

Good Neighbor Insurance

690 E. Warner Rd., Ste. 117
Gilbert, AZ 85296 USA

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480.633.9500 / 480.813.9100
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“Bupa offers me the protection I need so I can sail away with ease”



**Bupa Diamond Care
Membership Guide**



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Welcome to Bupa

Thank you for choosing Bupa Diamond Care, brought to you by two of the largest international health insurance companies in the world, Bupa and IHI.

This Membership Guide contains the provisions and benefits of your Bupa Diamond Care policy and other important information about how to contact us and what to do if you need to use your coverage.

Please review your Certificate of Coverage, which shows the deductible you selected and any exclusions and/or amendments to your coverage.

If you have any questions about your plan, please contact the IHI/Bupa Helpline. You can find our contact information in the "Contacting us" section of this Membership Guide.

USA Medical Services

Your direct line to medical expertise

As part of the Bupa group, USA Medical Services provides Bupa group members with the most professional support at the time of a claim. We understand that it is natural to feel anxious at a time of ill health, so we will do everything we can to help make arranging your treatment as easy as possible and provide you with the advice and assistance you require.

USA Medical Services wants you to have the peace of mind that you and your family deserve. In the event of a medical crisis, whether it is simply scheduling an appointment, arranging a hospital stay, or the need of an air ambulance, our medical professionals at USA Medical Services are just a phone call away, 24 hours a day, 365 days a year. Our staff of medical personnel will be in constant communication with you and your family, guiding you through any medical crisis to the proper medical specialist and/or hospital.

When the worst happens, USA Medical Services is just a phone call away

In the event of an emergency, USA Medical Services mobilizes its extensive worldwide air and ground emergency transportation. We provide advanced alert of patient arrival to the medical facility and maintain continuous critical communication during transport. While treatment and initial care are being provided, USA Medical Services monitors your progress and reports any change in your status to your family and loved ones.

When every second of your life counts...count on USA Medical Services.

Manage your policy online

As an IHI and Bupa customer, you have access to a range of online services. At www.bupalatinamerica.com you will find:

- A useful health guide with general advice on lifestyle diseases, exercise, second opinions, and counseling on treatments
- Tips on how to file a claim
- News about Bupa
- Information on our range of products
- Free premium quote

Sign up as an online customer – free and easy

Our online customer solution is a service for you who wish to avoid postal delays, letters lost in the mail, sorting of insurance documents and filing in binders. Click on 'Register', follow the guide, and get access to:

- A complete overview of your policy
- A copy of your application
- The status on the reimbursement of recent claims
- Online premium payments and receipts
- Change your demographics information

Options

Choice of deductible

We offer a range of annual deductible options to help you reduce the price you pay for your coverage – the higher the deductible, the lower the premium. You can choose between the following deductibles:

	Plan					
Deductible	1	2	3	4	5	6
In-Country	0	1,000	2,000	5,000	10,000	20,000
Out-of-Country	1,000	2,000	3,000	5,000	10,000	20,000

There is only one deductible per person, per policy year. However, to help you reduce the cost of your family's coverage, we apply a maximum of two met out-of-country deductibles on your policy, per policy year.

Please refer to the Table of benefits and the Policy Provisions for more details.

Choice of coverage

We offer you the choice of either Worldwide or Latin America Only coverage (which includes the Caribbean) in order to accommodate your specific regional or pricing needs. Please note, however, that the Latin America Only coverage does not provide coverage in Mexico, the USA, or outside the Latin American region.

Contacting us

IHI/Bupa Customer Service Helpline

- Open 9:00 A.M. to 5:00 P.M. (EST)
- Our customer service team can help you with:
 - Any queries regarding your membership
 - Questions about your coverage
 - Making changes to your coverage
 - Updating your personal information

Tel: +1 (305) 398-7400

Fax: +1 (305) 275-8484

Email: bupa@bupalatinamerica.com

Web: www.bupalatinamerica.com

In the event of a medical emergency outside of our usual business hours, please contact the USA Medical Services Team at:

Tel: +1 (305) 275-1500

Fax: +1 (305) 275-8555

Email: usamed@usamedicalservices.com

The Insurer is located at:

8, Palaegade
DK-1261 Copenhagen K
Denmark

Mailing address:

Bupa
7001 SW 97th Avenue
Miami, Florida 33173
USA

Your benefits (as of January 1st, 2009)

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The Policyholder has, by taking out this insurance policy, given International Health Insurance danmark a/s his/her irrevocable consent to the transfer by International Health Insurance danmark a/s of the policy to Bupa Insurance Limited. The Policyholder will receive separate notification from International Health Insurance danmark a/s in the event that International Health Insurance danmark a/s utilizes this consent to the transfer of the insurance policy.

Agreement

International Health Insurance danmark a/s (IHI) (hereinafter referred to as the "Insurer") agrees to pay you (hereinafter referred to as the "Policyholder") the benefits provided by this policy. All benefits are subject to the terms and conditions of this policy.

Ten (10) day right to examine the policy: This policy may be returned within ten (10) days of receipt for a refund of all premiums paid. The policy may be returned to the Insurer or to the Policyholder's Producer. If returned, the policy is void as though no policy had been issued.

Important notice about the application: This policy is issued based on the application and payment of the premium. If any information shown on the application is incorrect or incomplete, or if any information has been omitted, the policy may be rescinded or cancelled, or coverage may be modified at the sole discretion of the Insurer.

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

Eligible dependents include the Policyholder's spouse or domestic partner, natural born children, legally adopted children, stepchildren, or children to whom the Policyholder has been appointed legal guardian by a court of competent jurisdiction, who have been identified on the health insurance application and for whom coverage is provided under the policy.

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

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

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

Notification to the Insurer

The Insured is asked to contact USA Medical Services, IHI's Claims Administrator, at least seventy-two (72) hours in advance of receiving any medical care. Emergency treatment should be notified within seventy-two (72) hours of beginning such treatment.

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

USA Medical Services can be contacted 24 hours a day, 365 days a year:

In the USA:	+1 (305) 275-1500
Free of charge from the USA:	+1 (800) 726-1203
Fax:	+1 (305) 275-8555
E-mail address:	usamed@usamedicalservices.com
Outside the USA:	PHONE NUMBER CAN BE LOCATED ON YOUR ID CARD, OR AT WWW.USAMEDICALSERVICES.COM

Table of benefits

Maximum coverage for all covered medical and hospital charges while the policy is in effect is limited to the terms and conditions of this policy. Unless otherwise stated herein, all benefits are per Insured, per policy year.

INSUREDS ARE NOT REQUIRED TO OBTAIN TREATMENT FROM THE BUPA PROVIDER NETWORK.

