Bupa

TERMS AND CONDITIONS

CORPORATE CARE

TRINIDAD & TOBAGO

Coverholder at LLOYD'S

BENEFITS

NOTES ON BENEFITS AND LIMITATIONS

- The Table of Benefits is just a summary of benefits Payable to Members. For complete details, please review the Terms and Conditions of the policy.
- All benefits are in U.S. dollars, per Member, per membership year, unless otherwise stated.
- All benefits are subject to any applicable deductible, unless otherwise stated.
- Some benefits are subject to coinsurance, after the deductible has been applied, and taking into account the benefits specific limits.
- Any diagnostic or therapeutic procedure, treatment, or benefit is covered only if resulting from a condition covered under the membership.
- The Insured must notify the Insurer at least seventy-two (72) hours before receiving any medical care. Emergency treatment must be notified within seventy-two (72) hours after the start of said treatment. If the Insured does not contact the Insurer as established in the Policy, he / she will be responsible for thirty percent (30%) of all covered medical and hospital expenses related to the claim, in addition to the deductible and coinsurance of your plan, if applicable. If the Insured does not notify the Insurer before their treatment, the Insurer does not guarantee direct payment to the provider.
- Consult the Table of Benefits to confirm if the member is obligated or not to use the Bupa Providers Network.
- All reimbursements are paid in accordance with the Usual, Customary, and Reasonable (UCR) fees for the specific service. UCR is the maximum amount that the insurer will consider eligible for payment, adjusted for a specific region or geographical area.
- The insurer, USA Medical Services, and/or any of their applicable related subsidiaries and affiliates will not engage in any transactions with any parties or in any countries where otherwise prohibited by the laws in the United States of America. Please contact the insurer for more information about this restriction.

POLICY CONDITIONS

IN-PATIENT BENEFITS AND LIMITATIONS

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

(a) For coverage outside the insurer's provider network:

i. Standard private or semi-private hospital room and board is limited to a maximum benefit of one thousand dollars (US$1,000) per day.

ii. Room and board within an intensive care unit is limited to a maximum benefit of three thousand dollars (US$3,000) per day.

(b) For coverage within the the insurer's 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) Accommodation for an overnight stay in a hospital is not covered if the Member could have received care as out-patient treatment. Hospital charges are not covered if the Member could have received care as outpatient treatment.

(d) Emergency medical treatment is covered as provided in policy condition 6.6.

1.2 MEDICAL AND NURSING FEES: Physician, surgeon, anesthesiologist, assistant surgeon, specialists, and other medical and nursing fees are covered only when they are medically necessary for the surgery or treatment and approved in advance by USA Medical Services. Medical and nursing 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.

1.3 PRESCRIPTION DRUGS: Drugs prescribed while in-patient are covered at a hundred percent (100%).

1.4 DIAGNOSTIC PROCEDURES: Hospital fees for laboratory tests, X-rays, magnetic resonance imaging (MRI), CT scan, positron emission tomography (PET), and other diagnostic tests, are covered at a hundred percent (100%) when the procedures are recommended by a doctor to help determine or assess the patient's condition, and are carried out in a hospital as part of a hospitalization.

1.5 PROVIDER NETWORK: To obtain a list of providers within the Provider Network, please contact the Corporate Service Team.

(a) The list of hospitals and physicians in the Provider Network is available from USA Medical Services or online at www.bupasalud.com, and may change at any time without prior notice.

(b) In order to ensure that the provider of medical services is part of the Provider Network, all treatments must be coordinated by USA Medical Services.

(c) In those cases where the Corporate Provider Network is not specified, there is no restriction on which hospitals may be used in those countries.

1.6 1.6 COMPANION OF A HOSPITALIZED CHILD: Consult your Table of Benefits to confirm if your product offers this coverage. The 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 the amount specify under the Table of Benefits.

1.7 BARIATRIC SURGERY: Consult your Table of Benefits to confirm if your product offers this coverage. The procedure will be covered after a waiting period of twenty-four (24) months and meeting the following criteria:

(a) Have a body mass index (BMI) of forty (40) or over and have been diagnosed as being morbidly obese;

(b) Have a body mass index (BMI) between thirty-five (35) and forty (40) and has a serious weight-related health problem;

(c) Can provide documented evidence of other methods of weight loss which have been tried over the past twenty-four (24) months, and

(d) Have been through a psychological assessment which has confirmed that it is appropriate for the insured to undergo the procedure.

The bariatric surgery technique needs to be evaluated by the insurer's medical teams and is subject to the insurer's medical policy criteria.

The insured must contact the insurer for pre-authorization before proceeding with treatment. Benefit may not be paid unless pre-authorization has been provided.

1.8 MENTAL HEALTH IN HOSPITALIZATION: Consult your Table of Benefits to confirm if your plan/ option offers this coverage. The expenses derived from psychiatric and / or psychological treatment, as long as it is medically necessary product of a covered disease or ailment, and therapies are granted during the stay in the hospital. The insured must contact the insurer to receive prior authorization before undergoing treatment. The insurer reserves the right to not pay the expenses unless prior authorization has been granted.

OUT-PATIENT BENEFITS AND LIMITATIONS

2.1 AMBULATORY SURGERY: Ambulatory or out-patient surgical procedures performed in a hospital, clinic, or doctor's office are covered at a hundred percent (100%). These surgeries allow the patient to go home the same day that they have the surgical procedure.

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

(a) Doctor/specialist consultation fees: Doctor and specialist fees for a consultation received as out-patient treatment are covered as indicated in your Table of Benefits.

(b) Out-patient diagnostic tests: Fees and charges for laboratory exams (such as blood and urine tests), X-rays, echocardiograms, ultrasounds, MRI, CT scans, endoscopic procedures (such as colonoscopy and cystoscopy), and other diagnostic procedures are covered as indicated in your Table of Benefits when recommended by the patient's doctor to help determine or assess the patient's condition.

2.3 PRESCRIPTION DRUGS:

After hospitalization

Prescription drugs first prescribed after a hospitalization or ambulatory surgery for a medical condition covered under this policy are covered up to the maximum amount indicated in the Table of Benefits. A copy of the prescription from the insured's attending physician must be included with the claim form.

Without hospitalization

Prescription drugs not prescribed after a hospitalization or ambulatory surgery for a medical condition covered under this policy are covered up to the maximum amount indicated in the Table of Benefits, and are subject to co-insurance. A copy of the prescription from the insured's attending physician must be included with the claim form.

2.4 PHYSICAL THERAPY AND REHABILITATION SERVICES: Physical therapy and rehabilitation services are covered as indicated in your Table of Benefits up to a maximum of thirty (30) days per membership year and not separately for each

condition or therapy. Services must be pre-approved by USA Medical Services. Evidence of medical necessity and a treatment plan are required for approval.

2.5 HOME HEALTH CARE: Home health care after a covered hospitalization is covered at as indicated in the Table of Benefits, up to a maximum of thirty (30) days per membership year. Home health care is covered when:

(a) medically necessary, without which the patient would have to stay in the hospital
(b) starts immediately after the hospitalization
(c) is provided by a fully qualified nurse in the patient's home
(d) is carried out under the supervision of a doctor.

2.6 ROUTINE HEALTH CHECKUP: Routine physical examinations are covered up to as indicated in your Table of Benefits per Member, per membership year, with no deductible. Routine physical examinations may include diagnostic studies.

2.7 VACCINES: The company will cover the costs and administration of medically required vaccines, according to the national vaccination program (children and adults), including the Human Papillomavirus (HPV) vaccine to protect against cervical cancer, influenza vaccine (flu), legally vaccinated required for travel, vaccines against pneumococcus, and medicines against malaria.

