 U.S. Provider Network

If your plan is subject to a U.S. Provider Network, it will be indicated in your Table of Benefits. The Insurance Company shall pay these Providers directly for Covered Expenses whenever possible. To determine if a Provider is a member of their plan's U.S. Provider Network, Insureds shall contact the Insurance Company before scheduling or receiving any medical services.

Covered Expenses resulting from treatment outside the U.S. Provider Network may be subject to an Out-of-Network Fee of forty percent (40%) of eligible charges. Payment to non-preferred Providers will be made through reimbursement up to the Usual, Customary, and Reasonable (UCR) charges, as these Providers may not accept payment made directly by the Insurance Company.

6.2 Best Doctors Insurance Centers of Excellence Provider Network

Some benefits in your plan may be subject to using the Best Doctors Insurance Centers of Excellence Provider Network. To determine if a Provider is a member of the Best Doctors Insurance Centers of Excellence Provider Network, Insureds shall contact the Insurance Company before scheduling or receiving any medical services. It is recommended to obtain the up-to-date list of Providers that are part of the Best Doctors Insurance Centers of Excellence Provider Network directly from the Insurance Company. The Best Doctors Insurance Centers of Excellence Provider Network may change at any time without prior notice.

6.3 Best Doctors Insurance Maternity Network

Some benefits in your plan may be subject to using the Best Doctors Insurance Maternity Network. To determine if a Provider is a member of the Best Doctors Insurance Maternity Network, Insureds shall contact the Insurance Company before scheduling or receiving any medical services. It is recommended to obtain the up-to-date list of Providers that are part of the Best Doctors Insurance Maternity Network directly from the Insurance Company. The Best Doctors Insurance Maternity Network may change at any time without prior notice.

6.4 Premium Providers Network

Covered Expenses resulting from treatment within the Premium Providers Network may be subject to a Coinsurance when this is specified in your Table of Benefits. To determine if a Provider is a member of the

Premium Providers Network, Insureds shall contact the Insurance Company before scheduling or receiving any medical services. It is recommended to obtain the up-to-date list of Providers that are part of the Premium Providers Network directly from the Insurance Company. The Premium Providers Network may change at any time without prior notice.

6.5 The Insurance Company is not a medical Provider and is not responsible for the medical care received from a Provider that is part of any of these networks.

ART. 7 COVERAGE PROVISIONS

7.1 Maximum Covered Amount

The Maximum Covered Amount is the most that the Insurance Company will pay in any Policy Year for all covered benefits in the selected Area of Coverage for an Insured under this Policy. All benefit limits, including those in any selected Riders, accumulate towards the Maximum Covered Amount.

Your Maximum Covered Amount per Insured per Policy year is indicated in the Table of Benefits.

7.2 Policy Waiting Period

This Policy has a thirty (30) day Policy Waiting Period that starts on the Cover Effective Date of each Insured. During this time, coverage will only apply to Illnesses or Injuries caused by a covered Accident or a condition of infectious origin that occurs or is manifested for the first time during this period. Any other condition or symptom that is not caused by a covered Accident or a condition of infectious origin that occurs during the Policy Waiting Period will be permanently excluded from coverage.

7.3 Benefit Waiting Period

Certain benefits in this Policy contain a Benefit Waiting Period which is indicated in the Table of Benefits. Benefit Waiting Period starts on the Cover Effective Date of each Insured. When a new benefit or a new Module is added, the Benefit Waiting Period will be calculated as of the Renewal Date when such benefit or Module becomes effective as shown in the Table of Benefits.

ART. 8 COVERED EXPENSES

All benefits apply per Insured, per Policy Year, and are subject to any applicable Individual and Family Deductibles, Coinsurance, fees, exclusions, and other terms of this Policy, except when otherwise specified in the Table of Benefits. Any limitations established during the underwriting process will supersede what is stipulated in the Table of Benefits. The Insurance Company shall pay the Usual, Customary, and Reasonable (UCR) charges for the following Covered Expenses incurred by an Insured when indicated in the Table of Benefits.

Certain types of incurred medical expenses may have limitations or specific conditions that must be met for them to be considered Covered Expenses under the Policy. Certain medical expenses will only be considered Covered Expenses to the extent that they are included herein and in the Table of Benefits, and only under the terms and conditions set forth below in this article.

8.1 Hospitalization Benefits

8.1.1 Hospital Admission

Covered Expenses for the daily accommodation and meals (room and board) during a hospital admission include charges for lodging, board, nursing services, and basic supplies in either a Private Room (single occupancy) or Semi-Private Room (shared with one other patient). This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.1.2 Intensive Care Unit

Covered Expenses for the daily charges associated with admission to a Hospital's Intensive Care Unit, including specialized nursing, monitoring, life-support systems, and related Medically Necessary consumables required for critically ill patients. This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.1.3 Accommodation and Meals Provided by Hospital for Companion of Hospitalized Insured

Covered Expenses included in the Hospital bill related to overnight Hospital accommodation and meals for one (1) companion of a hospitalized Insured (no age limit). For the accommodation to be covered, the Hospital stay for the Insured must be considered a Covered Expense under this Policy.

8.1.4 Diagnostic Procedures During Hospitalization

Covered Expenses for Medically Necessary diagnostic tests and procedures performed during an inpatient hospital stay, including but not limited to laboratory tests, imaging (X-rays, CT scans, MRI, ultrasound), gastroscopy, colonoscopy, biopsy, pathology, cardiac EP studies, and other diagnostic examinations required for monitoring, confirming, or evaluating the patient's condition. Benefits are payable only when such services are ordered by the treating Physician and directly related to the cause of Hospitalization.

8.1.5 Prescription Medications During Hospitalization

Covered Expenses for medications, including allergy medications and Highly Specialized Medications (HSM), are limited to those that:

a. Are prescribed during a Hospitalization.

b. Are approved by the FDA or the EMA for the treatment of the Insured's medical condition.

8.1.6 Rehabilitation During Hospitalization

Covered Expenses for physical therapy, respiratory therapy, cardiac rehabilitation, speech therapy, and occupational therapy when prescribed and certified by the treating Physician, are Medically Necessary to treat the condition, and are provided by a professional licensed in the country where the treatment takes place.

8.2 Inpatient and Day Patient Benefits

8.2.1 Emergency Room

Covered Expenses for Medically Necessary treatment received in a Hospital's emergency room for sudden Illness or Accidental Injury that requires immediate medical attention. Coverage includes Physician fees, nursing care, diagnostic services, and supplies used during the Emergency visit. Benefits are payable only when the condition reasonably requires Emergency care, and treatment is provided within twenty-four (24) hours of the onset of symptoms or Injury.

8.2.2 Surgery

Covered Expenses for Medically Necessary surgical procedures performed by a licensed surgeon, including pre-operative assessments, the surgery itself, and post-operative care during Hospitalization. Coverage includes surgeon's fees, anesthesiologist's fees, operating room charges, nursing, and standard surgical supplies. Benefits are payable only when the surgery is deemed Medically Necessary and directly related to the condition being treated. This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.2.3 Surgeon and Anesthesiologist Fees

Covered Expenses for principal surgeon, assisting physician/surgeon, and anesthesiologist fees are limited to the Usual, Customary, and Reasonable (UCR) charges for particular procedures or based on special rates established or contracted by the Insurance Company for a geographic area, country, or specific Provider.

8.2.4 Organ and Tissue Transplants

Covered Expenses for organ and tissue Transplants include Medically Necessary treatments, procedures, services, and supplies related to a covered organ or tissue Transplant. This limit includes any transplant-related benefits previously paid under another Policy, plan or Rider of the Insurance Company or any of its affiliate companies.

The procedures and the facilities where the treatments, procedures, and services are carried out must be approved in advance by the Insurance Company. The Insured must notify the Insurance Company as soon as they have been diagnosed as a candidate for the Transplant. This benefit requires pre-authorization and coordination from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article. The Insurance Company may request an InterConsultation® prior to approval. The Insurance Company reserves the right to submit the Transplant related medical documentation to one or more Transplant specialists to establish Medical Necessity.

The benefit includes:

a. All pre-transplant care, which includes those services directly related to an evaluation of the need for the Transplant, evaluation of the Insured for the Transplant procedure, preparation and stabilization of the Insured for the Transplant procedure.

b. All pre-surgical work-up, including all laboratory tests and X-ray exams, CT scans, magnetic resonance imaging (MRIs), ultrasounds, biopsies, Prescription Medications, and supplies.

c. The cost of organ or tissue procurement, transportation, harvesting, and Living Donor expenses up to the maximum indicated in the Table of Benefits.

d. The procedure to Transplant the organ or tissue and the coverage of an artificial heart or mono or bi-ventricular devices that allow the viability of the patient until he receives the definitive Transplant.

e. All post-Transplant related care, including but not limited to any follow-up, Medically Necessary treatment resulting from the Transplant, and any complications that arise after the Transplant procedure, whether a direct or indirect consequence of the Transplant.

f. Any medication or therapeutic measure used to ensure the viability and permanence of the transplanted organ or tissue.

Advanced Medical Treatments related to Organ and Tissue Transplants will be coordinated through the Patient Navigation Services.

No payments will be made for any treatment, procedure, service, or surgery when:

a. It is not Medically Necessary.

b. It is considered elective, Experimental or Investigative.

c. It is performed when the Insured had access to alternative procedures and/or treatments, with the same level of results and care to treat the medical condition or Illness that caused the need for a Transplant.

d. It is originated by or as a result of a Transplant from the use of a mechanic artifact or artificial equipment aimed to replacing a human organ or where the donor is an animal.

e. It is performed because of a previously failed Transplant carried out prior to the Insured's Cover Effective Date or a not-approved Transplant carried out after the Cover Effective Date.

8.2.5 Reconstructive or Corrective Surgery Related to a Covered Illness, Injury, or Surgery

Covered Expenses include Medically Necessary surgery that is:

a. Indicated for the treatment of a covered Illness that is not an undisclosed Pre-existing Condition or otherwise specifically excluded from coverage, or

b. Required in relation to an Injury caused by a covered Accident that occurs after the Insured's Cover Effective Date and while the Policy is in force, or

c. Indicated for the treatment of nose or septum deformities caused by a covered Accident, trauma, or Cancer in the nose.

This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

Evidence of trauma in the form of fracture must be confirmed by radiological means (X-ray, CAT scans, MRIs) and must be submitted to the Insurance Company for evaluation at the time of requesting approval.

8.2.6 Bariatric Surgery, Gastric Bypass, and Other Weight Loss Surgical Procedures, Including Medication and Complications

Covered Expenses for these surgeries, procedures, and treatments, including medication and complications, when the following conditions are met:

a. The twenty-four (24) month Benefit Waiting Period has been completed as of the Cover Effective Date.

b. An InterConsultation® confirms the procedure is the best alternative and is Medically Necessary, if required by the Insurance Company.

c. Treatment is performed within the Provider network specifically designated by the Insurance Company for this benefit in the corresponding authorization.

This benefit requires pre-authorization and coordination from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article. If a change of plan is requested where the amount of this benefit is higher, the lower amount offered in the previous plan shall prevail for twenty-four (24) months as of the change of plan.

8.2.7 Prophylactic Surgery to Reduce Cancer Risk

Covered Expenses for surgery when the following conditions are met:

a. The Insured has a known predisposition to Cancer deleterious mutation (BrCA1, BrCA2, or other strong genetic predisposition of Cancer susceptibility) confirmed by genetic tests performed after the Benefit Waiting Period.

b. An InterConsultation® confirms the surgery is Medically Necessary, if required by the Insurance Company.

c. The twelve (12) month Benefit Waiting Period has been completed as of the Cover Effective Date.

This benefit requires pre-authorization and coordination from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

The maximum amount of this benefit includes all procedures and complications related to the authorized prophylactic surgery. The cost of genetic tests or similar procedures that determined the genetic predisposition mentioned in paragraph a, may be included in this benefit's maximum amount. The costs of any genetic testing before the Benefit Waiting Period is completed will not be covered.

If a change of plan is requested where the amount of this benefit is higher, the lower amount offered in the previous plan shall prevail for twelve (12) months as of the change of plan.

8.2.8 Surgical Treatment for Symptomatic Disorders of the Feet

Covered Expenses for the surgical treatment of symptomatic disorders of the feet and any treatment secondary to a covered Accident, trauma, or infection. The twenty-four (24) month Benefit Waiting Period must have been completed as of the Cover Effective Date, except in cases of a covered Accident, trauma or infection, where the mentioned Benefit Waiting Period does not apply. This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.2.9 Surgical Implants or Prosthesis (excluding dental)

Covered Expenses for Medically Necessary surgical implants, internal prosthetic devices, or medical appliances required as an integral part of a surgical procedure. This includes items such as artificial joints, pacemakers, vascular stents, surgical mesh, plates, screws, and other internal devices prescribed by the attending Physician. Dental prostheses, dental implants, and cosmetic implants are excluded. Benefits are payable only when the device is prescribed as Medically Necessary and directly related to a covered surgery. This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.2.10 Cochlear Implants for Congenital Condition

Covered Expenses for a Cochlear Implant related to a Congenital Condition, including surgery, complications, physical therapy, and follow-up visits when the following requirements are met:

a. The procedure is Medically Necessary due to a covered Illness or Injury that first manifests and is diagnosed after the Cover Effective Date (not a Pre-existing Condition).

b. The Insured's treating Physician notifies the Insurance Company in advance that the Insured is a candidate for the Cochlear Implant surgery or treatment.

This benefit requires pre-authorization and coordination from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.2.11 Refractive Eye Surgery

The Insurance Company will cover the cost of one (1) refractive surgery per eye, lifetime per Insured, for the correction of vision problems such as astigmatism, myopia, or hypermetropia, after a twenty-four (24) Benefit Waiting Period when included in the Table of Benefits, subject to the following medical criteria:

- The Insured has 3 (three) diopters or more in the eye being treated, and
- The treatment is performed by a recognized and accredited Provider (Physician, Hospital, or clinic).