Maximum coverage per Insured, per policy year	No limit
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In-patient benefits	Coverage
Hospital services	100%
Hospital room and board (private/semi-private)	100% in a Bupa Hospital Network/ \$2,000 per day in other hospitals
Intensive care unit	100% in a Bupa Hospital Network/ \$4,000 per day in other hospitals
Guest meals	\$50 per day
Surgeon and anesthesiologists fees	100%
Diagnostic services (pathology, X-rays, MRI/CT/PET scan, ultrasound, and endoscopies)	100%
Drugs prescribed while in-patient	100%
Cancer treatment (chemotherapy/radiotherapy)	100%
Prostheses and appliances implanted during surgery	100%
Accommodation charges for companion of a hospitalized child	\$400 per day

Out-patient benefits	Coverage
Physicians and specialists visits	100%
Prescribed drugs: <ul style="list-style-type: none"> • Following hospitalization or out-patient surgery • Out-patient or Non-Hospitalization 	100% (for a maximum of 6 months; \$3,000 per year thereafter) \$700

Cancer treatment (chemotherapy/radiotherapy)	100%
Physical therapy/rehabilitation (must be pre-approved)	100%
Diagnostic services (pathology, X-rays, MRI/CT/PET scan, ultrasound and endoscopies)	100%
Dialysis	100%
Home health care (must be pre-approved)	100%

Other benefits	Coverage
Air ambulance (must be pre-approved)	100%
Ground ambulance	100%
Maternity (includes normal maternity, cesarean delivery, and all pre- and post-natal treatment) <ul style="list-style-type: none"> • 10-month waiting period • No deductible applies • Plans 1, 2 and 3 only 	\$8,500 (per pregnancy)
Complications of maternity and newborn <ul style="list-style-type: none"> • 10-month waiting period 	100%
Well baby care	5 visits (within 6 months of delivery)
Provisional coverage for newborn children	\$50,000 (for a maximum of 90 days after delivery)
Congenital and hereditary disorders	100%
Transplant procedures (per lifetime)	\$750,000 (per diagnosis)
Emergency dental coverage	100%
Repatriation of mortal remains	100%
Hospice / terminal care	100%
Complementary therapist	100% (maximum of 80 visits/sessions)
Health checkup (all inclusive) <ul style="list-style-type: none"> • No deductible applies 	\$600
Prescribed dietician guidance	4 visits

Notes on benefits

Full details of the policy terms and conditions are in the Policy Provisions, Administration, and Exclusions and Limitations sections of this Membership Guide. The Table of benefits is only a summary of coverage.

All costs are subject to the usual, customary and reasonable for the procedure and territory.

Members are asked to notify USA Medical Services prior to beginning any treatment.

All benefits are subject to any applicable deductible, unless otherwise stated.

Policy Provisions

- 1. ANESTHESIOLOGIST FEES:** Coverage for anesthesiologist fees must be approved in advance by USA Medical Services and is limited to the lesser of:
 - (a) The usual, customary and reasonable fee for anesthesiology charges; or
 - (b) Special rates established for an area or country as determined by the Insurer.
- 2. ASSISTING PHYSICIAN/SURGEON FEES:** Assisting physician/surgeon fees are covered only when an assisting physician/surgeon is medically necessary for that surgery and approved in advance by USA Medical Services. Assisting physician/surgeon fees are limited to the lesser of:
 - (a) The usual, customary and reasonable fees for the procedure; or
 - (b) Special rates established for an area or country as determined by the Insurer.
- 3. COMPANION OF A HOSPITALIZED CHILD:** Charges included in the hospital bill for overnight hospital accommodations for the companion of a hospitalized Insured child under the age of eighteen (18) will be payable up to four hundred dollars (\$400) per day.
- 4. COMPLEMENTARY THERAPIST:** Only out-patient treatment received from an osteopathic doctor, a chiropractor, a podiatrist, and/or a psychiatrist as well as acupuncture, homeopathic treatment or treatment for behavioral and developmental disorders including medically prescribed short term speech therapy and sleep disorders will be covered under this benefit. There is a maximum of eighty (80) visits/sessions per Insured, per policy year under this benefit.
- 5. COMPLICATIONS OF MATERNITY AND BIRTH: (Except for Diamond Plans 4, 5, and 6)** Maternity complications and/or newborn complications of birth (not related to congenital or hereditary disorders), such as prematurity, low birth weight, jaundice, hypoglycemia, respiratory distress, and birth trauma are covered as follows:
 - (a) Coverage under this policy is equal to the maximum policy limit herein, with no deductible.
 - (b) This benefit shall apply only if all the stipulations in the "Maternity Care" and "Newborn Coverage" provisions of this policy have been met.

- (c) This benefit does not apply to complications related to any condition excluded or not covered by the policy, including but not limited to maternity and newborn complications of birth in a pregnancy that is the result of any type of fertility treatment or any type of assisted fertility procedure, or non-covered pregnancies.

There is an optional rider available to cover newborn and maternity complications for Diamond Plans 4, 5 and 6.

- 6. **CONGENITAL AND HEREDITARY DISORDERS:** Coverage under this policy for congenital and hereditary disorders is equal to the maximum policy limit herein, after the applicable deductible.
- 7. **DEDUCTIBLE:**
 - (a) One (1) deductible per Insured, per policy year up to a maximum of the out-of-country deductible.
 - (b) Maximum two (2) deductibles per policy, per policy year, up to a maximum of two (2) met out-of-country deductibles. If an in-country deductible has been met, and services are then rendered out-of-country, the difference between the in-country and out-of-country deductibles will be the Insured's responsibility.
 - (c) Any eligible charges incurred by the Insured during the last three (3) months of the policy year, which are applied to that policy year's deductible, will be carried over and applied towards that Insured's deductible for the following policy year.
 - (d) In case of a serious accident, no deductible shall apply for the period of the first hospitalization.
- 8. **DIAGNOSIS:** For a condition to be considered a covered illness or disorder, copies of laboratory tests results, X-rays, or any other report or result of clinical examinations on which the diagnosis was based, are required as part of the positive diagnosis by a physician.
- 9. **DIETETIC GUIDANCE:** Each Insured is entitled to four (4) medically prescribed consultations with an authorized dietician per policy year. In all cases, a copy of the prescription from the attending physician must accompany the claim.
- 10. **EMERGENCY DENTAL TREATMENT:** Only emergency dental treatment needed as a result of a covered accident, and that takes place within ninety (90) days of the date of such accident, will be covered under this policy.
- 11. **EMERGENCY EVACUATION:** Emergency transportation (by ground or air ambulance) is only covered if related to a covered condition for which treatment cannot be

provided locally, and transportation by any other method would result in loss of life or limb. Emergency transportation must be provided by a licensed and authorized transportation company to the nearest medical facility. The vehicle or aircraft used must be staffed by medically trained personnel and must be equipped to handle a medical emergency.

Air ambulance transportation:

- (a) All air ambulance transportation must be pre-approved and coordinated by USA Medical Services.
- (b) The Insured agrees to hold the Insurer, USA Medical Services, and any company affiliated with the Insurer or USA Medical Services by way of similar ownership or management, harmless from negligence resulting from such services, or negligence resulting from delays or restrictions on flights caused by the pilot, mechanical problems, or governmental restrictions, or due to operational conditions.

12. EMERGENCY MEDICAL TREATMENT: All medical expenses from a non-network provider in relation to emergency medical treatment will be paid as if the Insured had been treated at a network hospital.