2.8 TREATMENT AT URGENT CARE FACILITIES OR WALK-IN CLINICS: Treatment at urgent care facilities or walk-in clinics in the United States of America that are necessary to treat a covered injury, illness or disease will be covered as indicated in the Table of Benefits.

2.9 MENTAL HEALTH OUT PATIENT: Consult your Table of Benefits to find out if your plan/option offers this coverage. The insurer will pay the expenses derived from the treatment psychiatric and / or psychological, as long as medically necessary, up to the limit maximum indicated in the Table of Benefits

MATERNITY BENEFITS AND LIMITATIONS

3.1 PREGNANCY, MATERNITY, AND BIRTH: Maternity benefits only apply for covered pregnancies under Plans 1 and 2. There is no maternity coverage under this membership for dependent children. Covered medical expenses related to maternity include:

- Pre-natal care, including non-invasive genetic prenatal screening (free fetal DNA screening), ultrasound scans, and vitamins required during pregnancy
- Obstetrician and hospital charges
- Post-natal care required by the mother immediately following childbirth
- Secondary conditions brought about by pregnancy, such as backache, high blood pressure, vaginal bleeding, nausea, and vomiting
- Well baby care is included in the maximum benefits for normal delivery or prescribed cesarean section, as described below

(a) Normal delivery: Medical expenses related to a normal delivery are covered up a maximum of eight thousand dollars (US$8,000) per pregnancy, with no deductible, when the insured mother has been covered under this membership for a continuous ten (10) calendar month period prior to the estimated delivery date.

(b) Prescribed cesarean section: Medical expenses related to delivering a baby by cesarean section are covered up to eight thousand dollars (US$8,000) per pregnancy, provided the mother has been a Member of this group for at least ten (10) calendar months before the estimated delivery date. This benefit will only apply when it is medically necessary for the baby to be delivered by cesarean section. Should the Member choose to have the baby delivered by cesarean section when it is not medically necessary, the benefit will only be payable up to the maximum specified for normal delivery in 3.1 (a).

3.2 NEWBORN COVERAGE:

(a) Provisional coverage:

If born from a covered pregnancy, each newborn will automatically be covered for complications of birth and for any injury or illness during the first ninety (90) days after birth, up to a maximum of ten thousand dollars (US$10,000) with no deductible. If not born from a covered pregnancy, there is no provisional coverage for the newborn.

(b) Permanent coverage:

i. Automatic addition: For the purpose of adding a newborn child to the parent's membership, a copy of the birth certificate including the newborn's full name, gender, and date of birth must be submitted to the insurer by the Group Administrator within ninety (90) calendar days of birth. Coverage with applicable deductible will then be effective as of the date of birth up to the maximum specified in the Table of Benefits.

Newborn coverage for complications of birth is limited to the maximum benefit described under 3.3.

ii. Non-automatic addition: The addition of babies born before the parent's membership has been in effect for at least ten (10) consecutive calendar months is subject to underwriting. To be added to their parent's membership, a completed Member Enrollment Form for Group Health Insurance, a Medical Supplement, and a copy of the birth certificate are required.

The addition of adopted children, children born as a result of a fertility treatment and children born by a surrogate mother are subject to underwriting. A completed Member Enrollment Form for Group Health Insurance, a Medical Supplement, and a copy of the birth certificate must be submitted in these cases, which will be subject to the standard underwriting procedures. Please contact the Corporate Service Team or your Group Administrator for more details.

(c) Well baby care is only covered as stated in 3.1.

3.3 COMPLICATIONS OF MATERNITY AND BIRTH: Complications of maternity and birth will be covered as indicated in the Table of Benefits, for medical expenses related to:

(a) Miscarriage, stillbirth, ectopic pregnancy, post-partum hemorrhage, and retained placenta

(b) Newborn complications (not related to congenital conditions or hereditary disorders), such as prematurity, low birth weight, jaundice, hypoglycemia, respiratory distress, and birth trauma

(c) For the purpose of this policy, a cesarean delivery is not considered a complication of pregnancy, maternity, and birth.

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

EVACUATION BENEFITS AND LIMITATIONS

4.1 MEDICAL EMERGENCY EVACUATION: Emergency transportation (by ground or air ambulance) is covered as described in your Table of Benefits 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.

Prior authorization must be obtained from the Insurer. Failure to obtain prior authorization from the Insurer may result in the denial of cover.

The selection of the closest medical transfer facility will be made according to the following prioritization:

(a) Nearest medical center within the country where the insured had the emergency and/or where the insured is located at the time when transport is requested or,

(b) Closest medical center in the country bordering the country where the insured had the emergency and/or where the insured is located at the time when transport is requested or,

(c) Medical center in another country within the region where the insured had the emergency and/or where the insured is located at the time when transport is requested or,

(d) In the case of medical evacuation to the United States of America, the appropriate medical center in the city closest to the country where the insured is hospitalized will be considered. The Insurer will not authorize transfers to another city in the United States of America unless medically necessary due to the availability of treatment at the nearest facility.

In cases where a ground ambulance is required, due to an accident, the insurer must be notified within seventy-two (72) hours of the occurrence of the event.

Scheduled care that is not considered an emergency will not be covered by the Emergency Medical Evacuation benefit.

(a) Ground ambulance transportation: The maximum amount payable for this benefit, as indicated in the Table of Benefits, and will only be covered when the services of the local ground ambulance used are to transport the insured:

   i. from the location of an accident to the hospital,

   ii. for transfer from one hospital to another, or

   iii. from your home to the hospital, if it is

      - medically necessary,
      - related to a covered condition, and
      - transportation by any other means could result in loss of life or limb

(b) Air ambulance transportation:

   i. All air ambulance transportation must be evaluated, pre-approved and coordinated by USA Medical Services. If the insured does not obtain prior authorization, the Insurer reserves the right not to pay expenses.

   ii. The maximum amount payable for this benefit is twenty-five thousand dollars (US$25,000) per incident.

   iii. The Member 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.

(c) Return journey: In the event that the Member is transported for the purpose of receiving treatment, he/she and the accompanying person, if any, shall be reimbursed for the expenses for a return journey to the place from where the Member was evacuated. The return journey shall be made no later than ninety (90) days after treatment has been completed. Coverage shall only be provided for traveling expenses equivalent to the cost of an airplane ticket on economy class, as a maximum. Transportation services must be pre-approved and coordinated by USA Medical Services. If the insured does not obtain prior authorization, the Insurer reserves the right not to pay expenses.

(d) The Insurer will not pay any other costs related to the transfer, such as travel expenses.

4.2 REPATRIATION OF MORTAL REMAINS: In the event a Member dies outside of his/her country of residence, the insurer will pay up to five thousand dollars (US$5,000) 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 membership. 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.

OTHER BENEFITS AND LIMITATIONS

5.1 CANCER TREATMENT: Doctor fees specifically related to planning and carrying out in-patient treatment for cancer—including, without limitation, bone marrow transplant, radiotherapy, chemotherapy, and oncology—are covered at a hundred percent (100%). Hospital charges for administering tests and drugs, such as those needed for chemotherapy, specifically related to treatment for cancer that requires hospitalization are also covered at a hundred percent (100%). All benefits will be paid up to the maximum limit per membership year indicated in the Table of Benefits.

5.2 END-STAGE RENAL FAILURE: Eligible expenses for dialysis for the treatment of kidney failure are covered at a hundred percent (100%) up to the maximum limit per membership year indicated in the Table of Benefits.

5.3 TRANSPLANT PROCEDURES: Treatment required for transplant procedure services is covered as indicated in the Table of Benefits, after the applicable deductible. The benefit for transplant procedures begins once the need for the transplant has been determined by a physician, certified by a second surgical or medical opinion, and approved by USA Medical Services. Benefits are subject to all the terms, conditions, exclusions and limitations of your membership. This benefit includes:

(a) Pre-transplant care, which includes services directly related to evaluation of the need for the transplant, and the preparation and stabilization of the patient for the transplant procedure.