This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.2.12 Oncology Treatment

Covered Expenses for Medically Necessary tests and treatment of Cancer: chemotherapy, radiotherapy, immunotherapy, hormone therapy, and other clinically approved Oncology Treatment. Genetic Therapy and CAR T cell therapy are covered under a separate benefit. Other Advanced Medical Treatments related to Oncology Treatments will be coordinated through the Patient Navigation Services.

Coverage includes related Physician fees, nursing care, diagnostic monitoring, and Prescription Medications when directly associated with an active Oncology Treatment. Benefits are payable only when the treatment is prescribed by an oncologist or treating Physician and in accordance with recognized medical standards.

This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.2.13 Genetic Therapy / CAR T Cell Therapy

Covered Expenses for Medically Necessary Genetic Therapy and CAR T cell therapy related to Oncology Treatments or other covered conditions will be coordinated through Patient Navigation Services in accordance with recognized medical standards. This benefit requires pre-authorization and coordination from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.2.14 Dialysis

Covered Expenses for Medically Necessary dialysis treatment for acute kidney failure or chronic end-stage renal disease. Coverage includes hemodialysis or peritoneal dialysis sessions, related medications, supplies, and the services of Physicians, Nurses, and technicians directly involved in the procedure. Benefits are payable only when treatment is prescribed by a nephrologist and performed in a licensed medical facility. This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.3 Outpatient Benefits

8.3.1 Physicians and Specialists Visits

Covered Expenses include consultations and follow-up visits with general Physicians and medical specialists when Medically Necessary for the diagnosis, treatment, or monitoring of a covered condition. Coverage includes Physician fees and associated examination costs but excludes wellness, preventive, or non-Medically Necessary consultations.

8.3.2 Diagnostic Procedures

Covered Expenses for outpatient Medically Necessary diagnostic tests and procedures, including but not limited to laboratory tests, imaging (X-rays, CT scans, MRI, ultrasound), gastroscopy, colonoscopy, biopsy, pathology, cardiac EP studies, and other diagnostic examinations required for monitoring, confirming, or evaluating the patient's condition. Benefits are payable only when such services are ordered by the treating Physician and directly related to a covered condition. Major Diagnostic Procedures require pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.3.3 Prescription Medication

Covered Expenses for outpatient Prescription Medications, including allergy medications, are limited to those that:

a. Require a prescription by a Physician or authorized pharmacist and are not sold over the counter.

b. Are approved by the FDA or the EMA for the treatment of the Insured's medical condition.

c. Are dispensed within one (1) calendar year of being prescribed, subject to federal and state laws or the regulation of the local jurisdiction.

The Insurance Company will approve claim reimbursements for extended prescriptions for up to three (3) months at a time.

When the Policy is within thirty (30) days of the Renewal Date, the Insurance Company will approve claim reimbursements for thirty (30) days.

8.3.4 Highly Specialized Medications (HSM)

Covered Expenses for high-cost, high-complexity outpatient Prescription Medications to treat complex, extraneous, or Chronic Conditions including dementia and Alzheimer's disease.

Generic Drugs and Biosimilar Drugs will be prioritized whenever clinically appropriate, while preserving flexibility for the treating Physician's prescription.

Coverage applies only when the medication is Medically Necessary and prescribed by a licensed Physician in accordance with recognized medical guidelines.

This benefit requires pre-authorization and coordination from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.3.5 Rehabilitation Therapy

Covered Expenses for Physical Therapy, Respiratory Therapy, Cardiac Rehabilitation services are paid up to the maximum indicated in the Table of Benefits provided that they have been prescribed and certified by the treating Physician, they are Medically Necessary to treat the condition, the appropriate treatment plan is submitted, and the services are provided by a professional licensed in the country where the treatment takes place.

This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article. For subsequent therapies after the initially approved thirty (30) days, an updated treatment plan and progress report must be submitted to the Insurance Company to determine coverage based on Medical Necessity.

The Insurance Company may perform audits and inspections when it deems appropriate to ensure the continuity of Medical Necessity. The Insured and/or their relatives must offer all the necessary cooperation for these inspections. The benefit may be suspended if these audits or inspections cannot be performed due to lack of cooperation.

8.3.6 Autism Spectrum Disorders

Covered Expenses for Medically Necessary evaluation, diagnosis, and treatment of Autism Spectrum Disorders include Physician consultations, psychiatric care, Prescription Medications, and evidence-based therapeutic interventions directly related to the management of the disorder. Benefits are payable only when treatment plan that considers Medical Necessity is prescribed by a licensed Physician or psychiatrist and in accordance with recognized medical guidelines.

These services require pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

Educational, academic, or non-medical therapies are excluded.

8.3.7 Occupational, Orthoptic, and Speech Therapies

Covered Expenses for Occupational Therapy, Orthoptic Therapy, and Speech Therapy as rehabilitation services for a covered Accident or Illness. A treatment plan that considers Medical Necessity is required. For subsequent therapies after the initially approved thirty (30) days, an updated treatment plan and progress report must be submitted to the Insurance Company to determine coverage based on Medical Necessity.

The Insurance Company may perform audits and inspections when it deems appropriate to ensure the continuity of Medical Necessity. The Insured and/or their relatives must offer all the necessary cooperation for these inspections. The benefit may be suspended if these audits or inspections cannot be performed due to lack of cooperation.

Educational, academic, or non-medical therapies are excluded.

These services require pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.3.8 Psychologist Visits

Covered Expenses include consultations and follow-up visits with a Psychologist when Medically Necessary for the diagnosis, treatment, or monitoring of a covered condition and prescribed by a Psychiatrist.

These services require pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

Educational, academic, or non-medical therapies are excluded.

8.3.9 Home Health Care (Private Nurse)

Covered Expenses prescribed and certified by the treating Physician instead of Hospitalization and provided by a professional licensed in the country where the treatment takes place. Services are limited to eight (8) hours a day and include part-time or recurrent skilled nursing care.

This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article. Additionally, a treatment plan that considers Medical Necessity is required.

The Insurance Company may perform audits and inspections when it deems appropriate to ensure the continuity of Medical Necessity. The Insured and/or their relatives must offer all the necessary cooperation for these inspections. The benefit may be suspended if these audits or inspections cannot be performed due to lack of cooperation.

Services do not cover Custodial Care as defined in this Policy.

8.3.10 Complementary and Alternative Medicine

Covered Expenses for Homeopathy, Acupuncture, Naturopathy, Chinese or Oriental Medicine, Chiropractic, Osteopathy, and Electromagnetic Therapy aimed at restoring the Insured's normal physical function. The treatment must be performed by a professional licensed in the country where the consultation and/or treatment takes place.

8.4 Preventive Benefits

8.4.1 Adult Routine Health Check-Up

Covered Expenses for one (1) routine physical examination for Insureds age eighteen (18) and over include laboratory tests, X-rays, preventive vaccines, and any other medical expenses related to a Routine Health Checkup as defined herein. No Individual Deductible applies.

8.4.2 Preventive Colon Cancer Screening

Covered Expenses for preventive colon Cancer screening (colonoscopy) for Insureds forty-five (45) years old or older every ten (10) years. For Insureds considered high risk, the benefit is available every two (2) years. High-risk Insureds are those including but not limited to those with a strong family history of colorectal Cancer or certain types of polyps, a known family history of a hereditary colorectal Cancer syndrome such as familial adenomatous polyposis (FAP) or Lynch syndrome (also known as hereditary non-polyposis colon Cancer or HNPCC).

8.4.3 Pediatric Routine Health Check-up

The Insurance Company will cover expenses for Pediatric Routine Health Check-ups include laboratory tests, X-rays, and preventive vaccines specified in the recommended immunization schedule from the health authority in the country where the Insured resides, and any other medical expenses related to a Pediatric Routine Health Checkup as defined herein and in the Table of Benefits. No Individual Deductible applies.

- Newborn to twelve (12) months old: During the newborn's first year, the Policy will cover six (6) visits for general medical checkups, including lab tests, and X-ray.
- 1 to 17 years old: After the child's first year and up to the age of seventeen (17), inclusive, the Policy will cover one (1) visit for general medical checkup per Policy Year, including lab tests, and X-rays. From the age of eighteen (18), the Insured Dependent may use the "**Adult Routine Health Check-Up**" benefit as of the Renewal Date following their eighteenth (18th) birthday.

8.5 Maternity Benefits

8.5.1 Maternity Care

a. Covered Expenses for maternity care include normal delivery, Elective Cesarean section, non-Emergency Cesarean section, and pre- and postnatal treatment. No Individual Deductible applies. Emergency Cesarean sections are considered Complications of Maternity and are covered as indicated in the "Complications of Maternity and Birth" benefit, as long as the ten (10) month Benefit Waiting Period has been completed.

b. The ten (10) month Benefit Waiting Period for Maternity Care always applies, whether or not the thirty (30) day Policy Waiting Period has been waived. Any maternity-related service that occurs before the ten (10) month Benefit Waiting Period will not have coverage.

c. For Domestic Partners of the same sex insured under the same Policy, only one (1) Maternity Care benefit may be claimed during the same Policy Year. Both Insureds must be evaluated to qualify for the Maternity Care and Complications of Maternity and Birth benefits.

d. For Insured Dependent daughters that have been insured for more of ten (10) months under their parent's Policy, the Maternity Care Benefit Waiting Period (including Complications of Maternity and Birth, and Stem Cells Extraction and Preservation benefits) will be eliminated when issuing their own coverage as Primary Insured or Spouse under a similar plan with the same Maternity Care benefits.

This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

Childbirth only (normal delivery, Elective Cesarean section, and non-Emergency Cesarean section) resulting from a pregnancy that is the result of any type of Assisted Reproductive Technology will be covered up to the maximum maternity care benefit as long as the Maternity Care Benefit Waiting Period has been completed, but it will not be considered for coverage under any other Policy benefit, such as services for Complications of Maternity and Birth and Newborn Inclusion Without Underwriting.

If a change of plan is requested where the amount of this benefit is higher, the lower amount offered in the previous plan shall prevail for ten (10) months as of the change of plan.

8.5.2 Complications of Maternity and Birth

After completion of the ten (10) month Benefit Waiting Period, Covered Expenses for medical treatment, Hospitalization, and related services for pathological conditions arising from an abnormal course of pregnancy and/or delivery, include but are not limited to acute nephritis, nephrosis, cardiac failure, pre-eclampsia, ectopic pregnancy, gestational diabetes, termination of pregnancy requiring medical intervention due to fetal death, and spontaneous end of pregnancy at a stage where the embryo or fetus is incapable of surviving independently.

Also included are Covered Expenses for medical treatment, Hospitalization, and related services for disorders of a newborn directly related to birth, not due to Congenital or Hereditary Conditions, which manifest during the first thirty (30) days of life, including but not limited to hyperbilirubinemia (jaundice), cerebral hypoxia, hypoglycemia, prematurity, respiratory distress, and birth-related traumatisms.

For the purposes of this Policy, the following shall not be considered Complications of Maternity and Birth:

a. Elective Cesarean sections, Cesarean sections performed solely due to a prior Cesarean, non-Emergency Cesarean sections, or uterine scars from previous surgery;
b. Spotting, Braxton-Hicks contractions, or bed rest prescribed during pregnancy without further complications;
c. Normal and usual symptoms resulting from pregnancy;
d. Services or treatments for a Chronic Condition not related to pregnancy, even if occurring during gestation.

This lifetime benefit includes any previous payments made against any Complications of Maternity and Birth benefit under any other Policy, plan, module, and/or maternity complications Rider provided by the Insurance Company or any affiliate.

Coverage is not provided for complications in a pregnancy that is the result of any type of Assisted Reproductive Technology or a non-Covered Maternity or pregnancy.

If a change of plan is requested where the amount of this benefit is higher, the lower amount offered in the previous plan shall prevail for ten (10) months as of the change of plan.

8.5.3 Newborn Inclusion Without Underwriting When Born from a Covered Maternity

Covers the automatic inclusion of a newborn under the Policy without the need for medical underwriting, provided the newborn is born from a Covered Maternity. Coverage begins from the date of birth and is subject to notification to the Insurance Company within sixty (60) days of the newborns' date of birth, a copy of the birth certificate, and the pregnancy notification including method of conception. The applicable additional premium amount must also be paid to insure the newborn as a Dependent Child. Benefits for the newborn will follow the same terms, conditions, and exclusions applicable to the Policy. Congenital conditions are covered under the "Congenital and Hereditary Disorders Diagnosed Before 18 Years Old" benefit.

To include a newborn after sixty (60) days or a newborn that is the result of any type of Assisted Reproductive Technology, full underwriting will apply.

8.5.4 Premium Waiver for Dependent Children

Premium payments for eligible Insured Dependent Children born from a Covered Maternity will be deducted from the annual Policy premium (or corresponding prorated portion) when indicated in the Table of Benefits. This benefit applies to the youngest eligible Insured Dependent Child(ren) while the Policy is active as long as the following conditions are met:

a. The Insured Dependent Child must have been born from a Covered Maternity.
b. The Insured Dependent Child must have uninterrupted coverage under the plan where they were born.
c. If the Insured Dependent Child moves to another plan, the premium waiver benefit will not transfer to the new plan.

8.5.5 Stem Cell Extraction and Preservation

The cost of the extraction and preservation of umbilical cord blood Stem Cells will be covered as indicated in the Table of Benefits only for a Covered Maternity. **This benefit does not apply towards the Individual Deductible** and is subject to the Maternity Care Benefit Waiting Period.