13. EXTENDED COVERAGE TO ELIGIBLE DEPENDENTS UPON DEATH OF POLICYHOLDER: In the event of the death of the Policyholder, the Insurer will provide continued coverage for the surviving dependents insured under this policy by affording two (2) years worth of coverage at no charge if the cause of the death of the Policyholder results from a covered condition under this policy. This benefit only applies to covered dependents under the existing policy, and will automatically terminate in the event of marriage of the surviving spouse/domestic partner, or for surviving dependents who are not otherwise eligible for coverage under this policy and/or are issued their own separate policy. **This extended coverage does not apply to any optional rider.**

14. HOME HEALTH CARE AND REHABILITATION SERVICES: An initial period of up to thirty (30) days will be covered if approved in advance by USA Medical Services. Any extensions in increments of up to thirty (30) days must be approved in advance or the claim will be denied. Updated evidence of medical necessity and a treatment plan are required in advance to obtain each approval.

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

- (a) For coverage outside the Bupa Provider Network,
 - i. Standard private or semi-private hospital room and board is limited to a maximum benefit of two thousand dollars (\$2,000) per day.

- ii. Room and board within an intensive care unit is limited to a maximum benefit of four thousand dollars (\$4,000) per day.
- (b) For coverage within the Bupa Provider Network,
 - i. Standard private or semi-private hospital room and board is covered up to one hundred percent (100%) of the usual, reasonable and customary hospital charges.
 - ii. Room and board within an intensive care unit is covered up to one hundred percent (100%) of the usual, reasonable and customary hospital charges.
- (c) Guest meals under this provision are limited to a maximum benefit of fifty dollars (\$50) per day.
- (d) Charges included in the hospital bill for local calls, TV, and newspapers will be covered.

16. MATERNITY CARE: (Except Diamond Plans 4, 5 and 6)

- (a) There is a maximum benefit of eight thousand five hundred dollars (\$8,500) for each pregnancy, with no deductible, for the respective Insured mother.
- (b) Pre- and post-natal treatment, childbirth and cesarean deliveries are included in the maximum maternity benefit listed in this policy.
- (c) This benefit applies for covered pregnancies. Covered pregnancies are those for which the actual date of delivery is at least ten (10) months after the effective date of coverage for the respective Insured parent. The respective Insured parent may not be a dependent male child.
- (d) There is no maternity coverage under this policy for dependent children that are 18 years old or older. To be eligible for coverage under this provision, the dependent child that is 18 years old or older must apply and be approved for coverage under her own separate policy.
- (e) The ten (10) month waiting period for maternity coverage always applies regardless of whether or not the sixty (60) day waiting period for coverage under this policy has been waived.
- (f) Complications of maternity are not covered under this provision, as they are limited to the maximum benefits described in Provision 5.

17. NEWBORN COVERAGE:

- (a) **If born from a Covered Pregnancy:**
 - i. **Provisional coverage:** If born from a covered pregnancy, each newborn will automatically be covered for any injury or illness during the first ninety (90) days after birth, up to a maximum of fifty thousand dollars (\$50,000) with no deductible.
 - ii. **Well baby care** will be covered, but is limited to a maximum benefit of five (5) visits within six (6) months of the child's delivery.

- iii. **Permanent coverage:** For permanent coverage of a child born from a covered pregnancy, a notification of birth including full name, gender and date of birth of the newborn must be submitted within ninety (90) days of birth. Coverage with applicable deductible will then be effective as of the date of birth up to the policy limits.

The premium for the addition is due at the time of the notification of birth. If such notification is not received within ninety (90) days of birth, a health insurance application is required for the addition, and will be subject to underwriting.

Newborn coverage for complications of birth is limited to the maximum benefits described in Provision 5.

- (b) **If NOT born from a Covered Pregnancy,** there is no provisional coverage for the newborn. To add a newborn to the policy, submission of a completed health insurance application, which is subject to underwriting by the Insurer, and payment of the premium are required.

18. NOSE AND NASAL SEPTUM DEFORMITY: When nose or nasal septum deformity is the result of trauma during a covered accident, surgical treatment will only be covered if authorized in advance by USA Medical Services. The evidence of trauma in the form of fracture must be confirmed radiographically (X-rays, CT scan, etc.)

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

20. PRE-EXISTING CONDITIONS: Pre-existing conditions fall into two (2) categories:

(a) Disclosed at the time of the application:

- i. Free of symptoms, signs, and treatment during the five (5) year period prior to the effective date of the policy, pre-existing conditions are covered upon expiration of the sixty-day (60-day) waiting period, unless specifically excluded by an amendment to the policy.
- ii. With symptoms, signs, or treatment any time during the five (5) year period prior to the effective date of the policy, pre-existing conditions will be covered after two (2) years from the effective date of the policy, unless specifically excluded by an amendment to the policy.

- (b) Not disclosed at the time of application:** Pre-existing conditions not disclosed at the time of the application will **NEVER** be covered during the lifetime of the policy. Furthermore, the Insurer retains the right to rescind, cancel or modify the policy based on the Insured's failure to disclose any such conditions.

21. **PRESCRIPTION DRUGS:** Prescription drugs must be for a medical condition covered by the policy and are subject to the following:
- (a) **Hospitalizations:** Prescription drugs first prescribed during a covered in-patient hospitalization or after an out-patient surgery are covered for a maximum period of six (6) continuous months after the date of discharge. Thereafter, the maximum benefit for prescription drugs is three thousand dollars (\$3,000) per Insured, per policy year.
 - (b) **Out-patient and Non-Hospitalizations:** Prescription drugs (including highly specialized drugs) not first prescribed during a covered in-patient hospitalization or after an out-patient surgery are limited to a maximum benefit of seven hundred dollars (\$700) per Insured, per policy year.

In all cases, a copy of the prescription from the attending physician must accompany the claim.

22. **REPATRIATION OF MORTAL REMAINS:** In the event an Insured dies outside of his/her country of residence, the Insurer will pay the charges toward repatriation of the deceased's remains to his/her country of residence if the death resulted from a covered condition under the terms of the policy. Coverage is limited to only those services and supplies necessary to prepare the deceased's body and to transport the deceased to his/her country of residence. Arrangements must be coordinated in conjunction with USA Medical Services.
23. **REQUESTED SECOND SURGICAL OPINION:** If a surgeon has recommended a non-emergency surgical procedure, the Insured should notify USA Medical Services at least seventy-two (72) hours prior to the scheduled procedure. If a second surgical opinion is deemed necessary by either the Insurer or USA Medical Services, it must be conducted by a physician chosen and arranged by USA Medical Services. Only those second surgical opinions required and coordinated by USA Medical Services are covered. In the event the second surgical opinion contradicts or does not confirm the need for surgery, the Insurer will also pay for a third surgical opinion from a physician chosen in agreement between the Insured and USA Medical Services. If the second or third surgical opinion confirms the need for surgery, benefits for the surgery will be paid according to this policy.
24. **ROUTINE HEALTH CHECKUP:** Each Insured is entitled to one routine physical examination per policy year. The maximum benefit per Insured, per policy year is six hundred dollars (\$600) with no deductible. Routine physical examinations may include diagnostic studies and vaccinations.

25. SPECIAL TREATMENTS: Prosthesis, orthotic devices, durable medical equipment, implants, radiation therapy, chemotherapy and highly specialized drugs will be covered, but must be approved and coordinated in advance by USA Medical Services. Special treatments will be covered by the Insurer or reimbursed at the cost that the Insurer would have incurred if purchased from one of its providers.