(b) Pre-surgical workup, including all laboratory and X-ray exams, CT scans, Magnetic Resonance Imaging (MRI), 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 (US$25,000), which is included as part of the maximum benefit for the transplant procedure. The donor workup, including testing of potential donors for a match is included in this benefit.

(d) The hospitalization, surgeries, physician and surgeon's fees, anesthesia, medication, and any other treatment necessary during the transplant procedure.

(e) 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 such procedure.

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

(g) Any home health care, nursing care (e.g. wound care, infusion, assessment, etc.), emergency transportation, medical attention, office visits, transfusions, supplies, or medication related to the transplant procedure.

Coverage of benefits is subject to USA Medical Services' approval of the provider or facility where the treatment will be provided. Failure to obtain approval by USA Medical Services will result in the claim being denied.

Treatment for transplant procedures involving artificial or animal organs is not covered. The purchase of an organ for transplant is not covered.

5.4 CONGENITAL AND/OR HEREDITARY DISORDERS: Medically necessary treatment of congenital conditions and hereditary disorders is covered as indicated in your Table of Benefits. The benefit starts once the congenital and/or hereditary condition has been diagnosed by a physician. The benefit is retroactive to any period prior to the identification of the actual condition.

5.5 SPECIAL TREATMENTS: Prosthesis, appliances, orthotic durable medical equipment (implanted during surgery), implants, radiation therapy, chemotherapy, and the following highly specialized drugs: Interferon beta-1a, PEGylated Interferon alpha-2a Alfa, Interferon beta-1b, Etanercept, Adalimumab, Bevacizumab, Cyclosporine A, Azathioprine, and Rituximab will be covered but must be approved and coordinated in advance by USA Medical Services.

5.6 EMERGENCY ROOM TREATMENT (with or without admission): The Bupa Corporate Care policy covers emergency medical treatment in connection with an acute illness or accident only when the Member's life or physical integrity is in immediate danger, and the emergency has been notified to USA Medical Services, as provided for under this guide. All medical expenses from a non-network provider in relation to emergency medical treatment will be paid as if the Member had been treated at a network hospital.

5.7 ACCIDENT-RELATED DENTAL TREATMENT: Accident-related dental treatment that is necessary to repair the injury of sound natural teeth as a result of an accident or injury is covered. Treatment must be provided and completed within six (6) months of the date of the accident or injury. The dentist must confirm that the teeth treated were injured as the result of an accident. A sound natural tooth has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant, and functions normally in chewing and speech. This coverage does not apply for dental implants, crowns, or dentures.

5.8 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.).

5.9 PALLIATIVE CARE COVERAGE FOR TERMINAL PATIENTS: Palliative care will be understood as care provided to patients who do not respond to the curative procedure and are in the terminal stage with a life expectancy of six (6) months or less. Derived from this coverage, the Insurer will pay for the services if the Insured receives a diagnosis of a terminal illness and if he or she can no longer receive treatment that leads to recovery for up to a maximum of twelve (12) months.

The Insurer will pay only for one of the following options:

1. Services of specialized centers for terminal patients and palliative care, the service consists of:
    - Accommodation in a hospice.
    - Care of a professional nurse, qualified by the competent national authority where the treatment or service is received.
    - Prescribed medications and therapies to reduce body pain.
    - Physical, psychological, social, and spiritual care.

2. Home nursing services for terminally ill and palliative care patients, the service consists of:
    - Care of a professional nurse, qualified by the competent national authority where the treatment or service is received.
    - Prescription medications and therapies to reduce body pain.
    - Custodial care provided by a qualified professional nurse.

These services must be approved in advance by the Insurer.

5.10 HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS): Coverage for treatment of the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) is limited to the maximum amount indicated in your Table of Benefits, per lifetime after twelve (12) months from the effective date of the Member's coverage, if the virus or antibodies have not been detected or manifested before or during this period.

5.11 TREATMENT AT URGENT CARE FACILITIES OR WALK-IN CLINICS: Verify your Table of Benefits to find out if your product offers this coverage. Coverage is offered per Insured, per membership year for treatments in urgent care centers and convenience clinics in the United States of America that are necessary to treat an injury, illness or ailment covered under the policy will be covered as indicated in the Table of Benefits.

5.12 AUSTISM: Verify your Table of Benefits to find out if your product offers this coverage. Coverage is offered per Insured, per year of membership as indicated in the Table of Benefits, for costs related to autism, including medical consultations, and medications once the syndrome (disorder) is diagnosed in any of its manifestations (spectrum). This benefit also includes speech therapy, occupational therapy and behavior modification therapy (ABA) as long as they are performed by a certified physician or specialist and in a medical institution (clinic or hospital and therapy center). This benefit must be preauthorize by the Insurer's medical team.

5.13 EXTENDED COVERAGE FOR ELIGIBLE DEPENDENTS DUE TO DEATH OF THE POLICYHOLDER: In the event that the policyholder dies, the Insurer will provide continued coverage for the surviving dependents insured under this policy for one (1) policy year at no charge if the cause of the death of the policyholder results from a covered condition (an accident, Illness or ailment) under this policy. This benefit applies only to covered dependents under the existing policy and will automatically terminate for a surviving spouse in the event of marriage or if a surviving dependent is issued their own separate policy.

This coverage will not be applicable if the beneficiaries of the deceased request the return of any unearned premium payable upon death pursaunt to the Terms of the General Conditions.

5.14 HAIR PROSTHESIS (WIG): Coverage is subject to the following conditions:

(a) When the Insured is undergoing treatment for cancer.

(b) The hair loss is directly and exclusively a consequence of the cancer treatment.

(c) Must be pre-authorized by the Insurer.

EXCLUSIONS AND LIMITATIONS

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

6.1 CHARGES RELATED TO NON-COVERED TREATMENT: 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.

(f) Personal items such as telephone calls, newspapers, guest meals, or cosmetics are not covered.

6.2 SELF-INFLICTED ILLNESS OR INJURY: 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.

6.3 EYE EXAMINATIONS AND AIDS: Routine eye exams, hearing aids, eye glasses, contact lenses, radial keratotomy, and any other procedures to correct eye refraction disorders. except when coverage is included in your Table of Benefits.

6.4 ALTERNATIVE MEDICINE: Chiropractic care, homeopathic treatment, acupuncture or any type of alternative medicine.

6.5 COSMETIC SURGERY: Cosmetic surgery or medical treatment which is primarily for beautification, unless required due to the treatment of an injury, deformity or illness that compromises functionality and that first occurred while the insured was covered under this policy. This also includes any surgical treatment for nasal or septal deformity that was not induced by trauma.

6.6 PRE-EXISTING CONDITIONS: Any charges in connection with pre-existing conditions, except if authorized in writing by the insurer.

6.7 EXPERIMENTAL OR OFF-LABEL TREATMENT: Any treatment, service, or supply that is not scientifically or medically recognized for a specific diagnostic or that is considered as off label use, experimental and/or not approved for general use by the U.S. Food and Drug Administration.

6.8 TREATMENT IN GOVERNMENTAL FACILITY: 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 that have been placed under the direction of government authority.

6.9 MENTAL HEALTH: Diagnostic procedures or treatment of psychiatric disorders, unless resulting from treatment for a covered condition according to the table of benefits. Mental illnesses, chronic fatigue syndrome, sleep apnea, and any other sleep disorders.

6.10 BEHAVIORAL AND DEVELOPMENT DISORDERS: Treatment related to learning difficulties, problems related to physical development, behavior disorders, developmental problems treated in an educational setting to support educational development, psycho pedagogical evaluations, psychometric tests, therapies for psycho educational or psycho pedagogical purposes, or child development treatments. Autism diagnoses and treatments are limited to coverage under the autism benefit when coverage is specified in the Table of Benefits.