8.6 Emergency Transportation Benefits

8.6.1 Ground Ambulance to Nearest Qualified Hospital to Stabilize Patient

Covered Expenses for Ground Ambulance transportation when the following conditions are met:

a. Such transportation is Medically Necessary to take the Insured to the closest Hospital to receive the most appropriate treatment that cannot be provided locally.
b. Such transportation is associated with an Emergency or Urgency related to a covered condition or Accident for which treatment cannot be provided where the patient is or where the Accident occurred.

c. Transportation by any other means would likely result in loss of life, physical integrity, or the viability of any of the Insured's organs.

d. The Ground Ambulance transportation has on board equipment and specialized medical instruments, a crew trained in emergency medical transports and is operated by a company legally licensed and authorized as ambulance attendant.

The Insured agrees to hold the Insurance Company and any company affiliated with the Insurance Company harmless from any delays or restrictions caused by mechanical problems, governmental restrictions, the ambulance driver or the ambulance service, or due to operational conditions, bad weather, or any other cause beyond the Insurance Company's control.

8.6.2 Air Ambulance to Nearest Qualified Hospital to Stabilize Patient

Covered Expenses for Air Ambulance transportation when the following conditions are met:

a. Such transportation is Medically Necessary to take the Insured to the closest Hospital to receive the most appropriate treatment that cannot be provided locally.

b. Such transportation is related to an Emergency related to a covered condition or Accident for which treatment cannot be provided where the patient is or where the Accident occurred.

c. Transportation by any other means would likely result in loss of life, physical integrity, or the viability of any of the Insured's organs.

d. The Air Ambulance transportation has on board equipment and specialized medical instruments, a crew trained in emergency medical transports and is operated by a company legally licensed and authorized as ambulance attendant.

This benefit requires pre-authorization and coordination from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

The Insured agrees to hold the Insurance Company, and any company affiliated with the Insurance Company harmless from any delays or restrictions on flights caused by mechanical problems, governmental restrictions, the pilot, or the airline, or due to operational conditions, bad weather, or any other cause beyond the Insurance Company's control.

8.6.3 Airfare Reimbursement After Air Ambulance Transportation

Airfare reimbursement for the Insured and one (1) close relative (Spouse/Domestic Partner, parent, child, or sibling) authorized to travel with the Insured back to their Country of Residence after Air Ambulance transportation. This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.6.4 Airfare Reimbursement for Travel to Centers of Excellence

Airfare reimbursement for the Insured and one (1) close relative (Spouse/Domestic Partner, parent, child, or sibling) authorized to travel with the Insured to receive treatment at a Center of Excellence. This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.7 Other Benefits

8.7.1 Congenital and Hereditary Disorders

Covered Expenses for Congenital Conditions and Hereditary Conditions are paid as indicated in the Table of Benefits. Advanced Medical Treatments related to Congenital and Hereditary Disorders will be coordinated through the Patient Navigation Services. Conditions that are the result of any Assisted Reproductive Technology are excluded from coverage. This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.7.2 HIV/AIDS

Covered Expenses for the treatment of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) when the antibodies of the HIV (seropositive) or the AIDS virus have not been detected before the Insured's Cover Effective Date. A twenty-four (24) month Benefit Waiting Period applies.

This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

Treatment, procedures, services, surgeries, or supplies will not be covered when:

a. HIV/AIDS is related to the use of any intravenous Illegal Substances.

b. The Insured is taking Experimental drugs or medications or undergoes Experimental treatment.

8.7.3 Sleep Apnea and Other Sleep Disorders

Covered Expenses for sleep apnea and other sleep disorders include sleep studies (polysomnogram) to help diagnose sleep-related conditions—such as sleep apnea and snoring—the provision of CPAP equipment, and related supplies when prescribed by a qualified healthcare professional. This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

Prescription Medication for the treatment of sleep apnea and other sleep disorders will be covered under the outpatient Prescription Medications benefit.

8.7.4 Durable Medical Equipment, External Prosthesis, Orthotic Devices

Covered Expenses for Durable Medical Equipment (DME), special devices, external prosthesis, and orthotic devices as long as the following criteria are met:

a. They provide a therapeutic benefit to the Insured due to certain medical conditions and/or Illnesses;

b. They are prescribed by a licensed Provider;

c. The Insured submits medical documentation that justifies Medical Necessity, and

d. They do not primarily serve as an element of comfort or convenience.

This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article. In the event that the benefit is authorized, and the Insured subsequently acquires the DME, special device, external prosthesis, or orthotic device, the Covered Expenses will be reimbursed in accordance with the Usual, Customary, and Reasonable (UCR) charges, previously authorized by the Insurance Company.

8.7.5 Palliative Care/Hospice Services

Covered Expenses for Palliative Care and hospice services when the attending Physician has certified that the Insured has been diagnosed with a terminal condition, has less than six (6) months to live, and a Palliative Care and/or hospice services treatment plan is previously submitted to the Insurance Company for review. This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

8.7.6 Accidents Related to the Practice of Professional Sports or High Risk Activities

Covered Expenses from Accidents sustained while participating in Professional Sports or in high-risk activities such as mountaineering, scuba diving, motor sports, skydiving, or similar activities. Coverage includes Emergency treatment, Hospitalization, surgery, and related Medically Necessary care directly resulting from the Accident. Benefits are payable only when the activity is conducted in compliance with applicable safety regulations and under professional supervision, where required.

8.7.7 Illness or Injury in Private Aircraft

Covered Expenses for Illness or Injury sustained as a passenger, pilot, and/or member of the crew in a Private Aircraft.

8.7.8 Dental Treatment Due to Covered Accident

Covered Expenses for the Medically Necessary treatment for the reconstruction or replacement of sound natural teeth that have been damaged or lost in a covered Accident. Treatment must take place within one hundred eighty (180) days from the date of the covered Accident.

8.7.9 Hearing Aids

Covered Expenses for Medically Necessary hearing aid devices after a twelve (12) month Benefit Waiting Period when included in the Table of Benefits provided that:

a. The Insured has a medical diagnosis, and the hearing aid has been prescribed by a licensed audiologist or otolaryngologist.
b. The degree of hearing loss (pure-tone average/PTA) is > 40 dB HL in the better ear.
c. Recent audiometric testing not older than six (6) months.
d. It is a regulated, prescription hearing aid (FDA/EMA-approved).

Claims must be submitted for reimbursement with a detailed invoice accompanied by a medical prescription.

The Insurance Company will not pay for hearing devices considered cosmetic or not strictly for medical use.

8.7.10 Repatriation of Mortal Remains or Cremation Services

In the event that an Insured passes away outside their Country of Residence, the Insurance Company will cover the cost of repatriating the remains to their Country of Residence or the cost of cremation of their mortal remains, provided such cremation takes place in the location of their death. This benefit is offered only if the death is a result of a covered Illness or Accident.

This benefit is limited solely to:

a. The preparation of the remains for transport and the transportation of the Insured's body to their Country of Residence or,

b. In the event that transportation of the remains does not occur, the expenses directly related to the cremation of the Insured's mortal remains.

Funeral expenses and any other expenses not strictly necessary for the services described in "a" and "b" above are not covered.

This benefit requires pre-authorization from the Insurance Company as set forth in the "Notification Requirement for Pre-Authorization and Coordination" article.

This benefit is considered secondary to any other repatriation benefit, or similar benefit, to which the Insured may be entitled to or have access, other than that offered by this Policy, which would take precedence over this benefit.

8.7.11 Primary Insured's Death Benefit

When this benefit is included in the Table of Benefits, in the event of the death of the Primary Insured, the Contracting Party (or, if the Contracting Party is the same as the Primary Insured, the designated Beneficiary or the legal heirs of the Primary Insured) may choose to maintain the coverage under the Policy for Insured Dependents covered under this Policy without having to pay the corresponding premiums for the period indicated in the Table of Benefits from the next Due Date or Renewal Date of the Policy, whichever occurs first, as long as the cause of the Primary Insured's death is due to an Illness or Accident covered under this Policy. During this period, the Insured Dependents, or if applicable, the Contracting Party or the Legal Representative, shall be fully and solely responsible for any advance payment for services, Individual and Family Deductibles, and any other administrative or other costs not covered under the terms of the Policy.

The decision to continue coverage for the Insured Dependents under this paragraph shall forfeit any right to unearned premium under "Refunds of Unearned Premium".

8.8 Optional Additional Coverage

8.8.1 CriticalSelect Rider

Coverage is available for Insureds aged between three (3) and sixty (60) and ends after they turn sixty-five (65) years old. Coverage under the CriticalSelect Rider is subject to the corresponding premium payment. All terms, provisions, exclusions, definitions, Amendments, and restrictions in the Primary Insured's health plan with the Insurance Company apply.

The Insurance Company will pay the Insured the Maximum Benefit selected in the Health Insurance Application and indicated in the Certificate of Coverage as a result of any Illness or procedure listed below that occurs after the Insured's Cover Start Date:

- Acute Myocardial Infarction (heart attack)
- Aortic coronary by-pass
- Benign brain tumor
- Cancer (life-threatening)
- Cerebral Vascular Accident (life-threatening)
- Limb loss (arm or leg)
- Loss of hearing/bilateral deafness
- Loss of vision/total blindness
- Multiple sclerosis
- Paralysis
- Parkinson's disease
- Renal failure
- Systemic lupus erythematosus (SLE)
- Transplant of the following organs: kidneys, heart, lungs, liver, pancreas, and/or bone marrow

The CriticalSelect Rider may only continue active as long as the Primary Insured has an active Policy with the Insurance Company. The coverage under the CriticalSelect Rider has a duration of twelve (12) months and shall be renewed automatically for a similar period with the corresponding premium payment subject to the definitions, conditions, and other provisions of the Policy that are effective at the time of renewal.

ART. 9 OTHER SERVICES

The Insurance Company provides and arranges access to the following additional services when the inclusion of these services is indicated in the Table of Benefits.

9.1 Patient Navigation Services: A coordinated set of support activities designed to help Insureds understand, access, and effectively optimize the use of their covered health benefits under the Policy. The Patient Navigation Team assists patients in overcoming barriers to care by providing individualized guidance across healthcare systems; providing support in locating appropriate providers, schedule appointments, coordinate referrals, overcome logistical barriers, and connect with community or clinical resources. These services do not replace clinical pre-authorization or case management but rather complement these services by providing direct support to the Insured to receive effective, timely, and appropriate care. By using Patient Navigation Services, the Insured may be eligible for reduced cost sharing as set forth in Art. 5, including a reduction in the Individual Deductible, for certain procedures at designated medical facilities.

9.2 InterConsultation®: A service that offers a meticulous review of the Insured's medical records performed by an independent Physician or medical professional which provides the patient with a Second Medical Opinion regarding diagnosis and treatment.

9.3 Best Doctors Concierge™: A service that assists the Insured with the coordination of medical appointments, hospital admissions, travel arrangements, accommodations, and transportation when medical services are to be rendered outside the Insured's Country of Residence. It is available to Insureds per an agreement between the Insurance Company and its administrator, Best Doctors Insurance Services, LLC. The Insured is responsible for all travel and accommodation costs incurred. Best Doctors Insurance Services, LLC shall only provide coordination assistance for the services described above.

9.4 Individual Case Management: A program that coordinates, supervises, and manages complex medical cases of long duration. Through this program, the Insurance Company works with Providers to ensure that Insureds receive the Medically Necessary services in the most appropriate clinical context according to their health situation and pursuant to the benefits covered by the Policy. The Insurance Company will establish when this program should be activated and, if needed, will ask for the Insureds' collaboration.

9.5 Elite Navigator™: A service that provides access to a personal physician advocate that helps Insureds understand their diagnostic tests and medical checkup results and provides support to empower them to have more effective conversations with their own treating physician. It is available to Insureds per an agreement between the Insurance Company and its administrator, Best Doctors Insurance Services, LLC only when this service is included in the Table of Benefits.

ART. 10 EXCLUSIONS

The Insurance Company will not consider Covered Expenses any that are:

a. Not Medically Necessary, or
b. For an Insured who is not under the care of a Physician or legally qualified professional, or
c. Not authorized or prescribed by a Physician or legally qualified professional, or
d. Performed by an unlicensed Provider, medical professional, or medical facility, or
e. Related to Custodial Care or personal care, or
f. Related to recreational or educational therapy, or
g. In excess of the Usual Customary, and Reasonable (UCR) charge.

Additionally, all the conditions and treatments described in the articles below shall be specifically considered exclusions under the Policy:

10.1 Any expense related to undisclosed Pre-existing Conditions, excluded anatomical regions, complications, and treatments related to excluded conditions.

10.2 Any Illness or Injury not caused by an Accident or Illness of infectious origin, which is manifested within the first thirty (30) days of the Cover Effective Date. Any condition or symptom that is not caused by an Accident or Illness of infectious origin that is manifested for the first time during this period will be considered a Pre-existing Condition and excluded permanently, even when coverage for that condition was offered in this Policy.

10.3 All medical services that are provided in cases where a third party is obligated to pay for the Insured's Covered Expenses, pursuant to a contract or by virtue of civil extra contractual responsibility or a court order.

10.4 The Insurance Company shall not make any payment, including for any claim or expense incurred for treatment, services, or supplies, that would be subject to any trade restriction or any economic or political sanctions that are applicable to the Insurance Company or any of its affiliates.

10.5 Any treatment, procedure, equipment, medication or combination of medications, Hospitalization, service, or supply that at the moment of being offered is not scientifically or medically recognized for the treatment indicated by the norms of the United States; that has not yet been approved for the condition or indication specified by the FDA and/or the EMA (even if it is in the process of medical trials) when such approval is required, regardless of where the medical expenses have been incurred, or in cases where the Insured is enrolled in a study or Experimental treatment sponsored by third parties, including but not limited to any derived medical service, its consequences, and/or complications.

10.6 Any treatment or expense incurred in a government facility, such as social security facilities, or private facility in which the Insured would be entitled to free care, as well as services or treatments for which payment would not have to be made even if there were no insurance coverage. This includes costs for procedures in institutions that receive government or private funding related to an investigative project for the procedure in question.