26. TRANSPLANT PROCEDURES: Coverage for transplantation of human organs, cells and tissues is provided only within the Insurer's Transplant Provider Network. There is no coverage outside the Transplant Provider Network. The maximum amount payable for this benefit is seven hundred fifty thousand dollars (\$750,000) per Insured, per diagnosis, per lifetime after the applicable deductible. This transplant benefit begins once the need for transplantation has been determined by a physician, has been certified by a second surgical or medical opinion, and has been approved by USA Medical Services, and is subject to all the terms, provisions and exclusions of the policy.

This benefit includes:

- (a) Pre-transplant care, which includes those services directly related to evaluation of the need for transplantation, evaluation of the Insured for the transplant procedure, and preparation and stabilization of the Insured for the transplant procedure.
- (b) Pre-surgical workup, including all laboratory and X-ray exams, CT scans, Magnetic Resonance Imaging (MRI's), ultrasounds, biopsies, scans, medications and supplies.
- (c) The costs of organ, cell or tissue procurement, transportation, and harvesting including bone marrow, stem cell or cord blood storage or banking are covered up to a maximum of twenty-five thousand dollars (\$25,000) per diagnosis, which is included as part of the maximum transplant benefit.
- (d) Post-transplant care including, but not limited to any medically necessary follow-up treatment resulting from the transplant and any complications that arise after the transplant procedure, whether a direct or indirect consequence of the transplant.
- (e) Any medication or therapeutic measure used to ensure the viability and permanence of the transplanted organ, cell or tissue.
- (f) Any home health care, nursing care (e.g. wound care, infusion, assessment, etc.), emergency transportation, medical attention, clinic or office visits, transfusions, supplies, or medication related to the transplant.

27. WAITING PERIOD: This policy contains a sixty-day (60-day) waiting period, during which only illnesses or injuries caused by an accident occurring within this period, or diseases of infectious origin that first manifest themselves within this period, will be covered.

- 28. WAIVING OF WAITING PERIOD:** The Insurer will waive the waiting period only if:
- (a) Other medical expense insurance for the Insured was in effect with another company for at least one (1) continuous year; and
 - (b) The effective date of this policy begins within sixty (60) days of the expiration of the previous coverage; and
 - (c) The prior coverage is disclosed in the health insurance application; and
 - (d) We receive the prior policy and a copy of the receipt for the last year's premium payment, with the health insurance application.

If the waiting period is waived, benefits payable for any condition manifested during the first sixty (60) days of coverage are limited, while the policy is in effect, to the lesser benefit provided by either this policy or the prior policy.

Administration

- 1. AUTHORITY:** No Producer has the authority to change the policy or to waive any of its provisions. After the policy has been issued, no change shall be valid unless approved in writing by an officer or the Chief Underwriter of the Insurer, and such approval is endorsed by an amendment to the policy.
- 2. BEGINNING AND ENDING OF INSURANCE COVERAGE:** Subject to the provisions of this policy, benefits begin on the effective date of the policy and not on the date of application for insurance. Coverage begins at 00:01 hours Eastern Standard Time (USA) on the policy's effective date and terminates at 24:00 hours Eastern Standard Time (USA):
 - (a) On the expiration date of the policy; or
 - (b) Upon non-payment of the premium; or
 - (c) Upon written request from the Policyholder to terminate his/her coverage; or
 - (d) Upon written request from the Policyholder to terminate a dependent's coverage; or
 - (e) Upon written notification from the Insurer, as allowed by the conditions of this policy.

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

- 3. CHANGE OF PRODUCT OR PLAN:** The Policyholder can request to change a product or plan at any anniversary date. This request must be submitted in writing and received before the anniversary date. Some requests are subject to underwriting evaluation. During the first sixty (60) days from the effective date of the change, benefits payable for any illness or injury not caused by accident or disease of infectious origin, will be

limited to the lesser of benefits provided by the new plan or the prior plan. During the first twelve (12) months after the effective date of the change, benefits for maternity, newborn, congenital, and transplant will be limited to the lesser benefit provided by either the new plan or prior plan.

4. **CHANGES OF COUNTRY OF RESIDENCE:** The Insured must notify the Insurer in writing of any change of his/her country of residence within thirty (30) days of its occurrence. A change of country of residence may result in modification of coverage, at the Insurer's discretion. Failure to notify any change of the Insured's country of residence to the Insurer may result in cancellation of the policy or modification of coverage on the next anniversary date, at the Insurer's discretion.
5. **COMPLAINT:** In the event of a disagreement between the Insured and the Insurer regarding this insurance policy and/or its provisions, before beginning any arbitration or legal proceeding, the Insured shall request a review of the matter by the IHI Complaints Officer. In order to begin such review, the Insured must submit a written request to the Complaints Officer. This request shall include copies of all relevant information sought to be considered, as well as an explanation of the decision that should be reviewed and why. The request shall be sent to the attention of the IHI Complaints Officer, c/o USA Medical Services. Upon submission of a request for review, the Complaints Officer will determine whether any further information and/or documentation is needed and act to timely obtain it. The Complaints Officer will notify the Insured of his/her decision and the underlying rationale within thirty (30) days.
6. **COMPLAINTS AND LEGAL ACTIONS:** If a disagreement persists upon completion of the complaint as determined in Clause 5: "Complaint", the Insured may file a complaint with the Danish Insurance Appeals Board.

Ankenævnet for Forsikring (Insurance Appeal Board)
Anker Heegaards Gade 2
1572 Copenhagen V, Denmark

The Appeals Board will only process the complaint if it is proved that the Insurer was contacted and the matter was unsuccessfully resolved.

The Insured confers exclusive jurisdiction in Copenhagen, Denmark for determination of any rights under this insurance policy and/or its provisions, and shall be settled in accordance with Danish law.

7. **CURRENCY:** All currency values stated in this policy are in U.S. dollars.

8. **DUTY TO COOPERATE:** The Insured shall make all medical reports and records available to the Insurer and, when requested by the Insurer, shall sign all necessary authorization forms for the Insurer to obtain medical reports and records. Failure to cooperate with the Insurer or failure to authorize the release of all medical records requested by the Insurer may cause a claim to be denied.
9. **ENTIRE CONTRACT/CONTROLLING CONTRACT:** The Policy (this document), the Health Insurance Application, the Certificate of Coverage, and any riders or amendments thereto, shall constitute the entire contract between the parties. The Spanish and Portuguese translations are provided for the convenience of the Insured. **The English version of this policy will prevail and is the controlling contract in the event of any question or dispute regarding this policy.**
10. **GRACE PERIOD:** If premium payment is not received by the due date, the Insurer will allow a grace period of thirty (30) days from the due date for the premium to be paid. If the premium is not received by the Insurer prior to the end of the grace period, this policy and all of its benefits will be deemed terminated as of the original due date of the premium. Benefits are not provided under the policy during the grace period.
11. **OTHER INSURANCE COVERAGE:** If the Insured has another policy that provides benefits also covered by this policy, benefits will be coordinated. All claims incurred in the country of residence must be submitted in the first instance against the other policy. This policy shall only provide benefits when such benefits payable under the other policy have been paid out and the policy limits of such policy have been exhausted. Outside the country of residence, IHI will function as the primary insurer and retains the right to collect any payment from local or other insurers.
12. **PAYMENT OF CLAIMS:** It is the Insurer's policy to make payments directly to physicians and hospitals worldwide. When this is not possible, the Insurer will reimburse the Policyholder either the contractual rate given to the Insurer by the provider involved or in accordance with the usual, customary, and reasonable fees for that geographical area, whichever is less. Any charges or portions of charges in excess of these amounts are the responsibility of the Insured. If the Policyholder is deceased, the Insurer will pay any unpaid benefits to the beneficiary or estate of the deceased Policyholder. USA Medical Services must receive the complete medical and non-medical information required in order to determine compensability before: 1) Direct payment is approved; or 2) Policyholder is reimbursed.
13. **PHYSICAL EXAMINATIONS:** The Insurer shall have the right and opportunity to request a physical examination at its own expense, of any Insured whose illness or