6.11 CHARGES IN EXCESS OF UCR: 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.

6.12 COMPLICATIONS OF NON-COVERED CONDITIONS: 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 membership.

6.13 DENTAL TREATMENT NOT RELATED TO COVERED ACCIDENT: Any dental treatment or service not related to a covered accident, or that is not provided and completed within six (6) months of a covered accident.

6.14 POLICE OR MILITARY RELATED INJURIES: 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.

6.15 HIV/AIDS: Any treatment before the twelve (12) month waiting period.

6.16 ELECTIVE HOSPITAL ADMISSION: An elective admission more than twenty-three (23) hours before a planned surgery, unless authorized in writing by USA Medical Services.

6.17 TREATMENT BY IMMEDIATE FAMILY MEMBER: Treatment performed by the spouse, parent, sibling, or child of any member under this membership.

6.18 OVER-THE-COUNTER AND NON-PRESCRIPTION DRUGS: Over-the-counter or non-prescription drugs are not covered. Any contraceptive medication or device, except when its primary purpose is not contraceptive but rather medically necessary to treat a medical condition or diagnosis.

6.19 PERSONAL OR HOME-BASED ARTIFICIAL KIDNEY EQUIPMENT: Personal or home-based artificial kidney equipment, unless authorized in writing by USA Medical Services.

6.20 TISSUE AND/OR CELL STORAGE: Storage of bone marrow, stem cell, cord blood, or other tissue or cell, except as provided for under the condition for transplant procedures of this membership. Costs related to the acquisition and implant of an artificial heart, other artificial or animal organs, and all expenses for cryopreservation of more than twenty-four (24) hours.

6.21 TREATMENT RELATED TO RADIATION OR NUCLEAR CONTAMINATION: 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.

6.22 WEIGHT RELATED TREATMENT: Any expense, service or treatment for obesity, weight control, or any form of food supplement, except when coverage is included in your Table of Benefits.

6.23 GROWTH TREATMENT: Treatment by a bone growth stimulator, bone growth stimulation or treatment relating to growth hormone, regardless of the reason for prescription.

6.24 CONDITIONS RELATED TO SEX OR GENDER ISSUES AND SEXUALLY TRANSMITTED DISEASES: Any expense for gender reassignment, sexual dysfunction including but not limited to impotence, inadequacies, disorders related to sexually-transmitted human papillomavirus (HPV), and any other sexually transmitted diseases.

6.25 FERTILITY AND INFERTILITY TREATMENTS: Any kind of fertility and infertility treatment and procedure, including but not limited to tubal ligation, vasectomy, and any other elective procedure to prevent pregnancy that is meant to be permanent, as well as reversal of voluntary sterilization, artificial insemination, and the use of a surrogate mother.

6.26 FERTILITY AND INFERTILITY TREATMENT COMPLICATIONS: Maternity complications as a result of any type of fertility and infertility treatment or any type of assisted fertility procedure.

6.27 MATERNITY TREATMENT DURING 10-MONTH WAITING PERIOD: All maternity-related treatment to a mother or a newborn during the ten (10) month pregnancy and maternity waiting period.

6.28 ABORTION: Any voluntarily induced termination of pregnancy, unless the mother's life is in imminent danger.

6.29 PODIATRIC CARE: Cosmetic podiatric care, or that is not medically necessary, as well as pedicures, special shoes and supports of any type or shape and / or podiatric care to treat functional disorders of the feet, except when you specify coverage in your Table of Benefits.

6.30 TREATMENT OF THE JAW: Any expenses associated with the treatment of the upper maxilla, the jaw, and/or the complex of muscles, nerves, or other tissue related to the temporomandibular joint caused by a dental condition, previous dental treatment, and/or their complications, including but not limited to any diagnosis where the primary condition is dental.

6.31 NOSE AND NASAL SEPTUM DEFORMITY: Except when it is the result of multiple trauma during a covered accident. Surgical procedures 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.).

6.32 EMERGENCY TRANSPORTATION RELATED COSTS: Any additional or secondary costs related to the need for emergency transportation, such as hotel accommodations.

6.33 EPIDEMIC/PANDEMIC DISEASES: Treatment for or arising from any epidemic and/or pandemic disease and vaccinations, medicines, or preventive treatment for or related to any epidemic and/or pandemic disease are not covered, except the vaccines that are specified in the vaccination benefit and/or in the Table of Benefits.

6.34 EUTHANASIA OR ASSISTED DEATH: This policy does not cover any expense derived from euthanasia or assisted death, in any of its modalities (active voluntary, passive voluntary or assisted suicide), even if in the country where the insured is located, such procedure is legalized and/or regulated.

6.35 HAIR PROSTHESIS (WIGS): acquisition expenses for hair prosthesis as a consequence of a diagnosis for cancer are excluded if:

(a) They are not pre-authorized by the insurer.

(b) They are associated with maintenance of wigs, including, but not limited to wig holders, styling services, hair care products and necessary adjustments.

ADMINISTRATION

GENERAL

7.1 CONTRACT: Certain underwriters at Lloyd's (referred to as the "insurer") agree to provide to the Members the benefits described in the Contract. The insurer is offering this insurance coverage to residents of Trinidad & Tobago. Bupa Worldwide Corporation (Bupa) is an approved Lloyd's coverholder and is issuing this contract to you on the insurer's behalf. All benefits are subject to the terms and conditions of the Contract. The Contract is governed by an agreement between your Group Administrator and the insurer, which covers the terms and conditions of your membership. This means that there is no legal contract between the Member and the insurer.

The insurer makes no warranty that benefits offered to the Group under the Contract satisfy mandatory benefits requirements in the countries in which group Members reside. The Contract is enforceable only by the parties. No rights of enforcement or any other rights are given to any third parties, including those described in the Contract.

The Contract is not subject to the U.S. Patient Protection and Affordability Act (PPACA), nor the U.S. Employee Retirement Income Security Act (ERISA) of 1974 as amended, and is not required to offer continuation of coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) or any other federal or state continuation of coverage laws in the United States of America.

7.2 ENTIRE CONTRACT: The Terms and Conditions together with (i) the Membership Guide, (ii) the Application for Group Health Insurance, (iii) the Member Enrollment Form for Group Health Insurance of all Members, (iv) the Medical Supplement, (v) the Master Certificate, (vi) the Membership Certificates, and (vii) any riders and

amendments thereto (together referred to as the "Contract"), shall constitute the complete Contract between the insurer and the Group Administrator. Neither company rules nor oral understandings have any bearing on the Contract, unless they were included in the Contract prior to the Contract being signed. Once the Contract has been signed, the only changes that can be made to the Contract are riders, endorsements, or amendments agreed by both parties. The insurer may cancel, modify, or void the Contract if the Group Administrator has misled or attempted to mislead the insurer in any way, whether intentionally or negligently.

7.3 TERM: The term of the Contract between the insurer and the Group Administrator is one (1) year.

7.4 AMENDMENTS: If the Membership Certificate has been issued with an amendment, said amendment will automatically be part of the Contract. The complete Contract includes all amendments and riders added by the insurer.

7.5 CONTRACT INTERPRETATION: In the event that a dispute arises as to the interpretation of the Contract, the English version of the Contract shall be conclusive and take precedence over any other language version of the Contract.

7.6 CONTRACT DELIVERY: The Contract cannot be delivered in the United States of America.

7.7 AUTHORITY: No intermediary, producer, or consultant has the authority to make or confirm any changes to the membership on the insurer's behalf or to waive any of its provisions. After the Contract has been signed, no change shall be valid unless it is specifically agreed between the Group Administrator and the insurer, and also endorsed by an amendment to the Contract.