10.7 Any Hospital admission for more than twenty-four (24) hours before a scheduled surgery.

10.8 Treatment provided by more than one (1) surgical assistant, unless approved in advance by the Insurance Company.

10.9 Any treatment provided by a family member, including but not limited to the Spouse, parents, siblings, children, or by another person who regularly resides in the Insured's home, as well as any treatment provided in any entity or facility owned by, or under the operation or supervision of, the Insured or a family member, except those approved in advance by the Insurance Company.

10.10 Any over-the-counter medicine or non-Prescription Medication, dietary and/or nutrition supplement, appetite suppressant, vitamins, anti-aging medicine, medications or treatment for hair regeneration.

10.11 Any treatment of Injuries sustained while the Insured is serving as a member of a police or military unit or arising directly while participating in a war, mutiny, rebellion, revolution, acts of terrorism, events or similar acts, civil commotion, strike, alteration of public order or any illegal activity including the resulting imprisonment.

10.12 Injuries or Illnesses caused by, or related to atomic power, radioactivity from any nuclear material, nuclear waste, or the combustion of nuclear fuel or nuclear devices, as well as X-ray therapy or radiotherapy treatment without medical supervision.

10.13 Any care or treatment for, arising from, or related, both directly and indirectly, to self-inflicted Illness or Injuries, whether the Insured is of sound judgment or not; suicide; suicide attempts or failed suicides; alcohol consumption; use of drugs or pharmaceuticals in a manner other than the one prescribed by the Insured's Physician or contained in the product labeling; use of Illegal Substances or the illegal use of controlled substances; being under the influence of any of these substances; or due to fights or criminal acts in which the Insured participates due to their own gross negligence, except in cases where it is demonstrated through a final judgment issued by a competent court with jurisdiction that it was a matter of legitimate self-defense.

10.14 Treatment, services, and supplies provided by facilities that are nursing homes, assisted living facilities, long-term care facilities, health spas, hydrotherapy or naturist clinics, and any similar establishment that is not a Hospital.

10.15 Inpatient or outpatient treatment, services, and supplies provided by facilities that are mental institutions.

10.16 Elective or cosmetic surgery or medical treatment when the main purpose is for beautification and not Medically Necessary due to an Injury, Accident, deformity, or Illness covered by this Policy that first occurred after the Insured's Cover Effective Date.

10.17 Any surgical treatment for nasal septum or nasal deformity that was not induced by an Accident or trauma, their complications, side effects, or consequences.

10.18 Cosmetic podiatry or non-Medically Necessary podiatric care, including but not limited to pedicure, chiropractic treatments, orthopedic shoes, or other special shoes and inserts of any type or shape related to symptomatic foot disorders including but not limited to corns, calluses, bunions, Hallux Valgus, hammer toe, Morton's Neuroma, flat feet, and weak arches.

10.19 Any cost related to personal artificial kidney equipment for home use, the acquisition and implantation of an artificial heart, external mono or bi-ventricular devices, and artificial or animal organs.

10.20 Any expenses related to cryopreservation, storage of tissue, or Stem Cell lasting more than twenty-four (24) hours, except for laboratory tests, Transplant procedures, and for Stem Cell preservation when included in the Table of Benefits.

10.21 Any expense related to the repair or replacement of damaged Durable Medical Equipment, unless the product life cycle has expired, and any expense related to the duplication of Durable Medical Equipment that have the same function or purpose.

10.22 Procedures, services, and supplements for the treatment of chronic fatigue syndrome.

10.23 Procedures, services, and supplements for the treatment of sleep apnea and any other sleep disorders, unless coverage is included in the Table of Benefits.

10.24 Any expense, service, surgical procedure, supplement, or non-surgical treatment for obesity, weight control, losing or gaining weight and their related complications, unless coverage is included in the Table of Benefits.

10.25 Any treatment related to growth disorders, bone growth stimulation, or growth hormone deficiency, regardless of the reason for prescription.

10.26 Complementary and Alternative Medicine, including homeopathy, acupuncture, naturopathy, Chinese or oriental medicine, chiropractic, osteopathy, electromagnetic therapy, and any other similar treatment, as well as any complications derived from such treatments, unless coverage is included in the Table of Benefits.

10.27 Any medical examination or diagnostic study that is part of a Routine Health Checkup and vaccinations for Insureds under eighteen (18) years old, unless coverage is included in the Table of Benefits.

10.28 Issuance of medical certificates and examinations as to the suitability of the Insured for employment or travel.

10.29 Prophylactic treatments and genetic testing or similar procedures, except those covered under the "Prophylactic Surgery to Reduce Cancer Risk" benefit when included in the Table of Benefits.

10.30 Inpatient procedures and treatments when the main reason for the Hospitalization is a mental or psychiatric Illness or a behavioral or developmental disorder.

10.31 Inpatient or Outpatient Treatment with a psychologist, cognitive-behavioral therapist, or mental health clinician, unless specific coverage is included in the Table of Benefits.

10.32 Treatments related to learning difficulties, issues related to behavioral disorders (educational or academic problems, behavioral issues deemed disciplinary rather than medical, conditions related to social maladjustment without a diagnosable disorder), or treatments provided in an educational setting to support educational development; psychopedagogical evaluations, psychometric tests, therapies for psychoeducational or psychopedagogical purposes, or child development treatments.

10.33 Any dental or orthodontic treatment, including but not limited to surgical procedures involving the jaw, regardless of the cause or etiology, except when Medically Necessary as a result of a covered Accident as provided in the "Dental Treatment Due to Covered Accident" benefit.

10.34 Routine eye examinations, prescription glasses, contact lenses, procedures to correct eye refraction disorders like nearsightedness, farsightedness, and astigmatism, routine hearing exams, and hearing aids, unless coverage is included in the Table of Benefits.

10.35 Cochlear Implants, unless coverage is included in the Table of Benefits.

10.36 Any expense for any test, treatment, medication, and/or procedure related to a pregnancy, pre- or postnatal care, childbirth and any related Complications of Maternity and/or Complications of Birth, unless coverage is included in the Table of Benefits.

10.37 Any expense for male or female sterilization or birth control.

10.38 Any expense for reversal of sterilization, infertility treatment, artificial insemination, in vitro fertilization, conditions suffered by the mother or newborn as result of any type of Assisted Reproductive Technology; treatments or prosthesis to improve or restore sexual dysfunction or inadequacies.

10.39 Any expense for the medical treatment of gender dysphoria, including but not limited to gender-affirming therapy and gender-affirming surgery.

10.40 Any interruption of the pregnancy voluntarily induced, unless there is evidence of a medical condition of the patient that justifies the procedure or that is the result of rape.

ART. 11 NOTIFICATION REQUIREMENT FOR PRE-AUTHORIZATION AND COORDINATION

11.1 Pre-authorization Requirement: The Insured must obtain pre-authorization before incurring any medical expenses associated with Emergency and non-Emergency medical treatment or services for any of the benefits, medical treatments, and services listed below when covered under the Policy, by calling the telephone number that appears on the reverse side of their insurance identification card, as follows:

a. Any non-Emergency medical treatment or service included in the list below: at least three (3) days in advance.

b. All Emergencies for treatments or services included in the list below: within two (2) days after the event, by the Insured or an individual acting on their behalf, unless such notification is not possible due to a reason beyond the Insured´s control.

For services that require pre-authorization, the Insurance Company may require the use of the Patient Navigation Services as part of the pre-authorization process.

The benefits, medical treatments, and services listed below will not be covered if the corresponding pre-authorization has not been obtained:

a. All Hospital admissions, including the Intensive Care Unit

b. All inpatient and outpatient surgeries, including but not limited to:
   - Organ and Tissue Transplants
   - Reconstructive or Corrective Surgery Related to a Covered Illness, Injury, or Surgery
   - Bariatric Surgery, Gastric Bypass, and Other Weight Loss Surgical Procedures, Including Complications
   - Prophylactic Surgery to Reduce Cancer Risk
   - Symptomatic Disorders of the Feet
   - Surgical Implants or Prosthesis
   - Cochlear Implants
   - Refractive Eye Surgery

c. Oncology Treatment
d. Genetic Therapy / CAR T Cell Therapy
e. Dialysis
f. Outpatient Major Diagnostic Procedures
g. Outpatient Highly Specialized Medications (HSM)
h. Outpatient Rehabilitation Therapy
i. Autism Spectrum Disorders
j. Occupational, Orthoptic, and Speech Therapies
k. Psychologist Visits
l. Home Health Care (Private Nurse)
m. Maternity Care
n. Air Ambulance
o. Airfare Reimbursement After Air Ambulance Transportation
p. Airfare Reimbursement for Travel to Centers of Excellence
q. Congenital and Hereditary Disorders
r. HIV and AIDS
s. Sleep Apnea and Other Sleep Disorders
t. Durable Medical Equipment, External Prosthesis, Orthotic Devices
u. Palliative Care/Hospice Services
v. Repatriation of Mortal Remains or Cremation Services

11.2 Coordination Requirement

In addition to requiring pre-authorization, the following benefits, medical treatments, and services must also be coordinated by the Insurance Company:

a. Organ and Tissue Transplants
b. Bariatric Surgery, Gastric Bypass, and Other Weight Loss Surgical Procedures, Including Complications
c. Prophylactic Surgery to Reduce Cancer Risk
d. Cochlear Implants
e. Genetic Therapy / CAR T Cell Therapy
f. Outpatient Highly Specialized Medications (HSM)
g. Air Ambulance

ART. 12 CLAIMS PROCESS

The Insurance Company may directly pay Providers worldwide for Covered Expenses upon receipt of all required and complete information to process the claim. When direct payment to Provider is not possible or when the Insured has already paid the Provider, the Insurance Company may reimburse the Primary Insured as set forth herein. No claim should be filed when the Provider has agreed to receive direct payment from the Insurance Company.

12.1 General Conditions

Claims must be received within twelve (12) months of the treatment or service date. Once the process begins, any additional information requested by the Insurance Company must be provided within ninety (90) days. Failure to do so may result in claim closure and release of liability.

To be reimbursed for Covered Expenses, the Insured must file a digital claim with the Insurance Company, submitting sufficient evidence of all expenses.

12.2 Required Documentation

The Insured must submit a digital claim through the Member Portal and upload the corresponding medical records and itemized invoices including:

a. Patient's name and date of birth,

b. Diagnosis and type of service (consultation, procedure, Hospitalization, tests, etc.),

c. Date and cost of each service,

d. Proof of payment,

e. Provider's name, specialty, and tax ID/affiliation.

For Covered Expenses in the United States of America, the Insured must provide:

a. Form CMS-1500 (from Physicians),

b. Form UB-04 (from Hospitals),

c. An itemized invoice including Provider information, services rendered, patient details, date, and coding (CPT/HCPCS/ICD-10).

For pharmacy expenses, include both the paid invoice and medical prescription, clearly identifying the Prescription Medication.

For Accidents, the Insured must also submit a written statement with Accident details, and a police report, when available.

When submitting claims for more than one Insured at once, each claim must be filed separately per Insured, Provider, and event, providing itemized expenses.

12.3 Cooperation

It is the obligation of the Insured to cooperate with the Insurance Company in all the necessary requirements for the processing of a payment reimbursement, such as audits and/or scheduled visits of personnel designated by the Insurance Company to confirm the certainty of a diagnosis, treatment, or claim. The Insured must allow access to medical information and healthcare Providers, especially for long-term or palliative care claims. Non-cooperation or refusal to cooperate for this purpose may lead to the suspension of benefits or denial of claims.

12.4 Reimbursement

Reimbursement may be made in the currency of the invoice, the Insured's local currency, or in U.S. Dollars—at the discretion of the Insurance Company.

Total reimbursement cannot exceed the amount actually paid by the Insured for the Covered Expenses. Payment is subject to Usual, Customary, and Reasonable (UCR) charges and cannot exceed actual costs incurred.

In the event of the death of the Primary Insured, unpaid benefits will be reimbursed to the designated Beneficiary or legal heirs.

Small Claims: Reimbursements under one hundred dollars (US$100) may be held and aggregated with subsequent reimbursements or applied toward future premiums—at the discretion of the Insurance Company. Any amount applied to an upcoming premium shall reduce the premium due.

Errors in Coverage: If excluded expenses were reimbursed by mistake or if a payment is later found inadmissible, the Insurance Company may request reimbursement from the Insured and will not be obligated to continue payments as of the date when the error was identified.

ART. 13 ADMINISTRATION: GENERAL ARTICLES

13.1 Pre-existing Conditions

Pre-existing Conditions declared in the Health Insurance Application may be covered under the Policy subject to the terms, conditions, and limitations contained in the Policy, including any applicable Policy Waiting Period, Benefit Waiting Period, any limitations and exclusions that may be contained in the Policy and/or in the Certificate of Coverage, and any Amendments.

Pre-existing Conditions not declared in the Health Insurance Application will not be covered. Risks associated to complications or other conditions directly or indirectly resulting from undeclared Pre-existing Conditions are not covered. The Insurance Company fully reserves the right to modify, retroactively exclude or limit coverage partially or totally, rescind, or cancel the Policy when learning of an omission, inexact declaration, or undeclared Pre-existing Condition in the Health Insurance Application.

13.2 Waiving of Policy Waiting Period

The Policy Waiting Period may be waived at the sole discretion of the Insurance Company (if indicated in the Certificate of Coverage) if:

a. At the time of applying for coverage, the Insured proves they were previously insured by a plan with similar international medical coverage, which was in force for at least one (1) continuous year immediately preceding the Policy Effective Date requested without any interruption in coverage;
b. The Health Insurance Application is submitted to the Insurance Company within thirty (30) days following the termination of the former coverage, and
c. The existence of prior coverage is declared in the Health Insurance Application, and the Insurance Company receives a copy of the former policy and last year's premium receipt or last renewal notice from that insurance company, along with the Health Insurance Application.

If the Policy Waiting Period is waived, benefits payable for any condition that occurs during the first thirty (30) days of the Cover Effective Date of each Insured, are permanently limited to the lesser benefit provided for that condition between this Policy or the former policy.