injury is the basis of a claim, when and as often as considered necessary by the Insurer during the pendency of the claim.

- 14. POLICY CANCELLATION OR NON-RENEWAL:** The Insurer retains the right to cancel, modify or rescind the policy if statements on the health insurance application are found to be misrepresentations, incomplete, or if fraud has been committed, leading the Insurer to approve an application when, with the correct or complete information, the Insurer would have issued a policy with restricted coverage or declined to provide insurance.

If the Insured changes country of residence, and the Insured's current plan is not available in the Insured's new country of residence, the Insurer retains the right to cancel or modify a policy in terms of rates, deductibles or benefits, generally and specifically, in order to offer the Insured the closest equivalent insurance coverage possible.

Submission of a fraudulent claim is also grounds for rescission or cancellation of the policy.

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

- 15. POLICY ISSUANCE:** The policy is deemed issued or delivered upon its receipt by the Policyholder in his/her country of residence.
- 16. POLICY MODE:** All policies are deemed annual policies. Premiums are to be paid annually, unless the Insurer authorizes other mode of payment.
- 17. PREMIUM PAYMENT:** The Policyholder is responsible for paying the premium on time. Premium payment is due on the renewal date of the policy or any other due date authorized by the Insurer. Premium notices are provided as a courtesy, and the Insurer provides no guarantee of delivering such notices. If a Policyholder has not received a premium notice thirty (30) days prior to the premium payment due date, and the Policyholder does not know the amount of the premium payment, he/she should contact his/her Producer or the Insurer. Payment may also be made online at www.bupalatinamerica.com.

18. **PREMIUM RATE CHANGES:** The Insurer retains the right to change the premium at the time of each renewal date. This right will be exercised on a "class" basis only on the renewal date of each respective policy.
19. **PROOF OF CLAIM:** The Insured must provide written proof of loss consisting of original itemized bills, medical records, and a claim form properly completed and signed to USA Medical Services at 7001 Southwest 97th Avenue, Miami, Florida 33173, within one hundred twenty (120) days after the treatment or service date. Failure to do so will result in the claim being denied. A completed claim form per incident is required for all claims submitted. Claim forms are provided with the policy or may be obtained by contacting your Producer or USA Medical Services at the address shown herein or through our website, www.bupalatinamerica.com. Bills received in currencies other than U.S. dollars will be processed in accordance with the official exchange rate, as determined by the Insurer, on the date of service. In order for benefits to be paid under this policy, dependent children, after their nineteenth (19th) birthday, must provide a certificate or affidavit from a college or university as evidence that they were full-time students at the time the policy was issued or renewed, **AND** a written statement signed by the Policyholder that the dependent child's marital status is single.
20. **REFUNDS:** If a Policyholder cancels the policy after it has been issued, reinstated or renewed, the Insurer will not refund the unearned portion of the premium. If the Insurer cancels the policy for any reason under the terms of this policy, the Insurer will refund the unearned portion of the premium minus administrative charges and policy fees, up to a maximum of sixty-five percent (65%) of the premium. The policy fee, USA Medical Services fee, and thirty-five percent (35%) of the base premium are non-refundable. The unearned portion of the premium is based on the number of days corresponding to the payment mode, minus the number of days the policy was in effect.
21. **REINSTATEMENT:** If the policy was not renewed within the Grace Period, it can be reinstated within sixty (60) days after the Grace Period at the Insurer's discretion, if the Insured provides new evidence of insurability consisting of a new health insurance application and any other information or document required by the Insurer. No reinstatement will be authorized after ninety (90) days of the termination date of the policy.
22. **SUBROGATION AND INDEMNITY:** The Insurer has a right of subrogation or reimbursement from or on behalf of an Insured to whom it has paid any claims, if such Insured has recovered all or part of such payments from a third party. Furthermore, the Insurer has the right to proceed at its own expense in the name of the Insured, against

third parties who may be responsible for causing a claim under this policy, or who may be responsible for providing indemnity of benefits for any claim under this policy.

- 23. TERMINATION OF COVERAGE UPON TERMINATION OF POLICY:** In the event a policy terminates for any reason, coverage ceases on the effective date of the termination, and the Insurer will only be responsible for any covered treatment under the terms of the policy that took place before the effective date of termination of the policy. There is no coverage for any treatment that occurs after the effective date of the termination, regardless of when the condition first occurred or how much additional treatment may be required.

Exclusions and Limitations

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

1. Treatment of any illness, injury, or charges arising from any treatment, service or supply:
 - (a) That is not medically necessary; or
 - (b) For an Insured who is not under the care of a physician, doctor or licensed professional; or
 - (c) That is not authorized or prescribed by a physician or doctor; or
 - (d) That is related to custodial care; or
 - (e) That takes place at a hospital, but for which the use of hospital facilities is not necessary.
2. Any care or treatment, while sane or insane, received due to self-inflicted illness or injury, suicide, attempted suicide, alcohol use or abuse, drug use or abuse, or the use of illegal substances or illegal use of controlled substances, including any accident resulting from any of the aforementioned criteria.
3. Routine eye and ear examinations, hearing aids, eye glasses, contact lenses, radial keratotomy and/or other procedures to correct eye refraction disorders.
4. Any medical examination or diagnostic study which is part of a routine physical examination, including vaccinations and the issuance of medical certificates and examinations as to the suitability for employment or travel, except as provided for under Provision 24 "Routine Health Checkup" of this policy.
5. Naturopathic treatment, naturopathic or homeopathic medications or any type of alternative medicine, except as provided for under the provisions of this policy.