7.8 TEN (10) DAY RIGHT TO EXAMINE THE CONTRACT: The Contract may be returned to the insurer within ten (10) days of receipt for a refund of all premiums paid. If returned, the Contract is void as if it had not been issued.

7.9 IMPORTANT NOTICE ABOUT THE APPLICATIONS: The Contract is based on the Application for Group Health Insurance, the Member Enrollment Form for Group Health Insurance and Medical Supplement, if applicable, and the payment of the premium. If any information shown on any of the applications is incorrect, incomplete, or has been omitted, the Group Administrator and/or the Principal Member must provide written notice of the correct information to the insurer. Failure to do that may result in the Contract or the Membership Certificate being rescinded or cancelled, or coverage being modified, at the sole discretion of the insurer.

7.10 OTHER DOCUMENTS: The Membership Guide, the Membership Certificate, and the identification card (ID card) provide details of the coverage, subject to any changes to the terms and conditions agreed between the insurer and the Group Administrator. The Group Administrator is responsible for informing Members of any changes to the terms and conditions affecting your membership. The Membership Certificate contains any conditions, treatments, or amendments for which coverage is restricted or excluded—if any—that apply to any of the Members, based on their medical history.

7.11 CONFIDENTIALITY: The confidentiality of patient and Member information is a priority to the insurer and its companies. To this end, the insurer fully complies with data protection laws (Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations) and medical confidentiality guidelines. The insurer sometimes uses third parties to process data on its behalf. Such processing is subject to contractual restrictions with regards to confidentiality.

7.12 CHANGE OF OPTION OR PLAN: On the anniversary date of the Contract, the Group Administrator can request to change option or plan (deductible) for the entire insured group. If the change is accepted, the insurer will adjust the premium from the effective date of such change. Changes of option or plan for an individual Member will not be accepted. For Community Rated groups, during the first sixty (60) days after the effective date of the change, benefits

will be limited to the lesser benefit provided by either the new option or plan or the prior option or plan, and during the first ten (10) months after the effective date of the change, benefits for maternity and newborn, will be limited to the lesser benefit provided by either the new option or plan or the prior option or plan. For Experience Rated groups, benefits of the new option or plan will begin on the effective date of the change.

7.13 CONTRACT CANCELLATION OR NON-RENEWAL: The insurer retains the right to cancel, modify, or rescind the Contract or any Membership Certificate if statements in the Member Enrollment Form for Group Health Insurance are found to be misrepresentations, incomplete, or if fraud has been committed, leading the insurer to approve a membership when, with the correct or complete information, the insurer would have issued the Membership Certificate with restricted coverage, premium loading, or declined to provide insurance.

The insurer retains the right to cancel, non-renew, or modify the Contract on a class basis as defined in this document.

The Group Administrator retains the right to cancel the contract upon renewal with two (2) months advance written notice.

7.14 NO COVERAGE UPON TERMINATION: In the event of termination 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 Contract that took place before the effective date of termination. 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.

7.15 REFUNDS: If the Contract or a Membership Certificate is cancelled after it has been issued, reinstated, or renewed, the insurer will refund the unearned portion of the premium. The unearned portion of the premium is based on the number of days corresponding to the payment mode minus the number of days the Contract or the Membership Certificate was in effect.

7.16 INSOLVENCY: The insolvency, bankruptcy, financial impairment, voluntary plan of arrangement with creditors, or dissolution of the Group Administrator's business shall not impose upon the insurer any liability other than that specifically stated within the Contract.

7.17 HEADINGS: The headings in this document are for ease of reference only and shall not affect its interpretation or construction.

MEMBERSHIP

8.1 ELIGIBILITY: The insurer can enter into a Contract with legally incorporated companies. Legally incorporated companies located in the United States of America and its territories are not eligible, with the exception of Puerto Rico where the Contract may be issued solely on a surplus-lines basis. Members who are eligible for coverage include employees with an employment contract or any other agreement with the Principal Member and previously known and accepted by The Insurer and that have a minimum of eighteen (18) years of age (except for eligible dependents). There is no maximum age limit to apply for this Corporate Care coverage. There is no maximum renewal age for Members covered under the Contract. The insured group must maintain the minimum requirement of five (5) Principal Members in order to be considered for renewal.

Eligible dependents include the Principal Member's spouse or domestic partner and any unmarried biological children, legally adopted children, stepchildren, or children to whom the Principal Member has been appointed legal guardian by a court of competent jurisdiction, who have been identified on the Member Enrollment Form for Group Health Insurance and for whom coverage is provided under the membership.

Dependent coverage is available for the Principal Member's dependent children up to their twenty-fourth (24th) birthday if single. Coverage for such dependents continues through the next anniversary or renewal date of the policy, whichever comes first after reaching twenty-four (24) years of age if single.

If a dependent child marries, changes country of residence or if a dependent spouse ceases to be married to the Principal Member by reason of divorce or annulment or changes country of residence, coverage for such dependent under this membership will terminate on the next anniversary or renewal date of the membership, whichever comes first.

A dependent child born under the coverage of the insurance policy and who is classified as a Dependent Adult, based on the definition detailed in these Terms and Conditions, may continue to enjoy insurance coverage under this condition after reaching the age of twenty-four (24), for which the rates, benefits, restrictions and limitations corresponding to an adult person and specified in the Terms and Conditions and Table of Benefits of the policy will be applied for each renewal.

8.2 BEGINNING AND ENDING OF INSURANCE COVERAGE: Subject to the conditions of the Contract between the insurer and the Group Administrator, benefits begin and end as follows:

(a) The membership starts on the effective date shown on the Membership Certificate that the insurer issues to the Member for the current continuous period of Bupa Corporate Care membership under the Contract.

(b) The Group Administrator can end a membership, or that of any of the dependents, at any given time. The insurer cannot backdate the cancellation of a membership. The Group Administrator remains responsible for payment of premiums up to the effective date of cancellation.

(c) The insurer can end a membership:

i. If the Contract between the insurer and the Group Administrator is terminated.

ii. If the Group Administrator does not renew the membership.

iii. If the Group Administrator does not pay the premium or any other payment due under the contract with the insurer for any Member.

iv. If a Member changes his country of residence, as prescribed in Article 9.4 herein.

v. Upon the death of the Principal Member.

(d) The insurer can cancel or rescind any membership if there is evidence that the Member has misled or attempted to mislead the insurer. This includes giving false information or keeping necessary information from the insurer, or working with another party to give the insurer false information, either intentionally or carelessly, which may influence the insurer when deciding:

i. Whether any Member can join the group.

ii. The amount of the premium the Group Administrator has to pay.

iii. Whether the insurer will pay any claim.

8.3 NEW ENROLLMENT/LATE ENROLLMENT: New employees can be added to the group by submitting a completed Member Enrollment Form for Group Health Insurance, and if applicable, a Medical Supplement, as follows:

(a) Community Rated groups: Upon underwriting approval, Principal Members and dependents will be included (i) as per the effective date for new enrollment, or (ii) upon renewal date, thirty (30) days after the Member Enrollment Form for Group Health Insurance is received for late enrollment. A newborn from a covered pregnancy will be included as per date of birth without underwriting, if notification of birth is received within ninety (90) days (only in Plans 1 and 2).

(b) Experience Rated groups: Principal Members and dependents will be included without underwriting (i) as per the date the effective date for new enrollment, or (ii) upon renewal date, thirty (30) days after the Member Enrollment Form for Group Health Insurance is received for late enrollment. Any newborn will be included without underwriting as per the date of birth if notified within ninety (90) days.

The Group Administrator undertakes to enroll all individuals eligible to become Principal Members from the date they become eligible. Failure to do so shall be cause for terminating the Contract.