13.3 Personal Data

The Insurance Company is committed to the responsible collection, use, share, transfer, and safeguarding of Personal Data entrusted to it by our clients, in accordance with its Privacy Notice which can be found at www.bestdoctorsinsurance.com. By accepting and signing the Policy documents, the Contracting Party and the Insureds authorize the Insurance Company to process their Personal Data, including sensitive data, for purposes related to the administration of the Policy.

13.4 Authorization to Share Medical Information with the Independent Consultant

By accepting this Policy, the Primary Insured understands and agrees that the Independent Consultant will have access to the Primary Insured and Insured Dependents' health and confidential medical information (past, present and future) which may be submitted to the Insurance Company or any one of its affiliates or subcontractors without any prior notice to the Primary Insured. Furthermore, the Primary Insured understands and agrees that the Insurance Company will make this information available to the Independent Consultant on the Insured's behalf in order to facilitate the transfer of information between the Primary Insured and the Insurance Company during the processing of claims and the provision of medical services. The Primary Insured agrees that the Insurance Company may provide/deliver such information to the Independent Consultant in any manner chosen by the Insurance Company at its entire discretion. Therefore, the Insurance Company is not obligated to request consent from the Insureds every time it needs to share the confidential medical information.

13.5 Authority

No Independent Consultant has the authority to modify the Policy or to waive any of its terms and conditions. After issuance, modifications to the Policy shall not be valid unless approved in writing by an authorized officer of the Insurance Company and such approval is validated by an Amendment to the Policy. Any material errors in the documents constituting the contract do not obligate the Insurance Company and may be corrected once detected through an Amendment to the Certificate of Coverage.

13.6 Change of Country of Residence

The Primary Insured must notify the Insurance Company in writing of any changes to their Country of Residence within the first thirty (30) days of its occurrence. Change of Country of Residence may result in an adjustment of the premium, Individual Deductible, or plan, or the cancellation of the Policy based on the new geographical area effective at the Insurance Company's sole discretion. Failure to notify the Insurance Company of any change in the Primary Insured's Country of Residence may result in a modification or cancellation of the Policy.

13.7 Coordination of Benefits with Other Insurance Coverage

Should there be other health insurance coverage (but not local government-sponsored programs) or third party that has a legal responsibility or liability to pay, it must be declared at the time of completing the Health Insurance Application or upon such coverage is acquired. A government-sponsored plan is any health program or benefit offered and/or provided by any government agency. Upon filing a claim, proof of the other insurance coverage must be submitted along with a copy of the itemized invoices and proof of the payments made by the other insurance company or government-sponsored program.

The Insurance Company will begin the process of coordination of benefits by determining which amounts paid by the other insurance company or government-sponsored program will be applied to the Individual Deductible, according to the benefits and limitations of this Policy. The total amount of payments may not exceed the amount of Covered Expenses incurred.

In all situations of private insurance plans, the Insurance Company will act as secondary insurer and only pay the proper share of the claim.

13.8 Order of Precedence in the Payment of Benefits

Outside the Insured's Country of Residence, the Insurance Company will function as the secondary insurer and retains the right to coordinate benefits and/or collect payment from any other insurer, prepaid medical plan, or government agency.

If an Insured is covered by an employer group plan, the primary payer is the group health insurance plan that covers the Insured as an employee, subscriber, dependent, or member. The secondary payer is the Insurance Company's health insurance plan that covers the patient as a Primary Insured or Insured Dependent.

13.9 Refunds of Unearned Premium

If the Contracting Party or the Insurance Company cancel the Policy after it has been issued, reinstated, or renewed, the Insurance Company will reimburse the Contracting Party the portion of the unearned premium for the time period remaining on the Policy coverage as of the termination date up to a maximum of sixty-five (65%) percent of the net premium amount. However, the Insurance Company shall keep thirty-five percent (35%) of the net premium to cover administrative costs, which will not be reimbursed. The portion of the unearned premium is calculated based on the number of days remaining on the Policy after the termination date taking into account the recurrency of payment minus the number of days during which the Policy was in effect. If the amount of unearned premium to be refunded is less than one hundred dollars (US$100), such unearned premium shall not be refunded.

Upon the death of the Primary Insured and the presentation of documents reasonably required by the Insurance Company, the portion of the unearned premium corresponding to the deceased Primary Insured shall be paid to the Contracting Party. If the Contracting Party and the Primary Insured are the same person, the portion of the unearned premium corresponding to the deceased Primary Insured shall be reimbursed to the designated Beneficiary or to the Primary Insured's legal heirs.

13.10 Currency

All currency values stated in this Policy are in American Dollars (US$).

13.11 Medical Examinations, Second Opinion and Duty to Cooperate

The Insurance Company reserves the right to request a medical examination, or a Second Medical Opinion from any Insured whose condition or Injury is the basis of a claim when and as often as it is considered necessary by the Insurance Company, while the claim is being evaluated.

The Insured must promptly provide all the information requested by the Insurance Company in relation to their health before, during, and after the issuance of the Policy as well as provide their express consent to the medical professionals and institutions where they were treated to allow them to provide the Insurance Company all the necessary information to gather complete medical records for the Insured in each case.

13.12 Medical Reports

The Insurance Company will request all the necessary medical records and reports directly to the Provider when a direct payment has been agreed with the Provider or to the Insured in case of reimbursements.

The Insured is ultimately responsible for obtaining all medical records, reports, and information necessary to process a claim. The Insured understands that in order to obtain medical records from Providers, the Insurance Company will need to have duly signed authorization forms executed by the Insured, which may be requested by the Provider or Insurance Company. Failure to obtain the necessary authorization or the relevant medical records or reports on time, as established in this Policy might result in a claim being delayed or denied.

13.13 Policy Cancellation or Non-Renewal

The Policy will be considered automatically cancelled if any of the following circumstances occur:

a. Failure to pay the full premium due as required.

b. The Contracting Party notifies the Insurance Company in writing of their decision not to continue having insurance coverage.

c. Written notice by the Insurance Company to the Contracting Party informing them that the Policy has been cancelled pursuant to the "Fraud, False Statement, Omission, or Deception" article.

Early cancellation of the Policy will take place without affecting the Insured´s right to receive payments for Covered Expenses incurred prior to the cancellation date, except in the case of fraud, false statement, omission, or deception. Any treatment received after the Policy cancellation date will not be covered, regardless of the date when the condition, Injury, Illness, or Accident occurred or first manifested and regardless of whether additional treatment might be needed.

The Insurance Company may not cancel an Insured's Policy as a penalty for an Insured's claim record.

In case of cancellation or non-renewal of the Policy, the Insured Dependents may be allowed to continue being covered under a new Policy without underwriting evaluation as long as they comply with the requirements as specified in the "Eligibility and Coverage Termination" article. Those Insured Dependents will be subject to the same terms, conditions, exclusions, and Amendments in the previous Policy and will have to submit a new Health Insurance Application within thirty (30) days from the cancellation or non-renewal date of the Policy under which they were Insured Dependents.

If the Insurance Company cancels or rescinds the Policy due to fraud, false statement, omission, or deception, it reserves the right to issue a new Policy for any Insured Dependents under the cancelled Policy.

13.14 Fraud, False Statement, Omission, or Deception

If an Insured attempts or succeeds in obtaining benefits for themselves or for another person through fraud, false statement, omission, or deception which would not otherwise have been due or payable, the Insurance Company, at its sole discretion, may unilaterally cancel or terminate the Policy, even retroactively from inception, resulting in the Primary Insured and the Insured Dependents automatically losing all their rights to coverage under this Policy. Furthermore, as a consequence of fraud, false statement, omission, or deception, either the Primary Insured or the Contracting Party will be responsible for immediately reimbursing the Insurance Company, upon the Insurance Company's first request, for all payments made by it to the Primary Insured or directly to the Provider under this Policy. Likewise, the Insurance Company reserves the right to refuse the request to refund any portion of the unearned premium, as well as to withhold any amount or sums that were owed or due to the Primary Insured or Insured Dependents under the Policy from inception.

13.15 Policy Issuance

Under the principle of customers' mobility, this Policy is issued and delivered in Bermuda.

13.16 Payment Frequency

This Policy is considered an annual contract. Premiums may be paid annually, semiannually, or quarterly when previously approved by the Insurance Company.

13.17 Grace Period

A thirty (30) day Grace Period is allowed by the Insurance Company for the payment of the total premium due. The Grace Period will begin at the Policy Due Date. If the total premium due is not paid within the Grace Period, the Insurance Company will terminate coverage at 11:59 p.m. on the last day of the period covered by the last payment made. The Covered Expenses incurred by the Insureds during the Grace Period will be paid provided only that the total premium due is paid before the end of the Grace Period.

13.18 Premium Payment

Payment of the total premium is the responsibility of Contracting Party or the Primary Insured, absent a Contracting Party. The total premium is payable annually on the Policy Renewal Date or any other Due

Date previously authorized by the Insurance Company. Payment of the total premium makes the Policy effective during the period for which the premium has been paid. Any excess premium paid will not result in an increase of liability by the Insurance Company. It will only give the right of reimbursement of such excess amount paid without adding any interest, and it will be reimbursed in the same manner as it was paid. Failure to pay the total premium owed as agreed will give the Insurance Company the right to the unilateral and complete rescission of the Policy.

The receipt of a renewal notification or statement by the Contracting Party, or any other person or entity related to the Policy, is not a condition precedent to the Contracting Party's obligation to pay the premium required by the Policy. If the Contracting Party has questions about the amount due or the timing thereof, the Contracting Party may contact the Independent Consultant or the Insurance Company.

Any attempts by the Insurance Company to collect the premium amount owed does not mean that the Insurance Company is waiving its right to cancel the Policy for lack of payment of the premium owed. If the premium owed is for the renewal of the Policy, failure to pay it in full after the expiration of the Grace Period will be interpreted as an express decision by the Contracting Party to not renewing the Policy, and it will be considered automatically cancelled.

13.19 Rate Changes

The Insurance Company retains the right to change the premium rates as a whole, and not individually, at the time of each Renewal Date. No individual Insured will be penalized with a premium increase based on their claim history.

13.20 Policy Reinstatement

Upon cancellation of a Policy due to failure to make the required premium payment after the Grace Period has expired, the Policy may be reinstated pursuant to the following at the discretion of the Insurance Company:

a. If the Contracting Party pays the required premium amount due within thirty (30) days after the expiration of the Grace Period, the Policy may be reinstated without the Primary Insured and Insured Dependents having to fill out a new Certificate of Good Health for underwriting evaluation.

b. Delinquent policies may be renewed at the discretion of the Insurance Company upon receiving a Medical Questionnaire (contained in the Health Insurance Application) or the Certificate of Good Health provided by the Insurance Company for the Primary Insured and Insured Dependents.

13.21 Dispute Resolution and Applicable Law

a. Any dispute, controversy, or claim arising out of or relating to the Policy, including as to the formation, existence, validity, interpretation, breach, or termination thereof, whether the claims asserted are arbitrable, including any dispute, controversy, or claim that concerns alleged non-contractual liability based on events that have occurred before, during, or subsequent to the issuance of this Policy, shall be submitted to final and binding arbitration in accordance with the Bermuda International Conciliation and Arbitration Act 1993 ("1993 Act") (including Schedule 2 to the 1993 Act, but excluding Part II of the 1993 Act concerning conciliation), as that legislation is amended from time to time, or

in accordance with any successor legislation to that statute. In case the 1993 Act were held to be inapplicable to any such dispute, controversy, or claim, then the arbitration provided for herein shall be conducted in accordance with Bermuda's Arbitration Act 1986 ("1986 Act"), as that legislation is amended from time to time, or in accordance with any successor legislation to that statute.

b. The arbitral tribunal will consist of three (3) arbitrators selected in agreement by the parties. Within forty-five (45) days after the commencement of arbitration, each party shall select one (1) person to act as arbitrator. If one of the parties does not name its arbitrator within forty-five (45) days of the commencement of arbitration, the arbitrator shall be appointed by the Appointments Committee of the Bermuda branch of the Chartered Institute of Arbitrators ("CIArb"), or if for any reason they decline to or are unable to act, then by a Judge of the Supreme Court of Bermuda (Commercial Court); and the two (2) arbitrators so selected shall agree and select a third arbitrator ("Tribunal Chair") within sixty (60) days of the commencement of the arbitration.

c. If the selected arbitrators are unable or fail to agree upon the third arbitrator within the allotted time, the third arbitrator shall be appointed by Appointments Committee of the Bermuda branch of CIArb, or if for any reason they decline to or are unable to act, then by a Judge of the Supreme Court of Bermuda (Commercial Court). All arbitrators shall serve as neutral, independent, and impartial arbitrators. Arbitrators shall be either a retired judge or a lawyer with at least ten (10) years of active practice in insurance and/or reinsurance law.

d. The arbitral tribunal shall, so far as is permissible under the law and practice of the place of arbitration, have power to fix all procedural rules for the holding of the arbitration including a discretionary power to make orders as to any matters which it may consider proper in the circumstances of the case with regard to the pleadings, discovery, inspection of the documents, examination of witnesses and any other matter whatsoever relating to the conduct of the arbitration and may receive and act upon such evidence whether oral or written, strictly admissible or not, as it shall in its discretion think fit.

e. Each party shall pay the costs of their own representation and their party appointed arbitrator, plus one half of the costs of the third arbitrator and all expenses reasonably associated with the arbitration. All costs and expenses of the parties and of the arbitration shall be determined by the arbitral tribunal which may, taking into account the law and practice of the place of the arbitration, direct by whom and in what manner they shall be paid.

f. The seat and the place of the arbitration will be Bermuda. The language to be used in the arbitral proceedings will be English.

g. The arbitration agreement herein shall be specifically enforceable, in accordance with its applicable law, in any court having jurisdiction thereof.

h. Any award rendered by the arbitrators will be in writing, with findings of fact and law, and shall be final and binding on all parties.

i. Notwithstanding any contrary provision of the 1993 Act or of the 1986 Act, neither party will appeal any award rendered by the arbitrators, nor seek review, modification, or vacancy of such award(s) before any court, tribunal, or regulatory agency or authority. This article provides the sole recourse for the settlement of any disputes arising out of, in connection with, or relating to the Policy.

j. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction thereof.

k. The law applicable to this Policy, to the arbitration agreement set out in this article, and to all procedural and substantive aspects of the arbitration provided for herein, shall be the law of Bermuda (without prejudice to the specificity of paragraph (a) of this article).