6. Any illness or injury not caused by an accident or a disease of infectious origin which is first manifested within the first sixty (60) days from the effective date of the policy.
7. Elective or cosmetic surgery or medical treatment which is primarily for beautification, unless necessitated by injury, deformity or illness which first occurs while the Insured is covered under this policy. This also includes any surgical treatment for nasal or septal deformity that was not induced by trauma.
8. Any charges in connection with pre-existing conditions, except as defined and addressed in this policy.
9. Any treatment, service or supply that is not scientifically or medically recognized for the prescribed treatment or that is considered as off label use, experimental and/or not approved for general use by the Food and Drug Administration of the USA.
10. Treatment in any governmental facility, or any expense if the Insured would be entitled to free care. Service or treatment for which payment would not have to be made had no insurance coverage existed, or epidemics which have been placed under the direction of government authority.
11. Diagnostic procedures or treatment of in-patient psychiatric disorders, unless resulting from treatment for a covered condition. Mental illnesses and/or behavioral or developmental disorders, except as provided for in this policy.
12. Any portion of any charge in excess of the usual, customary and reasonable charge for the particular service or supply for the geographical area, or appropriate level of treatment being received.
13. Any expense for male or female sterilization, reversal of sterilization, sex change, sexual transformation, birth control, infertility, artificial insemination, sexual dysfunction or inadequacies, disorders related to Human Papillomavirus (HPV), and/or sexually transmittable diseases.
14. Treatment or service for any medical, mental, or dental condition related to or arising as a complication of those medical, mental, or dental services or other conditions specifically excluded by an amendment to, or not covered by, this policy.
15. Any expense, service or treatment for obesity, weight control, or any form of food supplement, except as provided for in this policy.

16. Treatment by a bone growth stimulator, bone growth stimulation or treatment relating to growth hormone, regardless of the reason for prescription.
17. All treatment to a mother or to a newborn related to a non-covered pregnancy.
18. Any voluntarily induced termination of pregnancy, unless the mother's life is in imminent danger.
19. Maternity complications as a result of any type of fertility treatment or any type of assisted fertility procedure.
20. Any dental treatment or service not related to a covered accident, or that occurs beyond ninety (90) days from the date of a covered accident.
21. Treatment of injuries resulting while in service as a member of a police or military unit, or from participation in war, riot, civil commotion, illegal activities, and resulting imprisonment.
22. Acquired Immune Deficiency Syndrome (AIDS), HIV positive or AIDS related illnesses. However, diseases related to AIDS and HIV antibodies (HIV positive) are covered if proven to be caused by a blood transfusion received after the effective date of the policy. The HIV virus will also be covered if proven to have been contracted as a result of an accident occurring during the course of a normal occupation for the following professions: doctors, dentists, nurses, laboratory personnel, ancillary hospital workers, medical and dental assistants, ambulance personnel, midwives, fire brigade personnel, policemen/-women, and prison officers. The Insured shall notify the Insurer within fourteen (14) days after such accident, and at the same time provide a negative HIV antibody test dated prior to the accident.
23. An elective admission more than twenty-three (23) hours before a planned surgery, unless authorized in writing by the Insurer.
24. Treatment by the spouse, parent, sibling, or child of any Insured under this policy.
25. Prescription medications that are not first prescribed during an in-patient hospitalization or part of treatment after an out-patient surgery, except as provided for under the provisions of this policy. Over the counter or non-prescription drugs, as well as the following:
 - (a) Drugs that are not medically necessary, including any drugs given in connection with a service or supply that is not medically necessary.

- (b) Contraceptive drugs, other than oral contraceptives, or devices, even if ordered for non-contraceptive purposes.
 - (c) Drugs or immunizations to prevent disease or allergies.
 - (d) Drugs for tobacco dependency.
 - (e) Cosmetic drugs, even if ordered for non-cosmetic purposes.
 - (f) Drugs taken at the same time and place where the prescription is ordered.
 - (g) Charges for giving, administering or injecting drugs.
 - (h) Any refill that is more than the number of refills ordered by the physician, or is made more than one year after the latest prescription was written.
 - (i) Immunization agents, biological sera, blood and blood plasma.
 - (j) Therapeutic devices, appliances or injectables, including colostomy supplies and support garments, regardless of intended use.
 - (k) Progesterone suppositories.
 - (l) Vitamin supplements.
26. Personal or home-based artificial kidney equipment, unless authorized in writing by the Insurer.
27. Storage of bone marrow, stem cell, cord blood, or other tissue or cell, except as provided for under the provisions of the policy. Cost related to the acquisition and implantation of an artificial heart, other artificial or animal organs, and all expenses for cryopreservation of more than twenty-four (24) hours.
28. Injury or illness caused by, or related to, ionized radiation, pollution or contamination, radioactivity from any nuclear material, nuclear waste, or the combustion of nuclear fuel or nuclear devices.

Definitions

1. **ACCIDENT:** Any sudden or unforeseen event produced by an external cause resulting in injury.
2. **ACCIDENTAL BODILY INJURY:** Damage inflicted to the body caused by a sudden and unforeseen external cause.
3. **AIR AMBULANCE TRANSPORTATION:** Emergency air transportation from the hospital where the Insured is admitted to the nearest suitable hospital where treatment can be provided.

4. **AMENDMENT:** A document added to the policy by the Insurer that clarifies, explains, or modifies the policy.
5. **ANESTHESIOLOGIST FEES:** Charges made by an anesthesiologist for the administration of anesthesia during the performance of a surgical procedure, for the supervision of a Certified Registered Nurse Anesthetist administering anesthesia during the performance of a surgical procedure, or for medically necessary services for pain control.
6. **ANNIVERSARY DATE:** Annual occurrence of the effective date of the policy.
7. **APPLICANT:** The individual who completes the health insurance application for coverage.
8. **APPLICATION:** Written statements on a form by an Applicant about themselves and/ or their dependents, used by the Insurer to determine acceptance or denial of the risk. Health insurance application includes any oral statements made by an Applicant during a Company-held medical interview, medical history, questionnaire, and other document provided to, or requested by, the Insurer prior to the issuance of the policy.
9. **ASSISTING PHYSICIAN/SURGEON FEES:** Charges made by a physician or surgeon who assist the principal surgeon in the performance of a surgical procedure.
10. **BLOCK:** The Insureds of a policy type (including deductible) or a territory.
11. **BUPA PROVIDER NETWORK:** A group of hospitals and physicians approved and contracted to treat Insureds on behalf of the Insurer. The list of hospitals and physicians in the Bupa Provider Network is available from USA Medical Services or online at www.usamedicalservices.com, and may change at any time without prior notice.
12. **CALENDAR YEAR:** January 1st through December 31st of any given year.
13. **CERTIFICATE OF COVERAGE:** Document of the policy that specifies the effective date, conditions, extent and limitations of coverage, and lists the policyholder and each covered dependent.
14. **CLASS:** The Insureds of all policies of the same type, including but not limited to benefits, deductibles, age group, country, plan, year groups, or a combination of any of these.