The insurer may void, at its discretion, the coverage of a Principal Member and his or her dependents if it reasonably believes or suspects that a Principal Member or his or her dependents have deceived or misled the insurer. The insurer may cancel a group Member's enrollment if at any time it becomes unlawful for the insurer to provide coverage to any individual.

8.4 CHANGES OF COUNTRY OF RESIDENCE: The Member must notify the insurer in writing of any change in his/her country of residence within a maximum period of thirty (30) calendar days of its occurrence. A change of country of residence may result in modification of coverage, deductible, or premium according to the geographical area, subject to the insurer's procedures.

8.5 CHANGES TO THE COVERAGE: The terms and conditions of the membership may be changed from time to time through the contract between the Group Administrator and the insurer.

8.6 CHANGES TO THE MEMBERSHIP CERTIFICATE: The insurer will send each Member a new Membership Certificate if:

(a) Another dependent, such as a newborn child or a spouse, is being added to the membership with the Group Administrator's approval.

(b) The insurer needs to record any other changes requested by the Group Administrator or any changes the insurer is entitled to make.

The new Membership Certificate will replace any earlier version in the Member's possession, as per the effective date shown on the new Membership Certificate.

8.7 CHANGES TO THE CONTACT INFORMATION: If the address or contact information for a Member changes, the Member must inform the Group Administrator, who in turn shall inform the insurer of the change.

8.8 RIGHT TO CONVERT TO AN INDIVIDUAL PLAN: If the membership ends, it may be possible for the Principal Member and the dependents included in the membership to join an individual plan with the same restrictions in effect under this Bupa Corporate Care plan, after meeting the eligibility requirements of that specific plan. Members under a Community Rated group shall be eligible to convert their coverage without underwriting when moving to a product of equal benefits and equal or higher deductible. For Members under an Experience Rated group, the conversion to an individual plan is always subject to underwriting evaluation.

Should the Member have the right to convert and wish to proceed, a completed Individual Health Insurance Application must be received by the insurer within thirty (30) days after the termination of the Member's coverage.

Nevertheless, neither the Contract, the Group Administrator Guide, nor the Membership Guide are subject to the U.S. Patient Protection and Affordability Act (PPACA), nor the U.S. Employee Retirement Income Security Act (ERISA) of 1974 as amended, and the insurer is not required to offer continuation of coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) or any other federal or state continuation of coverage laws in the United States of America.

8.9 NO COVERAGE UPON TERMINATION: In the event of termination 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 Contract that took place before the effective date of termination. 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.

RENOVATION

9.1 MEMBERSHIP RENEWAL: Each membership renewal is subject to the Group Administrator renewing the Contract. Individual membership is subject to the Group Administrator's discretion.

9.2 PREMIUM PAYMENT: It is the responsibility of the Group Administrator to pay the insurer the appropriate premium for the membership of all Members covered under the contract between the insurer and the Group Administrator.

PAYMENTS

10.1 INVOICES: The insurer shall issue invoices in advance detailing the amount of premium due annually. The insurer may also issue interim invoices or refunds to reflect enrollments, cancellations, and variations to coverage requested by the Group Administrator. The Group Administrator shall pay the insurer the premium due every year by the invoice's due date.

When a Principal Member or dependent joins the group after the beginning of the insured period, the insurer shall calculate the pro-rata premium payable in respect of that individual, and the Group Administrator shall pay to the insurer such amount within thirty (30) days of the due date of the invoice.

When a Principal Member or dependent leaves the group after the beginning of the insured period, the insurer shall calculate the pro-rata premium payable in respect of that individual, and the insurer shall promptly refund, when applicable, any amount in excess of the pro-rata premium already paid by the Group Administrator to the insurer in respect of the Principal Member or dependent.

For Contract purposes, the pro-rata premium includes all amounts paid for the Member for the corresponding coverage period, calculated in proportion to the period during which such Member was enrolled in the group.

10.2 POLICY MODE: Premiums are to be paid annually, unless the insurer authorizes other mode of payment.

10.3 LATE PAYMENT: The Group Administrator is responsible for paying the premium on time. Premium payment is due on the renewal date of the Contract or on 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 the Group Administrator has not received a premium notice thirty (30) days prior to the premium payment due date, and the Group Administrator does not know the amount of the premium payment, the Group Administrator should contact the producer or the insurer. **The premium must be paid by the Group Administrator in one single payment.**

10.4 PREMIUM RATE CHANGES: The insurer retains the right to change the premium rates at the time of each renewal date. Any adjustment will be notified to the Group Administrator at least thirty (30) days prior to the effective date of such change. The Group Administrator may terminate the Contract from the effective date of such a proposed change if the parties are not able to agree such a change.

10.5 GRACE PERIOD: If premium payment is not received by the due date, the insurer will allow a grace period of thirty (30) days for the premium to be paid. If the premium is not received by the insurer prior to the end of the grace period, the Contract and all of its benefits will be deemed terminated as of the original due date of the premium. Benefits are not provided under the Contract during the grace period.

10.6 REINSTATEMENT: If the Contract was not renewed within the grace period, it can be reinstated within thirty (30) days after the grace period. Payment of the due premiums will bring the Membership back in force with no gap of coverage. No reinstatement will be authorized after sixty (60) days of the due date of the premium.

CLAIMS

11.1 REQUIREMENT TO NOTIFY THE INSURER: The Member must contact USA Medical Services, the insurer's claims administrator, at least seventy-two (72) hours in advance of receiving any medical care. Emergency treatment must be notified within seventy-two (72) hours of beginning such treatment. If the Member fails to contact USA Medical Services as stated herein, he/she will be responsible for thirty percent (30%) of all covered medical and hospital charges related to the claim, in addition to the plan's deductible and co-insurance, if applicable.

11.2 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.

11.3 REQUIRED SECOND SURGICAL OPINION: If a surgeon has recommended a non-emergency surgical procedure, the Member must 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 membership.

IF THE MEMBER DOES NOT OBTAIN A REQUIRED SECOND SURGICAL OPINION, THE MEMBER WILL BE RESPONSIBLE FOR THIRTY PERCENT (30%) OF ALL COVERED MEDICAL AND HOSPITAL CHARGES RELATED TO THE CLAIM, IN ADDITION TO THE PLAN DEDUCTIBLE OR CO-INSURANCE, IF APPLICABLE.

11.4 DEDUCTIBLE: The Group Administrator has chosen a deductible plan for the Members in the plan. The deductible is stated in the Membership Certificate. Before the insurer starts paying benefits, the Member must pay a specified amount toward eligible expenses incurred by each Member, every membership year. This amount is the deductible. If the Member's family is covered in the membership, the deductible applies separately to each Member therein. However, a maximum of only two deductibles per membership year has to be met if two or more Members of the family claim benefits. Even if the amount being claimed for is less than the deductible, the Member must submit a claim form to the insurer if the Member wishes that those amounts be taken into account towards the annual deductible.

The eligible expenses incurred by the insured during the last three (3) months of the policy year that are used to accumulate the corresponding deductible for that year, will be applied to the insured's deductible for the following policy year, provided there are no eligible expenses incurred within the first nine (9) months of the policy year. In the event that the benefit is granted to apply to insured's deductible for the following policy year, and the insured subsequently submits claims or reimbursement requests for eligible expenses during the first nine (9) months of the policy year, the benefit granted will be reversed and the insured will be responsible for paying the deductible for the following policy year. This benefit does not apply to additional deductibles to the regular annual deductible of the policy, which may be applied for certain limitations of the Insured.

In case of a serious accident, no deductible shall apply for the period of the first hospitalization only. For all hospitalizations thereafter, the corresponding deductible shall apply.