13.22 Subrogation and Indemnity

The Insurance Company has a right of subrogation or reimbursement of payments it made for services rendered on behalf of the Insured, if and when the Insured has recovered all or part of the payments made or incurred from a third party. Furthermore, the Insurance Company has the right to proceed at its own expense on behalf of the Insured in any legal action against third parties who may be responsible for a claim being filed under this Policy or who may have caused an Injury or an Accident for which benefits are provided under this Policy. This is true even if the Insured does not receive the total amount of the claim from such third parties or if the payments received by the Insured are described as payments for anything other than health care expenses. The amount the Insured must reimburse the Insurance Company will not be reduced by attorney's fees or expenses incurred by the Insured.

The Insured must collaborate with the Insurance Company by submitting all necessary information, completing and signing the documentation necessary for the Insurance Company to recover the payments made. This means that the Insured must notify the Insurance Company prior to attempting to resolve any claim related to Injuries suffered by the act or omission of a third party to which the Insurance Company has paid benefits. The Insured will refrain from carrying out any acts, which might limit in any way the right of the Insurance Company to obtain full reimbursement for any payments made for medical services on behalf of the Insured.

13.23 Change of Individual Deductible or Plan

At the Renewal Date of the Policy, the Contracting Party may request a change to the Individual Deductible or to the plan. The Insurance Company reserves the right to accept such changes, or to issue approval subject to specific conditions and/or restrictions.

If the Contracting Party requests a change to a **lower Individual Deductible** or to a **plan with higher benefits**, the request will be subject to underwriting. If an Insured is under active medical treatment or has been recently diagnosed with a medical condition at the time of the request, the Individual Deductible and/or plan may not be changed.

If a change is approved, the following conditions shall apply:

a. **First Thirty (30) Days After the Change**

For any Illness or Injury (other than an Accident or an infectious Illness), coverage will be limited to:

- the **greater** of the Individual Deductibles between the previous plan and the new plan, and
- the **lesser** of the benefits between the previous plan and the new plan, except for those listed under Specific Benefits below.

b. **Benefit Waiting Periods**

- For all benefits subject to a Benefit Waiting Period, the required waiting period must be met before the benefit becomes payable.
- If, under the new plan, the amount of a benefit is higher than under the previous plan, the **lower benefit limit** of the previous plan shall prevail during the Benefit Waiting Period specified in the Table of Benefits, starting from the date of the change.
- For benefits with a Benefit Waiting Period that were **not included** under the previous plan, the Benefit Waiting Period shall begin from the effective date of the change for existing Insureds, or the Effective Date of Cover for newly added Insured Dependents.

c. **Specific Benefits**

The following benefits shall be limited to the **lesser** covered amount between the previous plan and the new plan:

- Prophylactic Surgery to Reduce Cancer Risk for the following twelve (12) months after the date of the change
- Bariatric Surgery, Gastric Bypass, and other Weight Loss Surgical Procedures for the following twenty-four (24) months after the date of the change
- Maternity Care and Complications of Maternity and Birth for the following ten (10) months after the date of the change.

If the previous plan did not include these benefits, the corresponding Benefit Waiting Period must be satisfied before any expenses related to these benefits shall be covered.

d. **Lifetime Benefits**

Any amounts already paid for lifetime benefits under any other Policy, plan, and/or Rider from the Insurance Company or any of its affiliates shall accumulate towards the same benefit under the new plan.

13.24 Insured Relationship with Medical and Hospital Service Providers

The Insurance Company is not a medical provider. Its role is limited to providing and administering insurance coverage for certain medical care activities performed by duly authorized and licensed medical providers, which are subject to the terms, conditions, exclusions, and limitations established in the Policy.

The Insurance Company does not offer and is not responsible for the quality of services or for medical indications or opinions, diagnoses, treatments, prescription of medications, or other medical services, including, but not limited to, implants, therapies, surgeries, and their possible side effects or interactions. All medical decisions, including the choice of treatments, therapies, prescriptions, and the use of implants or any other medical devices, are the sole responsibility of the Insured and their medical provider. The Insured is responsible for their decisions regarding the acceptance of medical indications and the carrying on with the corresponding treatments recommended by their medical Providers.

The Insured acknowledges that all medical indications, treatments, and therapies, including, but not limited to, the use of any medication, prosthesis, or implant, involve risks. The decision and acceptance to proceed with any of them is the sole and exclusive responsibility of the Insured and their medical provider, considering the possible benefits and risks.

The Insured assumes and releases the Insurance Company, its affiliates, officers, directors, employees, Independent Consultants, and agents from any claim, damage, loss, liability, impact, costs, and expenses arising from the treatments and medical services they may have received.

ART. 14 DEFINITIONS

Accident
Any violent, sudden, unforeseen and unintentional event produced exclusively by an external cause resulting directly from and independently of other causes which result in bodily Injury to the Insured.

Accredited University or School
An educational institution that has been evaluated and approved by its home country's Ministry of Education or a respected national accrediting body for meeting established educational quality standards.

Advanced Medical Treatment Providers Network
The Advanced Medical Treatment Providers Network is a network of Hospitals and Providers with which the Insurance Company has an agreement so that the Insureds can receive the required medical care related to Advanced Medical Treatments. This is a payment agreement network under which the Insurance Company will pay the Provider directly for incurred Covered Expenses which may be subject to any applicable fees, Individual and Family Deductibles, Coinsurance, fees, other terms of this Policy, and any limitations established during the underwriting process.

Advanced Medical Treatments
Cutting-edge therapies, techniques, and technologies that push the boundaries of traditional medicine to address complex health conditions and improve patient outcomes. These treatments often involve innovative approaches such as precision medicine, Genetic Therapy, immunotherapy, Stem Cell therapy, nanotechnology, and minimally invasive surgery. They aim to target diseases at the molecular level, customize treatment plans based on individual genetic makeup, harness the body's immune system to fight Cancer and other illnesses, regenerate damaged tissues, and enhance diagnostic accuracy and therapeutic efficacy. Advanced Medical Treatments represent the forefront of healthcare innovation, offering hope for patients with previously untreatable or challenging conditions.

Air Ambulance
Air transport with equipment and trained medical personnel for the transfer of an Insured from the Hospital where it is located to the nearest Hospital that has been coordinated by the Insurance Company. This plan offers this service only in case of Emergency, as defined in this Policy.

Alternative Medicine
Medical treatments that are used instead of traditional (mainstream) therapies. Alternative medical practices are generally not recognized by the medical community as standard or conventional medical approaches. When used in conjunction with traditional medicine, they are called Complementary Medicine.

Amendment
Document added to the Policy by the Insurance Company which clarifies, explains, or modifies the terms and conditions of the Policy.

Angioplasty
Nonsurgical procedure used to open clogged or narrow coronary arteries. The procedure involves introducing an inflatable balloon-tipped catheter through the skin in extremities and inflating the balloon once it traverses the stenosed arterial site. It pushes the atherosclerotic intraluminal plaque against the arterial wall and restores the luminal diameter, therefore normalizing the blood flow to the myocardium.

Area of Coverage
The geographic area where an expense must be incurred to be eligible for payment or reimbursement under this Policy. The Area of Coverage is listed in the Table of Benefits.

Assisted Reproductive Technology
Medical and/or surgical treatments and procedures that were developed to treat pathology related to infertility. These include but are not limited to artificial insemination, in vitro fertilization (INF), treatment with medicines to stimulate male and/or female fertility, intracytoplasmic sperm injection, etc.

Beneficiary
Person designated in the Health Insurance Application to receive the refund of any unearned premium and pending reimbursement of any Covered Expenses in case of the Primary Insured's death.

Benefit Waiting Period
Refers to a period of time that must be completed before the Insurance Company starts making payments for Covered Expenses for certain benefits, as indicated in the Policy and the Table of Benefits. To the extent that a new benefit is added after the Policy becomes effective for an Insured, and that new benefit includes a Benefit Waiting Period, that Benefit Waiting Period will be calculated as of the Renewal Date after the new benefit addition to the Policy.

Best Doctors Insurance Centers of Excellence Provider Network
This is a network of Hospitals with which the Insurance Company has an agreement so that the Insureds can receive certain benefits. This is a payment agreement network under which the Insurance Company will pay the Provider directly for incurred Covered Expenses that may be subject to any applicable fees, Individual and Family Deductibles, Coinsurance, fees, Policy limitations, and other limitations established during the underwriting process.

Best Doctors Insurance Maternity Network
This is a network of Hospitals with which the Insurance Company has an agreement so that the Insureds can receive maternity benefits. This is a payment agreement network under which the Insurance Company will pay the Provider directly for incurred Covered Expenses that may be subject to any applicable fees, Individual and Family Deductibles, Coinsurance, fees, Policy limitations, and other limitations established during the underwriting process.

Biosimilar Drug
A Biosimilar Drug is a biologic medication highly similar to those already approved by FDA: the original biologic (also called the reference product). Biosimilar Drugs are made from the same types of sources and have no clinically meaningful differences from the reference products. This means that they provide the same safety and effectiveness than the reference product over the course of treatment.

Brand Name Drug
A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand Name Drugs may be available by prescription or over the counter.

Cancer
Disease in which some of the body's cells grow uncontrollably and spread to other parts of the body. Abnormal or damaged cells grow and multiply when they should not. These cells may form tumors, which are lumps of tissue. Cancerous tumors spread into, or invade, nearby tissues and can travel to distant places in the body to form new tumors (metastasis). Cancerous tumors may also be called malignant tumors. Many Cancers form solid tumors, but Cancers of the blood, such as leukemias, generally do not.

Cardiac Rehabilitation
Medically Necessary supervised program that combines prescribed exercise, education, and counseling to improve cardiovascular health following a heart attack, heart surgery, or diagnosis of heart disease, as prescribed by a Physician.

Cerebral Vascular Accident
Cerebral Vascular Accidents (strokes) are caused by blood clots and broken blood vessels in the brain, which damage brain tissue. Symptoms include dizziness, numbness, weakness on one side of the body, and problems with talking, writing, or understanding language. The risk of a Cerebral Vascular Accident is increased by high blood pressure, older age, smoking, diabetes, high cholesterol, heart disease, atherosclerosis (a buildup of fatty material and plaque inside the coronary arteries), and a family history of Cerebral Vascular Accident.

Certificate of Coverage
Document that constitutes part of the Policy that specifies the Policy Effective Date, lists all individuals covered by the Policy with their Cover Start Date, and any conditions and/or limitations of coverage.

Chronic Condition
Condition that last one (1) year or more, may get worse over time, and requires ongoing medical attention and/or limit activities of daily living. Chronic Conditions can usually be controlled but not cured.

Cochlear Implant
A Cochlear Implant is a small, complex electronic device that can help to provide a sense of sound to a person who is profoundly deaf or severely hard-of-hearing. The Cochlear Implant consists of an external portion that sits behind the ear and a second portion that is surgically placed under the skin. An implant does not restore normal hearing. Instead, it can give a deaf person a useful representation of sounds in the environment and help them understand speech.

Complementary Medicine
Group of alternative diagnostic and therapeutic disciplines used together with conventional medicine. Complementary Medicine includes a large number of practices and systems of health care that, for a variety of cultural, social, economic, or scientific reasons, have not been adopted by mainstream Western medicine.

Complications of Birth
Those disorders of a newborn directly related to birth, not due to genetic or hereditary factors, which manifest during the first thirty (30) days of life, including, but not limited to, hyperbilirubinemia (jaundice), cerebral hypoxia, hypoglycemia, prematurity, respiratory deficit, or traumatisms during childbirth.

Complications of Maternity
Pathology or treatment as a result of the abnormal course of pregnancy and/or delivery, such as acute nephritis, nephrosis, cardiac failure, pre-eclampsia, ectopic pregnancy, gestational diabetes, termination of pregnancy requiring medical intervention due to fetal death, spontaneous end of a pregnancy at a stage where the embryo or fetus is incapable of surviving independently. For the purpose of this Policy, the following are not considered Complications of Maternity: Elective Cesarean or cesarean after a cesarean, spotting or rest prescribed by a Physician during pregnancy, the normal and usual symptoms resulting from pregnancy; service or treatment of a Chronic Condition not related to pregnancy, even if during the period of gestation requires a specific treatment due to complications of pregnancy which were the result of fertility treatments and pregnancy complications when the pregnancy is not covered by the Policy.

Congenital Condition
Organic disorder, malformation, embryopathy, persistence of tissue or embryonic or fetal structure, which has been acquired during the development of the fetus in the uterus or during birth, and not by inheritance, regardless of whether it is evident before birth, at the time of birth, or manifested later.

Contracting Party
Natural or legal person who has signed the Policy with the Insurance Company for the Insureds' coverage and who is responsible for the corresponding premium payment. The Contracting Party shall be the Primary Insured unless another party is listed on the Health Insurance Application or another form acceptable to the Insurance Company.

Country of Residence
The country in which the Insured resides the majority of any calendar or Policy Year, or where the insured has resided for more than one hundred and eighty (180) continuous days during any three hundred and sixty-five (365) day period while the Policy is in effect.

Cover Effective Date
The date indicated in the Certificate of Coverage for each Insured on which the Policy Waiting Period begins. The Cover Effective Date is also used to calculate any applicable Benefit Waiting Periods. When a new benefit with a Benefit Waiting Period is added after an Insured's Cover Effective Date, the Benefit Waiting Period will start counting as of the Policy's Renewal Date following the effective date of the benefit.