15. **COMPLICATION OF BIRTH:** Any disorder related to the birth of a newborn, not caused by genetic factors, manifested during the first thirty-one (31) days of life, including but not limited to hyperbilirubinemia (jaundice), cerebral hypoxia, hypoglycemia, prematurity, respiratory distress and birth trauma.
16. **COMPLICATION OF MATERNITY:** Abnormal course of the pregnancy and puerperium that impedes the mother to deliver naturally and with regular medical care. For the purpose of this policy, elective Cesarean or Cesarean after Cesarean are not considered a complication of maternity.
17. **CONGENITAL AND HEREDITARY DISORDERS OR ILLNESSES:** Any disorder or illness existing before birth, regardless of its cause, whether or not manifested or diagnosed at birth, after birth or years later.
18. **COUNTRY OF RESIDENCE:** The country:
 - (a) Where the Insured resides the majority of any calendar or policy year; or
 - (b) Where the Insured has resided more than one hundred eighty (180) continuous days during any three hundred sixty-five (365) day period while the policy is in effect.
19. **COVERED PREGNANCY:** Covered pregnancies are those where the actual date of delivery is at least ten (10) months after the effective date of coverage for the respective Insured parent. The respective Insured parent may not be a dependent male child.
20. **CUSTODIAL CARE:** Assistance with the activities of daily living that can be provided by non-medical/nursing trained personnel (bathing, dressing, grooming, feeding, toileting, etc.).
21. **DEDUCTIBLE:** The amount of covered charges that must be paid by the Insured before policy benefits are payable. Charges incurred in the country of residence are subject to an in-country deductible. Charges incurred outside the country of residence are subject to an out-of-country deductible.
22. **DIAGNOSTIC MEDICAL CENTER:** Medical facility licensed to perform comprehensive medical and/or diagnostic services.
23. **DIAGNOSTIC SERVICES:** Medically necessary services and laboratory testing used to diagnose or treat medical conditions, including pathology, X-rays, ultrasound, and MRI/CT/PET scans.

24. **DOMESTIC PARTNER:** A person of the opposite or same sex with whom the Policyholder has established a Domestic Partnership.
25. **DOMESTIC PARTNERSHIP:** A relationship between the Policyholder and one other person of the opposite or same sex. All the following requirements apply to both persons:
- They must not be currently married to, or be a Domestic Partner of, another person under either statutory or common law.
 - They must share the same permanent residence and the common necessities of life.
 - They must be at least 18 years of age.
 - They must be mentally competent to consent to contract.
 - They must be financially interdependent and must have furnished documents to support at least two (2) of the following conditions of such financial interdependence:
 - They have a single dedicated relationship of at least one (1) year
 - They have joint ownership of a residence
 - They have at least two (2) of the following:
 - A joint ownership of an automobile
 - A joint checking, bank or investment account
 - A joint credit account
 - A lease for a residence identifying both partners as tenants
 - A will and/or life insurance policy which designates the other as primary beneficiary

The Policyholder and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

26. **DONOR:** Person dead or alive from whom one or more organs, cells or tissue have been removed with the purpose of transplanting to the body of another person (recipient).
27. **DUE DATE:** The date on which the premium is due and payable.
28. **EFFECTIVE DATE:** The date stated in the Certificate of Coverage, on which coverage under this policy begins.
29. **EMERGENCY:** A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured's life or physical integrity in immediate danger if medical attention is not provided within twenty-four (24) hours.

30. **EMERGENCY DENTAL TREATMENT:** Treatment necessary to restore or replace damaged or lost teeth in a covered accident.
31. **EMERGENCY TREATMENT:** Medically necessary attention or services due to an emergency.
32. **GRACE PERIOD:** The thirty-day (30-day) period after the policy's due date during which the Insurer will allow the policy to be renewed.
33. **GROUND AMBULANCE TRANSPORTATION:** Emergency transportation to a hospital by ground ambulance.
34. **HOME HEALTH CARE:** Care of the Insured in the Insured's home, prescribed and certified in writing by the Insured's attending physician, as required for the proper treatment of the illness or injury, and used in place of in-patient treatment in a hospital. Home Health Care includes the services of a skilled licensed professional (nurse, therapist, etc.) outside the hospital, and does not include Custodial Care.
35. **HOSPITAL:** Any institution legally licensed as a medical or surgical facility in the country in which it is located, that is a) primarily engaged in providing diagnostic and therapeutic facilities for clinical and surgical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians; and b) not a place of rest, a place for the aged, a nursing or convalescent home or institution, or a long-term care facility.
36. **HOSPITAL SERVICES:** Hospital staff, nurses, scrub nurses, standard private or semi-private room and board, and other medically necessary treatments or services ordered by a physician for the Insured who is admitted to a hospital. These services also include local calls, TV, and newspapers. Private nurse and standard private room upgrade to a suite or junior suite are not included in Hospital Services.
37. **ILLNESS:** An abnormal condition of the body, manifested by signs, symptoms, and/or abnormal findings in medical exams, which make this condition different than the normal state of the body.
38. **INJURY:** Damage inflicted to the body by an external cause.
39. **IN-PATIENT HOSPITALIZATION:** Medical or surgical care that due to its intensity must be rendered during a hospital stay of more than twenty-three (23) hours. The severity of the illness must also justify the medical necessity of hospitalization. Treatment limited to the emergency room is not considered in-patient hospitalization.

40. **INSURED:** An individual for whom a health insurance application has been completed, the premium paid, coverage approved and initiated by the Insurer. The term "Insured" includes the Policyholder and all dependents covered under this policy.
41. **MEDICALLY NECESSARY:** A treatment, service or medical supply which is determined by USA Medical Services to be necessary and appropriate for the diagnosis and/or treatment of an illness or injury. A treatment, service or supply will not be considered medically necessary if:
- (a) It is provided only as a convenience to the Insured, the Insured's family, or the provider (e.g. private nurse, standard private room upgrade to suite or junior suite, etc.); or
 - (b) It is not appropriate for the Insured's diagnosis or treatment; or
 - (c) It exceeds the level of care needed to provide adequate and appropriate diagnosis or treatment; or
 - (d) Falls outside the standard of practice, as established by Professional Boards by discipline (MD, Physical Therapy, Nursing, etc.).
42. **NEWBORN:** An infant from the moment of birth through the first thirty-one (31) days of life.
43. **NURSE:** A professional legally licensed to provide nursing care in the country where the treatment is provided.
44. **OUT-PATIENT SERVICES:** Medical treatments or services provided or ordered by a physician for the Insured when he/she is not admitted in a hospital. Out-patient services include services performed in a hospital or emergency room if these services have a duration of less than twenty-four (24) hours.
45. **PHYSICIAN OR DOCTOR:** A professional legally licensed to practice medicine in the country where treatment is provided while acting within the scope of his/her practice. The term "Physician" or "Doctor" shall also apply to a professional legally licensed to practice as a dentist.
46. **POLICYHOLDER:** The named applicant on the health insurance application. This individual is the person entitled to receive reimbursement for covered medical expenses and the return of any unearned premium.
47. **POLICY YEAR:** The period of twelve (12) consecutive months beginning on the effective date of the policy and any subsequent twelve-month period thereafter.