11.5 PROOF OF CLAIM: The Member must request reimbursement throught my Bupa at www.bupasalud.com, or send an email to servicio@bupalatinamerica.com including copy of detailed invoices, medical records and proof of payment, within one hundred eighty (180) days after the treatment or service date. Failure to do so will result in the claim being denied. For claims related to car accidents, the following additional documentation is required for review: police reports, first insurance proof of coverage, emergency medical report, and results of toxicological screening. In order for benefits to be paid under this membership, 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 membership was issued or renewed, AND a written statement signed by the Member that the dependent child's marital status is single.

In the event that the Insured does not agree with what was determined by the Insurer in relation to any claim (closed) or in the event that the insurer needs additional information, they will have up to 180 days from the date of issuance of the explanation of benefits to present such information.

11.6 PAYMENT OF CLAIMS: The exchange rate used to reimburse for invoices issued in currencies other than U.S. dollars (US$) will be determined on the date of service at the insurer's discretion. Additionally, the insurer reserves the right to issue the payment or reimbursement in the currency in which the service or treatment was invoiced. 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 Principal Member 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 Principal Member. If the Principal Member is deceased, the insurer will pay any unpaid benefits to the beneficiary or estate of the deceased Principal Member. USA Medical Services must receive the complete medical and non-medical information required in order to determine compensability before direct payment is approved or the Principal Member is reimbursed.

The insurer will make payments either by check or electronic transfer. Sometimes, international banking regulations do not allow payments in the currency requested by the Principal Member. In these cases, the insurer will send the payment in U.S. dollars. It is the Principal Member's responsibility to pay any charges that are not eligible for payment under the membership. The insurer, USA Medical Services, and/or any of their applicable related subsidiaries and affiliates will not engage in any transactions with any parties or in any countries where otherwise prohibited by the laws in the United States of America. Please contact USA Medical Services for more information about this restriction.

11.7 COORDINATION OF BENEFITS: If any Member in your membership has a health insurance policy with another insurer that provides benefits also covered by this membership, benefits will be coordinated.

All claims incurred in the member's country of residence must be submitted in the first instance against the other policy. This membership 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, the insurer will function as your primary insurer and retains the right to collect any payment from local or other insurers.

The following documentation is required to coordinate benefits: Explanation of Benefits (EOB) and copy of bills covered by the local insurance company containing information about the diagnosis, date of service, type of service, and covered amount.

11.8 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 before the claim is agreed.

11.9 DUTY TO COOPERATE: The Member 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.

11.10 CLAIMS APPEALS: In the event of a disagreement between the Member and the insurer regarding this membership and/or its conditions, before beginning any arbitration or legal proceeding, the Member shall request a review of the matter by the insurer's appeals committee. In order to begin such review, the Member must submit a written request to the appeals committee. 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 insurer's appeals coordinator, c/o USA Medical Services. Upon submission of a request for review, the appeals committee will determine whether any further information and/or documentation is needed and act to timely obtain it. The appeals committee will notify the Member of its decision and the underlying rationale within thirty (30) days.

11.11 CLAIMS ARBITRATION, LEGAL ACTIONS, AND JURY WAIVER: Any disagreement that may persist upon completion of the claims appeal as determined herein, must first be submitted for arbitration. In such cases, the Member and the insurer will submit their difference to three (3) arbiters: Each party selecting an arbiter, and the third arbiter to be selected by the arbiters named by the parties herein. In the event of disagreement between the arbiters, the decision will rest with the majority. Either the Member or the insurer may initiate arbitration by written notice to the other party demanding arbitration and naming its arbiter. The other party shall have twenty (20) days after receipt of said notice within which to designate its arbiter. The two (2) arbiters named by the parties, within ten (10) days thereafter, shall choose the third arbiter and the arbitration shall be held at the place hereinafter set forth ten (10) days after the appointment of the third arbiter. If the other party does not name its arbiter within twenty (20) days, the complaining party may designate the second arbiter and the other party shall not be aggrieved thereby. Arbitration shall take place in Miami-Dade County, Florida, USA, or if approved by the insurer, in the Member's country of residence. The Member and the insurer agree that each party will pay their own expenses in regards to the arbitration.

The Member confers exclusive jurisdiction in Miami-Dade County, Florida for the determination of any rights under this membership. The insurer and any Member covered by this policy hereby expressly agree to trial by judge in any legal action arising directly or indirectly from this membership. The insurer and the Member further agree that each party will pay their own attorneys' fees and costs, including those incurred in arbitration.

11.12 SUBROGATION AND INDEMNITY: If treatment is needed as a result of a third party's fault, for example, an injury suffered in an accident in which the Member is a victim, the Member must notify the insurer in writing as soon as possible. If this is the case, the insurer requests that the Member takes any reasonable steps to:

(a) Recover from the party at fault (through their insurance company) the cost of the treatment paid for by the insurer, and

(b) Claim an interest, if entitled

If the Member is able to recover the cost of any treatment for which the insurer has paid, the Member must repay that amount (and any interest) to the insurer. The insurer has a right of subrogation or reimbursement from or on behalf of a Member to whom it has paid any claims, if such Member 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 Member against third parties who may be responsible for causing a claim under this membership, or who may be responsible for providing indemnity of benefits for any claim under this membership.

11.13 DISCRETIONARY PAYMENTS: Any ex gratia payments are made at the insurer's discretion. If the insurer makes a payment for which the Member is not entitled to under the membership, this amount will still count towards the maximum amount of benefits the insurer will pay under the membership. The insurer has no obligation to pay for treatments that are not covered by the membership, even in circumstances where the insurer has paid an earlier claim for similar or identical treatment, including ex gratia payments.

11.14 COINSURANCE: Please check your Table of Benefits to find out if this coinsurance applies to your coverage plan. Your policy contemplates the payment of a 20% coinsurance, after deductible, for all outpatient expenses incurred in the United States of America, with a maximum limit of US $ 10,000 per insured, per year of membership.

11.15 PAYMENT OF NON COVERED CLAIMS: The Insurer is under not obligated to provide coverage and/or pay excluded claims or claims not covered under the Terms and Conditions of the policy under any circumstances (such as, but not limited to, those cases where: the Insurer, by an error, on its part, made payments of a claim that is subsequently identified as excluded or not covered under the Terms and Conditions of the policy.)

Any payment for excluded conditions or conditions not covered by the Terms and Conditions of the policy shall be considered an error that in no way constitutes a right on the part of the Insured. Such payments shall not constitute a precedent and/or reference for other and/or future coverage related to the same or similar diagnosis or any related claim; therefore, the Insured does not have the right to demand coverage for any claim derived from the same event and/or any event, claim, or excluded condition or not covered under the Terms and Conditions of the policy.

In those cases where The Insurer makes payments on claims not covered by the Terms and Conditions of the policy, the Insurer may, at its sole discretion: i. request the return of any monies made in error to the Policyholder Insured (refund must be made within thirty days from the date of collection by the Insurer from the Insured); ii. reduce the paid amount in error from any pending or future claims; iii. reduce the paid amount in error from the unearned premium; iv. execute any necessary action to obtain a refund of the related amount to the claims paid in error.

DEFINITIONS

This is a list of definitions for some terms and phrases used in this document that have a specific meaning within the benefits and rules of the policy.

ACCIDENT: An unfortunate incident that occurs unexpectedly and suddenly, provoked by an external cause, always without the insured's intention, which causes injury or bodily trauma and requires immediate ambulatory medical attention and/or patient's hospital admission. The medical information related to the accident will be evaluated by the insurer, and the compensability will be determined under the general policy's provisions.

ACCIDENT-RELATED DENTAL TREATMENT: Treatment necessary to restore or replace damaged or lost teeth in a covered accident.

AIR AMBULANCE TRANSPORTATION: Emergency air transportation from the hospital where the insured is admitted to the nearest suitable hospital where treatment can be provided.