Covered Expenses
The Usual, Customary and Reasonable (UCR) charges for medical expenses incurred by an Insured in the Area of Coverage and after the Cover Effective Date and while the Policy is in effect in relation to that Insured, which the Insurance Company determines to be all of the following:

a. Provided for the purpose of preventing, evaluating, diagnosing, or treating a covered Illness or Injury;

b. Medically Necessary, and

c. Not a general exclusion in the Policy or an individual exclusion in the Certificate of Coverage.

The amount payable as Covered Expenses may be limited by other specific maximums described in the Table of Benefits or in any other sections of the Policy. Covered Expenses are subject to any applicable fees, Individual or Family Deductibles, and/or Coinsurance.

Covered Maternity
A maternity for which the Policy provides benefits after completing the Benefit Waiting Period of ten (10) calendar months.

Critical Condition
A serious medical state in which an ill or injured individual has dangerously unstable or abnormal vital signs and typically requires short-term life support measures (such as mechanical respiration or defibrillation) for stabilization and support prior to or during recovery. The defining attributes of Critical Condition are high risk of imminent death, vital organ dysfunction, requirement for care to avoid death, and potential reversibility.

Custodial Care
Services rendered that include but are not limited to personal assistance that does not require the skills of a professional.

Dental Treatment Due to Accident
Treatment necessary to restore or replace teeth, damaged or lost in a covered Accident.

Dependent Child
The following unmarried persons in relation to the Primary Insured: biological child, legally adopted child, stepchild, or minor child to whom the Primary Insured has been appointed Legal Representative by a court of competent jurisdiction.

Domestic Partner
Unmarried couples (neither with their partner or any other individual) of the same or opposite sex, who have a domestic partnership under either statutory or common law of their Country of Residence. The following requirements must be met to be in a domestic partnership: both must be at least eighteen (18) years of age and must have been living in the same household for at least twelve (12) consecutive months.

Due Date
The date when the total insurance premium is due and payable for the corresponding coverage period depending on the frequency of payment authorized by the Insurance Company.

Durable Medical Equipment
Durable Medical Equipment (DME) is any equipment that provides therapeutic benefits to a patient due to certain medical conditions and/or Illnesses. DME are used mainly to serve a medical purpose and can withstand daily or prolonged use. They are not useful for a person in the absence of Illness or Injury. They must be ordered or prescribed by a Physician. DME includes, among others, wheelchairs (manual and electric), hospital beds, traction equipment, canes, crutches, walkers, etc.

Elective Cesarean
Scheduled surgical intervention that is not considered Urgent or an Emergency. Elective Cesarean sections are typically planned in advance, unlike Emergency Cesareans, which are performed immediately due to a medical condition that endangers the life or health of the mother or fetus.

EMA
The European Medicines Agency (EMA) protects and promotes human and animal health by evaluating, authorizing, and monitoring medicines in the European Union (EU) and the European Economic Area (EEA). The EMA ensures the scientific evaluation, supervision, and monitoring of the safety of medicines for human and veterinary use in the EU.

Emergency
Life-threatening, sudden, and unforeseen Illness or Accident covered under this Policy that results in acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Serious jeopardy to the life or long-term health of the Insured, or

b. Serious impairment to bodily functions, or

c. Serious dysfunction or permanent damage to any organ or body part.

For the purpose of this definition, "immediate medical attention" means care required within twenty-four (24) hours of the onset of such symptoms. Conditions that do not meet these criteria, including routine medical evaluations, elective treatments, or Urgent consultations, shall not be considered an Emergency under this Policy.

Emergency Cesarean
Surgical intervention that must be performed immediately due to complications or medical conditions that endanger the life or health of the mother, fetus, or both.

Experimental or Investigative

Any treatment, procedure, equipment, drugs, device or supply that does not comply with the following criteria:

a. Controlled clinical research published in medical literature reviewed by other professionals of the same specialty, which shows that this service or device has a clear, beneficial result for one's health for a specific diagnosis.

b. At the time the service or device is provided, it complies with the generally accepted standards of medical practice of the competent health authority and in accordance with international standards, taking as reference what is indicated by the FDA and/or the EMA.

c. At the time the service or device is provided, it has been approved for the specific indication or application in question by the competent health authority and in accordance with international standards, taking as reference what is indicated by the FDA and/or the EMA, regardless of where the medical expenses are incurred.

Family Deductible

The amount that must be met collectively by all the Insureds under the Policy for Covered Expenses incurred in a Policy Year. All amounts applied to the Individual Deductible of each Insured under the Policy will be taken into account to reach the maximum Family Deductible amount equivalent to two (2) Individual Deductibles. Once the Family Deductible is met, the Individual Deductible for all members in the Policy will also be deemed met.

FDA

The U.S. Food and Drug Administration (FDA) is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices and blood derivatives. For international standards, it is a reference source regarding the authorization of drugs.

Generic Drug

A Prescription Medication that has the same active-ingredient formula as a Brand Name Drug. Generic Drugs usually cost less than Brand Name Drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as Brand Name Drugs.

Grace Period

The thirty (30) days after the Policy Due Date during which the Policy may be renewed.

Genetic Therapy

Genetic Therapy is a medical approach that involves altering the genes inside a person's cells to treat or prevent diseases. This can be achieved through various methods, including fixing or turning off faulty genes, replacing non-functional genes with a healthy copy to restore normal function, or modifying gene expression to correct mutations that lead to disease. Genetic Therapy has the potential to treat a wide range of conditions, including genetic disorders like cystic fibrosis, hemophilia, and muscular dystrophy; certain Cancers, to better recognize and attack cancer cells, and infectious diseases like HIV, by altering the genes of immune cells to resist infection.

Ground Ambulance
Ground transportation with medical equipment and personnel trained in the transportation of injured or ill persons.

Health Insurance Application
Written declaration signed by the Contracting Party and the individual that is applying to become a Primary Insured containing information about themselves and proposed dependents, if any, that is used to determine their insurability. The Health Insurance Application, which is relied upon by the Insurance Company in determining whether to issue coverage, includes any medical history questionnaires, verbal statements made by the Proposed Insureds during a medical interview conducted by the Insurance Company prior to the issuance of the Policy, and any other documents provided or requested by the Insurance Company. The Health Insurance Application becomes part of the Policy between the parties once the Policy is underwritten by the Insurance Company.

Hereditary Conditions
Genetic diseases whose main characteristic is their survival from generation to generation, transmitting from parents to children and so on. They are characterized by the transmission of physiological and anatomical particularities of an individual to those who descend from it, through genetic material.

Highly Specialized Medications (HSM)
High-cost, high-complexity drugs that are used in the treatment of complex, rare, or Chronic Conditions, such as Cancer, autoimmune diseases, multiple sclerosis, or dementia/Alzheimer's disease. These Prescription Medications must be prescribed by a specialist Physician, and often require special handling, administration, and monitoring. The use of Highly Specialized Medications may need careful oversight from a specialized health care provider who can watch for severe side effects, handle adjustments in dosage, and ensure that the medication is working as intended. Unless otherwise specified in the Policy, any medication not administered during an inpatient Hospital stay will be considered an outpatient drug. Coverage of Highly Specialized Medications is subject to Medical Necessity, pre-authorization, and compliance with the terms, conditions, and limitations of the Policy.

High-risk Activities
Activities with a significantly elevated potential for personal injury or harm, often involving speed, heights, dangerous tools, or substances, and require careful planning, safety precautions, and adherence to guidelines. Some examples of High-risk Activities include, but are not limited to sky diving, mountain climbing, hiking, bullfighting, any type of aviation sports, speleology, canoeing in rapids exceeding grade 5, parachuting, paragliding, hang gliding, parapenting, speed competitions, motorcycle races, sports or competitions with motor vehicles, scuba diving at a depth of over 30 meters (100 ft.), boxing, horseback-riding, and bungee jumping.

Hospital
Any institution that is legally licensed as a medical or surgical facility in the country in which it is located that is primarily dedicated to providing clinical and surgical services for injured or ill individuals under the supervision of a medical professional and not a place of rest, nursing, or convalescent home or institution, or a facility for long-term care.

Hospital Services
Any medical treatment provided to the Insured in a Hospital. Hospital Services comprise charges for room and board, in case of Hospitalization, as well as the use of all the Hospital's medical facilities, all treatments and medical services prescribed by a Physician, including intensive care, when Medically Necessary.

Hospitalization
Admission of the Insured to a Hospital facility for twenty-four (24) hours or more to receive medical or surgical care. The severity of the condition must justify or support the Medical Necessity for Hospitalization. The treatment that is limited to the emergency room is not considered a Hospitalization.

Illegal Substances
Pharmaceuticals or similar chemicals defined by the U. S. federal government to be illegal for sale to the general public (such as cocaine), Prescription Medications that are used for a purpose other than that specifically authorized by the FDA and/or the EMA (such as Oxycontin not used as specifically prescribed for pain relief), or the use of other chemicals that are traditionally sold for other purposes but are used in an illicit manner (such as imbibing rubbing alcohol).

Illness
Any health-related disorder of internal or external cause that affects the human body and requires medical care or surgical treatment.

Independent Consultant
Insurance advisor who guides and advises their clients (the Proposed Insureds) on available insurance products, helps them complete forms, serves as an intermediary between them and the Insurance Company, helps generate the sale, and assists the Insureds at the time of a claim, among other things.

Individual Deductible
The amount that an Insured must pay every Policy Year for Covered Expenses before benefits are available under this Policy. Such amount will not be reimbursed under the Policy. The Individual Deductible will be deemed met when the amount that the Insured must pay for Covered Expenses incurred in a Policy Year reaches the Individual Deductible set forth in the Certificate of Coverage or when the Family Deductible amount is met in the same Policy Year. The Individual Deductible may be different based on whether the medical service was received in the Country of Residence or elsewhere. If the Individual Deductible has been met in the Country of Residence and other medical services are rendered in the United States (where applicable), where the Individual Deductible may be higher as indicated in the Certificate of Coverage, the Insured is responsible for the difference between the two amounts.

Injury
Damage inflicted to the body of the Insured.

Insurance Company
Best Doctors Insurance Limited.

Insured
The Primary Insured and Insured Dependents enrolled in an active Policy at the time of receiving benefits for Covered Expenses and which are listed in the Certificate of Coverage. An individual will cease to be an Insured as set forth in the "Eligibility and Coverage Termination" article.

Insured Dependent
Individual under seventy-four (74) years of age at the time of inclusion in the Policy as Insured Spouse or Domestic Partner or Insured Dependent Child of the Primary Insured that meets the eligibility requirements set forth in the "Eligibility and Coverage Termination" article.

Insured Dependent Child
Dependent Child who has been included in the Health Insurance Application and who has been accepted for coverage, provided that a Dependent Child shall only be considered an Insured Dependent Child until the Renewal Date after reaching eighteen (18) years of age. If such Dependent Child is a full-time student at a university or school accredited at the time the Policy is issued or renewed, they may continue to be an Insured Dependent Child until the next Renewal Date after reaching twenty-four (24) years of age. Notwithstanding the foregoing, and regardless of age, a Dependent Child while cease to be an Insured Dependent Child on the Renewal Date after they marry.

Insured Spouse or Domestic Partner
The Primary Insured's Spouse or Domestic Partner who has been included in the Health Insurance Application and who has been accepted for coverage, provided that a Spouse or Domestic Partner shall only be considered an Insured Spouse or Domestic Partner until the Renewal Date when they no longer meet the eligibility requirements set forth in the "Eligibility and Coverage Termination" article.

Legal Representative
For the purposes of this Policy, the Legal Representative is the person who, in accordance with the applicable laws exercises the parental power or guardianship of the Insured and in that capacity, contracts the Insurance Policy. The Legal Representative will not enjoy the coverage of the Policy; however, they must comply with all the obligations of the Contracting Party regarding the payment of the premium, the notification of claims, the management of the request for reimbursement of the expenses covered by the Policy, the notifications between the parties, and any other obligation indicated in the General Conditions of the Policy.

Living Donor
Person who donates one of its organs, cells or tissue to be transplanted into the body of another person or receiver, with whom is compatible.

Major Diagnostic Procedures
The following Medically Necessary diagnostic tests and procedures used to monitor, confirm, or evaluate a patient's condition:

- CT scans and MRI (advanced imaging)
- Gastroscopy / upper digestive endoscopy (EGD)
- Colonoscopy

- Biopsies
- Cardiac electrophysiology (EP) studies
- Any other test or procedure that is invasive or requires specialized facilities and equipment, or sedation or anesthesia with clinical monitoring.

Medically Necessary, Medical Necessity

A medical service, supply, equipment, Prescription Medication, or Hospital admission that:

a. Is appropriate and essential for the diagnosis and treatment of an Insured's Illness.

b. Does not exceed the reach, duration, or intensity of the level of care necessary to provide a safe, adequate, and appropriate diagnosis and/or treatment.

c. Has been prescribed by a Physician.

d. Is consistent with the professional norms accepted within the medical scope of practice in the United States.

A standard Private Room upgrade to a suite or junior suite solely for the convenience of the Insured, the Insured's family and/or the medical Providers will not be considered Medically Necessary.

Myocardial Infarction

Myocardial infarction (heart attack) is a medical Emergency that occurs when blood flow to the heart muscle is blocked, causing damage or death of heart tissue. The most common cause is atherosclerosis, where fatty deposits (plaques) build up in the coronary arteries that supply blood to the heart. Other factors include blood clots, coronary artery spasm, high blood pressure, diabetes, smoking, obesity, and certain medications. Symptoms include chest pain, shortness of breath, nausea and vomiting, pain or discomfort in the left arm, shoulder, neck, or jaw, sweating, dizziness or lightheadedness. Diagnosis must be supported by an electrocardiogram (ECG) showing changes in heart rhythm and electrical activity, blood tests detecting elevated levels of cardiac enzymes, and imaging tests, such as echocardiography or angiography.