48. **PRE-EXISTING CONDITION:** A condition:
- (a) That is diagnosed by a physician prior to the effective date of the policy or its reinstatement; or
 - (b) For which medical advice or treatment was recommended by, or received from, a physician prior to the effective date of the policy or its reinstatement; or
 - (c) For which any symptom and/or sign, if presented to a physician prior to the effective date of the policy, would have resulted in the diagnosis of an illness or medical condition.
49. **PRESCRIPTION MEDICATIONS:** Medications whose sale and use are legally restricted to the order of a physician.
50. **RECIPIENT:** The person who has received, or is in the process of receiving an organ, cell or tissue transplant.
51. **REHABILITATION SERVICES:** Treatment provided by a legally licensed health professional intended to enable people who have lost the ability to function normally through a serious injury, illness, surgery, or for treatment of pain, to reach and maintain their normal physical, sensory, and intellectual function. These services may include: medical care, physical therapy, occupational therapy and others.
52. **RENEWAL DATE:** The first day of the next policy year. The renewal date occurs only on the anniversary date of the policy.
53. **RIDER:** A document added to the policy by the Insurer which adds and details an optional coverage.
54. **SECOND SURGICAL OPINION:** The medical opinion of a physician other than the current attending physician.
55. **SERIOUS ACCIDENT:** An unforeseen trauma occurring without the Insured's intention, which implies a sudden external cause and violent impact on the body, resulting in demonstrable severe bodily injury that requires immediate in-patient hospitalization within the next few hours after the occurrence of the severe injury to avoid loss of life or physical integrity. Severe injury shall be determined to exist upon agreement by both the attending physician and the Insurer's medical consultant, after review of the triage notes, emergency room and hospital admission medical records.
56. **TRANSPLANT PROCEDURE:** Procedure in which an organ, cell, or tissue is implanted from one part to another, or from one individual to another (of the same species), or

when an organ, cell (e.g. stem cell, bone marrow, etc.), or tissue is removed from the same individual and then received back.

- 57. **TRANSPLANT PROVIDER NETWORK:** A group of hospitals and physicians contracted on behalf of the Insurer for the purpose of providing transplant benefits to the Insured. The list of hospitals and physicians in the Transplant Provider Network is available from USA Medical Services and may change at any time without prior notice.
- 58. **USUAL, CUSTOMARY AND REASONABLE:** The usual, customary and reasonable charges for provided medical services in a geographical area, regardless of whether direct payment or reimbursement was used.
- 59. **WELL BABY CARE:** Routine medical care provided to a healthy newborn.

SUPPLEMENT

How does the USA Medical Services claim process work?

Members are asked to notify USA Medical Services as soon as they know they will need any type of treatment.

Four reasons why you should notify USA Medical Services at +1 (305) 275-1500:

1. **Assistance** in understanding and coordinating your benefits with direct 24-hour access to our team of physicians and medically trained personnel.
2. **Support** from our medical staff offering guidance to you or your family for the best possible medical care and services: top rated hospitals, reputable physicians and community resources.
3. **Access** to medically qualified representatives with extensive experience in the industry to help you avoid or reduce unnecessary medical expenses and overcharges.
4. By notifying us, we can provide the **best** possible care management before, during and after your treatment or service.

Before the claim: Once USA Medical Services is notified that an Insured needs any type of treatment, one of our doctors begins handling the case by communicating directly with the patient's doctor and medical facility. As soon as we receive all the necessary information from your provider, including medical records, our professional staff will coordinate direct payment and confirm your benefits. This is how we guarantee our Insureds a smooth admission to the hospital without worrying about payments or reimbursement. Additionally, we are here to coordinate and schedule air ambulances, second surgical and medical opinions, appointments with specialists, and other medical services.

During the claim: During treatment and/or hospitalization, our doctors and professional staff continue to monitor the patient by communicating frequently with the doctor and hospital staff, and following up on needed treatments, progress and outcomes. We can also provide information and support to your family about the latest medical advances and treatments. Members of our medical staff visit patients, contact families to provide assistance, answer questions, and ensure that the patient is receiving the best quality service.

After the claim: Following the patient's treatment or discharge from the hospital, our doctors at USA Medical Services will coordinate any follow-up treatment or therapy, and will make the necessary arrangements until the payment of the claim is completed.

Notification: The first step in the claim process

This section shows you what to do if your doctor informs you that you need a procedure or follow-up treatment. It also tells you what information you will need when you contact us, and what we will do to help you during the claim process.

The authorization of a claim is handled by our team of medical professionals at USA Medical Services. They will help you get access to treatment as promptly as possible and are there to offer you guidance and information, as well as confirm coverage for any procedure.

Please make sure that you have notified USA Medical Services by calling +1 (305) 275-1500 or sending an e-mail to usamed@usamedicalservices.com at least 72 hours in advance of receiving any medical care, or within the first 72 hours of receiving emergency treatment.

If your doctor tells you that you need to see a specialist or have some tests done:

Call or send an e-mail to USA Medical Services.

It will help us speed up your claim if you have the following details on hand:

1. The name of your referring doctor
2. Who you have been referred to
3. The test you need
4. What hospital you would like to go to

It will also help if you can ask your doctor for a copy of his/her case notes or records regarding your condition, as we will need to review them. You can email or fax them to us.

USA Medical Services will make arrangements for the tests, and confirm your coverage with the doctor and hospital. This normally takes a few days once we have all the information we need.

If your doctor tells you that you need surgery or other in-patient/day-patient treatment:

Call or send an email to USA Medical Services.

When you contact us, we will need the following:

1. The condition/symptoms being treated
2. The proposed treatment
3. Your referring doctor
4. The doctor and hospital you would like to go to

Again, it will help us expedite your claim promptly if you send us copies of your doctor's case notes or records.

Once we have all of the information we need, we will:

- Verify your policy is in effect for the time of your treatment
- Verify that the condition and treatment is eligible under the terms of your plan
- Confirm coverage to the hospital and doctor
- Schedule with the hospital a convenient appointment for you

Once you leave the hospital: To fully settle your claim, we will need a claim form, medical records, original invoices and the case notes. We usually receive these directly from the hospital; however, it may delay your claim if we do not get all these items and have to request them.

Once your claim has been approved, we will confirm the amounts paid and notify you of any amount you need to pay the hospital or doctor (for example, the deductible you chose on your plan).

In most cases, USA Medical Services will pay the hospital and doctor directly, but there are some cases when this may not be possible. This is usually the case when treatment took place in a hospital that is not part of a Bupa Hospital Network, if you did not notify us of the treatment, or if we require more information about your condition.

If your doctor recommends physical therapy or rehabilitation following surgery:

Call or send an e-mail to USA Medical Services.

When you contact us, we will need the following:

1. Your therapy plan
2. The therapist you will be seeing

Your doctor should provide a therapy plan that outlines how many therapist sessions you need and what kind of progress you are expected to make. We need to see this plan before we approve your therapy.

How to submit a claim after your treatment or service

If you have followed the right steps, we are probably in the process of issuing a direct payment to your provider. However, there are circumstances when this is not possible, and we will need to process a reimbursement to you. In those cases, there are certain guidelines that you should follow, which can be found below.

In order to expedite the processing of your claim, please be sure to complete the following steps:

1. Complete the claim form. Copy of the claim form can be found in your policy kit or at www.bupalatinamerica.com.
2. Attach all medical documents if you have not already sent them in. For example:
 - Physician's summary
 - Diagnostic and lab tests
 - Prescription
 - Medical equipment request
3. Enclose all original receipts. For example:
 - Invoices
 - Proof of payment
4. Send to USA Medical Services.
 - Send the claim no later than 120 days from the date of service.
 - Claims can be sent to the nearest Bupa location or representative.

USA Medical Services
7001 SW 97th Avenue, Miami, Florida 33173, USA
Tel. +1 (305) 275-1500 • Fax: +1 (305) 275-8555