Myocardial Revascularization Surgery

Myocardial Revascularization Surgery is a surgical procedure that aims to improve blood flow to the heart muscle (myocardium) by bypassing or widening narrowed coronary arteries. The surgery is typically performed under general anesthesia. The surgeon may use a traditional open-heart approach or a minimally invasive technique, such as robotic surgery or thoracoscopic surgery (through a small incision in the chest wall). Indications for Myocardial Revascularization Surgery include coronary artery disease with significant narrowing, myocardial ischemia (lack of blood flow to the heart muscle), heart failure due to coronary artery disease, and left main coronary artery disease (a large artery that supplies a large portion of the heart muscle).

Neurological Diseases

Diseases in which the central and/or peripheral nervous systems are affected by a disorder that arises and occurs primarily within the structures comprising the central and/or peripheral nervous system. No disease or disorder affecting the central and/or peripheral nervous system in a secondary manner or which has

been caused by conditions or factors outside the nervous system will be considered neurological disease for purposes of this coverage.

Neurosurgery
Neurosurgery, also known as neurological surgery or brain surgery, is a medical specialty focused on the surgical treatment and rehabilitation of disorders affecting the nervous system, including the brain, spinal cord, and peripheral nerves.

Nurse
An individual legally licensed by the local jurisdiction to provide nursing care to patients.

Occupational Therapy
Medically Necessary treatment provided by a licensed occupational therapist to help patients restore or improve their ability to perform daily activities and work functions, following an Illness, Accident, or disability.

Oncology Treatment
Range of therapies, including surgery, radiation, chemotherapy, hormone therapy, immunotherapy, and targeted therapy, all aimed at curing, shrinking, or preventing the spread of Cancer.

Orthoptic Therapy
Medically Necessary treatment provided by a licensed orthoptist to diagnose and manage disorders of eye movement, binocular vision, and visual coordination, including non-surgical management of strabismus and related conditions.

Out-of-Network Fee
Fixed percentage fee that is applied in products that are subject to a U.S. Provider Network whenever a treatment is received from a Provider outside the U.S. Provider Network.

Outpatient Treatment
Medical treatment or services that do not require a Hospital admission.

Palliative Care
Medical care for chronically ill patients who suffer from a serious condition that is not improving or reasonably predicted to improve with treatment.

Patient Navigation Services
Patient Navigation Services means the services described in Art. 9.1.

Personal Data
Information relating to a natural person who is identified or identifiable, including by indirect means, such as name, address, email, identification or registration number, photograph, and location data, when such information makes it possible to identify the data subject, either on its own or in combination with other information. Data relating to health, genetic data, and biometric data, when linked to a natural person, are treated by the Brazilian General Data Protection Law (Lei Geral de Proteção de Dados Pessoais – LGPD) as Sensitive Personal Data.

Physical Therapy
Medically Necessary treatment provided by a licensed physical therapist to restore or improve mobility, strength, function, and pain management following an Illness, Accident, surgery, or musculoskeletal condition.

Physician, Doctor
Professional licensed and registered with a legally formed organization to practice medicine in the country where treatment is provided. The term "Physician" or "Doctor" shall also include professionals legally licensed and similarly registered to practice dentistry.

Policy
The entire contract between the Insurance Company and the Contracting Party with regard to the benefits contained herein. The following documents constitute the Policy, and no other document, correspondence, discussions, agreements, and/or prior negotiation shall be considered part of the Policy:

a. The Conditions of Coverage (this document);
b. The corresponding Table of Benefits;
c. The Health Insurance Application;
d. Any document that may be required to add new Insured Dependents to the Policy, to modify the insured risk, to upgrade or downgrade to a different medical plan, to reinstate the Policy, or to claim payment of benefits under this Policy;
e. The Certificate of Coverage;
f. Any Amendments that modify the terms and conditions of the Policy;
g. Any Riders or Modules that include additional coverage.

In case of discrepancy, Amendments and Riders will prevail over the provisions of the Conditions of Coverage. The English version of this Policy will prevail and will be the controlling document in case of any doubt or dispute about the wording in the translated versions of this Policy. The Portuguese version of this document may be available as a courtesy to the Insured and may be requested directly from the Insurance Company or through the Independent Consultant. Documents may be sent in electronic format. The Insured has the right to request hard copies of these documents.

Policy Effective Date
The date when the Policy becomes effective as stated in the Certificate of Coverage. This date will only be effective after delivery of the insurance Policy to the Primary Insured and the expiration of the ten (10) day right to examine the Policy, during which the Primary Insured reserves the right to examine and return the Policy for a full refund.

Policy Waiting Period
The thirty (30) day period that begins on the Cover Effective Date of each Insured under the Policy, during which coverage will only apply to Illnesses or Injuries caused by a covered Accident or a condition of infectious origin that occurs or is manifested for the first time during this period. Any other condition or symptom that is not caused by a covered Accident or a condition of infectious origin that occurs during the Policy Waiting Period will be permanently excluded from coverage.

Policy Year
The period of twelve (12) consecutive months beginning on the Policy Effective Date and any subsequent period of twelve (12) months after the Policy renews.

Polytrauma
Severe trauma affecting multiple organ systems and tissues of the human body as a result of an external physical force. It can lead to temporary or permanent disability and, in some cases, even death.

Pre-existing Condition
a. Any condition that has been diagnosed by a Physician prior to the Cover Effective Date, or

b. Any condition for which a Physician was consulted, and medical treatment was recommended or received prior to the Cover Effective Date, or

c. Any condition, symptom, or occurrence that, if it had been presented to a Physician prior to the Cover Effective Date, would have resulted in a diagnosis of an Illness or disorder.

Premium Providers Network
This is a group of healthcare Providers where services are covered by the Insurance Company. Incurred Covered Expenses within the Premium Providers Network are subject to a Coinsurance payment by the Insured in addition to any other applicable fees, Individual and Family Deductibles, Policy limitations, and other limitations established during the underwriting process. To determine if a Provider is a member of the Premium Providers Network, Insureds shall contact the Insurance Company before scheduling or receiving any medical services. It is recommended to obtain the up-to-date list of Providers that are part of the Premium Providers Network directly from the Insurance Company. The Premium Providers Network may change at any time without prior notice.

Prescription Medication
A drug or medication whose sale or use is legally limited to the indication of a Physician.

Primary Insured
Individual who is at least eighteen (18) and less than seventy-four (74) years of age at the time of obtaining the insurance, who is entitled to the coverage under the Policy and to receive payment for the reimbursement of Covered Expenses under this Policy, and exercises the rights of the Insureds. The Primary Insured may or may not be the Contracting Party.

Private Aircraft
Any aircraft engaged in personal or business flight that is not regularly scheduled or chartered by a commercial airline.

Private Room
A standard Hospital room equipped to accommodate only one patient.

Professional Sports (Practice of)
Playing or training in relation to any sport for which the Insured receives their main source of income or similar benefit of any nature whether directly or indirectly.

Proposed Insured
Person for whom insurance coverage is requested.

Provider
Hospitals, diagnostic centers, laboratories, Physicians, specialists, pharmacies, and any facility that is legally authorized in the jurisdiction where they provide medical services. The quality of their services provided is not the responsibility of, or attributable to, the Insurance Company.

Renal Failure
Renal failure (kidney failure) occurs when one or both kidneys no longer function well on their own. Renal failure is sometimes temporary and develops quickly (acute kidney failure). Other times, it is a long-term condition that slowly gets worse over time (chronic kidney failure). Terminal stage of chronic renal failure is the complete and irreversible loss of kidney function, as a result of which treatment with dialysis or kidney Transplant becomes necessary.

Renewal Date
The recurring annual date on which the effectivity of the coverage resets for a new Policy Year. On this date, Policy terms may be reviewed or adjusted, including premiums, benefits, and coverage options. On this date, all the benefits and coverage of the Policy end unless full premium payment is made by the Due Date and no later than the end of the Grace Period.

Resident of the United States
A person shall be considered a Resident of the United States if their Country of Residence is the United States and they intend to make the United States their home on a long-term basis or their principal home for legal purposes, which can be evidenced by registering to vote, obtaining citizenship, or any other criteria established by the Insurance Company.

Respiratory Therapy
Medically Necessary treatment provided by a licensed respiratory therapist to assess, manage, and improve respiratory function in patients with acute or chronic lung diseases or other breathing disorders.

Rider
A document added to the Policy by the Insurance Company that provides additional optional coverage and another set of terms and conditions applying to that additional optional coverage.

Routine Health Checkup
A Routine Health Checkup, also known as a wellness visit or preventive care visit, is a regular appointment with a healthcare provider to monitor overall health and prevent potential problems before they become serious. It focuses on maintaining good health and identifying potential issues early, rather than treating existing illnesses. Routine Health Checkups may include a physical exam, a medical history review, screenings for certain conditions, vaccinations, and health advice.

Routine Pediatric Health Checkup
A Routine Pediatric Health Checkup, or well-child visit, is essential for monitoring a child's growth, development, and overall health, including vaccinations, screenings, and addressing parental concerns.

Routine Pediatric Health Checkups help identify potential health problems early on. They provide an opportunity to discuss any concerns or questions that parents may have about their child's health. They ensure that the child is receiving the necessary vaccinations and screenings to stay healthy and help track the child's growth and development.

Second Medical Opinion
The opinion of a Physician or Doctor different than the one currently treating the Insured.

Semi-Private Room
A standard Hospital room equipped to accommodate more than one single patient.

Serious Accident
Sudden or unexpected event caused by an external, involuntary, unforeseen, fortuitous, sudden, and violent source, resulting in demonstrable bodily harm or Injury that requires immediate Hospitalization of more than twenty-four (24) hours. For cases involving the nose, ligaments, spine, knees, and/or major joints, only fractures, ruptures, or Polytrauma will be considered Serious Accidents.

Severe Burns
Severe burns are a medical Emergency causing skin and tissue damage due to heat, electricity, radiation or chemicals. For purposes of this coverage, only those diagnosed as third-degree burns will be considered Severe Burns. Third-degree burns involve all the layers of skin and sometimes the fat and muscle tissue under the skin. Third-degree burns can destroy nerves, so there may be little or no pain.

Severe Infectious Disorders
Severe Infectious Disorders are caused by the multiplication of microorganisms and the presence of their toxins in the blood. Severe Infectious Disorders can be life-threatening and require prompt medical attention. The two (2) following criteria must be present concurrently to fulfill the severity criteria of the infection:

a. Positive blood cultures, positive cerebrospinal fluid culture, presence of an intra-abdominal abscess, or an infectious focus with positive culture that is causing the infection, and

b. Evidence of multi-organic failure manifested by the presence of at least one of the following criteria: severe metabolic acidosis, vasoconstriction that requires vasopressor therapy, respiratory failure requiring mechanical ventilation, renal insufficiency requiring hemodialysis, and disseminated intravascular coagulation requiring administration of blood derived products.

Spouse
The person to whom the Primary Insured is married to when the marriage is valid in the jurisdiction where it took place.

Stem Cells
Stem Cells are special human cells with the ability to develop into many different cell types. They can divide and renew themselves, and they play a key role in repairing damaged tissues and supporting the body’s natural healing processes.

Table of Benefits
Document that outlines the specific covered benefits, amounts, Individual Deductible, and Coinsurance details of the specific plan in a concise manner to help Insureds understand their coverage.

Transplant
A Medically Necessary procedure during which organs, tissue, or cells are surgically transplanted from a deceased or Living Donor to the recipient.

United States, U. S., USA
Refers to the United States of America.

Urgency / Urgent
Non-life-threatening conditions that require timely care within a reasonable period, generally twenty-four (24) to seventy-two (72) hours, such as high fever, minor fractures, urinary tract infections, or other acute conditions. If not treated, could be expected to result in:

a. Significant pain or discomfort;

b. Deterioration of the Insured's health, or

c. Complications that may lead to an Emergency as defined in this Policy.

Routine medical consultations, preventive care, elective treatments, and conditions that can safely be addressed at a later date shall not be considered an Urgency under this Policy.

U.S. Provider Network
The U.S. Provider Network is a group of healthcare Providers and/or network administrators in the United States where contracted services are covered by the Insurance Company and specified herein. Incurred Covered Expenses may be subject to any applicable fees, Individual and Family Deductibles, Coinsurance, fees, other terms of this Policy, and any limitations established during the underwriting process.

USD, US$
All refer to the currency of the United States of America.

Usual, Customary, and Reasonable (UCR)
Usual, Customary, and Reasonable (UCR) charges mean the level of fees typically charged for a given medical service, treatment, or supply within the geographic area where the service is provided, as determined by the Insurance Company. UCR reflects the prevailing charges made by Providers of similar training and experience for comparable services, considering the nature of the procedure, the complexity of the case, local market conditions, and any relevant public or private fee benchmarks.

Within the United States, UCR is based off the amount typically paid by the Company for a given medical service, treatment, or supply within the geographic area where the service is provided, based on actual amounts paid and contracts with medical providers.

Outside the United States, UCR is established using local or regional medical cost data, published fee schedules where available, historical claims data, and internationally recognized cost benchmarks, with adjustments for inflation, hospital category, and prevailing market rates.

CONDITIONS OF COVERAGE

MEDICAL ELITE™ *Pro*

PREMIER PLUS™ *Pro*

GLOBAL CARE™ *Pro*

MEDICAL SELECT™ *Pro*

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Best Doctors® INSURANCE

The insurance policy is issued by Best Doctors Insurance Limited, a company registered in Bermuda and is, therefore, subject to Bermuda's laws and jurisdiction. The administration services are offered by Best Doctors Insurance Services, LLC. on behalf of Best Doctors Insurance Limited.

The policy providing your coverage and the insurer providing this policy have not been approved by the Florida Office of Insurance Regulation (FLOIR).

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