AMENDMENT: A document added to the Contract between the insurer and the Group Administrator that clarifies, explains, or modifies the membership coverage.

ANNIVERSARY DATE: Annual occurrence of the effective date of the Contract.

AREA OF COVERAGE: Geographical area where the Member is entitled to receive treatment. This area may include or exclude the continental United States of America (herein referred to as USA), depending on the coverage option selected by the Group Administrator.

BENEFIT: Any eligible expense that the insurer will pay for, as specified in the Table of Benefits.

CLASS: The insureds of all memberships of the same type, including but not limited to benefits, deductibles, age group, country, plan, year groups, or a combination of any of these.

CO-INSURANCE: Coinsurance is the percentage of eligible medical expenses that the insured must pay, after satisfying / covering the deductible, for the benefits indicated in their Table of Benefits, inside and / or outside the country of residence and taking into account the benefits limits.

COMPLICATIONS OF PREGNANCY, MATERNITY, AND/OR BIRTH: Any condition caused by, and/or that occurs as a result of the pregnancy or the maternity, and any disorder related to the birth of a newborn, not caused by congenital or hereditary 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. For the purpose of this coverage, cesarean deliveries are not considered a complication of pregnancy, maternity, and/or birth.

CONGENITAL AND/OR HEREDITARY CONDITION: Any disorder or illness acquired during conception or the fetal stage of development as a result of the genetic make-up of the parents or environmental factors, whether or not it is manifested or diagnosed before birth, at birth, after birth, or years later.

CONSULTATION: A meeting with a doctor to assess or treat a condition.

CONTRACT: The agreement between the insurer and the Group Administrator under which the insurer has accepted the group's Members for coverage.

CORPORATE SERVICE TEAM: The insurer's team of professional and multilingual service executives trained to assist Members with questions regarding their membership, the status of their claims, their coverage, and the updating of their personal information.

CO-PAYMENT: The copayment is the fixed rate of covered expenses that all insured must pay directly to the provider of medical or hospital services before receiving services regardless of the benefit limits and it is indicated in their Table of Benefits.

COUNTRY OF RESIDENCE: The country where the Member resides the majority of any membership year, or where the Member has resided more than one hundred eighty (180) continuous days during any three hundred sixty-five (365) day period while the membership is in effect.

COVERED PREGNANCY: Pregnancies where the actual date of delivery is at least ten (10) calendar months after the effective date of coverage for the respective Member. The respective Member cannot be a dependent child. Only Plans 1 and 2 provide benefits for covered pregnancies.

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.).

DEDUCTIBLE: The amount of covered charges that must be paid by the Member before benefits are payable. There are two kinds of deductible considered under the membership, depending on the country where the treatment or service is provided.

DEPENDENT: Any person other than the Principal Member who is named in the Membership Certificate, who has been identified on the Member Enrollment Form for Group Health Insurance, and for whom coverage is provided under the membership. Eligible dependents include the Principal Member's spouse or domestic partner and any unmarried biological children, legally adopted children, stepchildren, or children to whom the Principal Member has been appointed legal guardian by a court of competent jurisdiction.

DEPENDENT ADULT: A person who presents long-term or permanent functional limitation or disability, understood as a restriction in their physical, mental, intellectual, or sensory capacity, determined by an authorized physician or legally declared; therefore, requiring assistance from a third party.

DIAGNOSIS: The process by which a physician identifies a medical condition by examination (laboratory tests results, X-rays, or any other report or result of clinical examinations), the nature and circumstances of such medical condition, and the decision reached from such examination.

DIAGNOSTIC PROCEDURES: Medically necessary procedures and laboratory testing used to diagnose or treat medical conditions, including pathology, X-rays, ultrasound, and MRI/CT/PET scans.

DOMESTIC PARTNER: A person of the opposite or same sex with whom the Principal Member has established a domestic partnership.

DOMESTIC PARTNERSHIP: A relationship between the Principal Member and one other person of the opposite or same sex. The Principal Member and domestic partner must jointly sign the required affidavit of domestic partnership. All the following requirements apply to both persons:

(a) They must not be currently married to, or be a domestic partner of, another person under either statutory or common law.

(b) They must share the same permanent residence and the common necessities of life.

(c) They must be at least eighteen (18) years of age.

(d) They must be mentally competent to consent to contract.

(e) They must be financially interdependent and must have furnished documents to support at least two (2) of the following conditions of such financial interdependence:

   i. They have a single dedicated relationship of at least one (1) year

   ii. They have joint ownership of a residence

   iii. 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 Principal Member and the domestic partner must jointly sign the required affidavit of domestic partnership.

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).

ELIGIBLE EXPENSES: Refers to those expenses incurred by the insured and that would be covered by the policy provided as long as is indicated under the Table of Benefits, even if those expenses are applied to the deductible.

EMERGENCY: A medical condition (illness or injury) manifesting itself by acute signs or symptoms which could reasonably result in placing the Member's life or physical integrity in immediate danger if medical attention is not provided within twenty-four (24) hours.

EMERGENCY MEDICAL TREATMENT: Medically necessary attention or services due to an emergency.

EPIDEMIC: The occurrence of more cases than expected of a disease or other health condition in a given area or among a specific group of persons during a particular period, and declared as such by the World Health Organization (WHO), or the Pan American Health Organization (PAHO) in Latin America, or the United States Centers for Disease Control and Prevention (CDC), or a local government or equivalent body (i.e. local ministry of health) where the epidemic is developing. Usually, the cases are presumed to have a common cause or to be related to one another in some way.

EUTHANASIA OR ASSISTED DEATH: voluntary, explicit, and consented act of ending the life of a person who has been previously diagnosed with a terminal phase of an illness/(terminal prognosis), through predetermined medical procedures, as they suffer from a severe and incurable disease, or a severe, chronic, irreversible, and incapacitating condition, causing constant and intolerable physical or psychological suffering.

EXPERIMENTAL: The service, procedure, device, drug, or treatment that does not adhere to the standard of practice guidelines accepted in the United States of America regardless of the place where the service is performed. Drugs must have approval from the U.S. Food and Drug Administration (FDA) for use for the diagnosed condition, or other federal or state government agency approval required in the United States of America, independent of where the medical treatment is incurred or where bills are issued.

GROUND AMBULANCE TRANSPORTATION: Emergency transportation to a hospital by ground ambulance.

GROUP ADMINISTRATOR: The authorized representative for the company, firm, business, or individual with whom the insurer has entered into an agreement to provide members with coverage under the group health insurance. This is the individual to whom the insurer will address all correspondence, and who has the responsibility to make payments and notify the insurer of any changes to a membership on behalf of the Member.

HAIR PROSTHESIS (WIGS): The hair prosthesis is a piece formed by a special base in the form of a mesh to which hair fibers are attached.

HIGHLY SPECIALIZED DRUGS: Medications with a special mechanism of action designed to treat highly complex and chronic medical conditions, with a high monthly cost and whose follow-up is done under the strict supervision of a specialist. The Insurer will evaluate and determine if it will cover the active component in any of its generic or commercially available presentations.

HOME HEALTH CARE: Care of the Member in the Member's home, prescribed and certified in writing by the Member'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 (e.g. nurse, therapist, etc.) outside the hospital, and does not include custodial care.

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.

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.

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.

IN-PATIENT HOSPITALIZATION: Medical or surgical care that due to its intensity must be rendered during a hospital stay of twenty-four (24) hours or more. 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.

INFECTIOUS DISEASE: A clinical condition resulting from the presence of pathogenic microbial agents, including pathogenic viruses, pathogenic bacteria, fungi, protozoa, multicellular parasites, and aberrant proteins known as prions, that can be transmitted from person to person.

INJURY: Damage inflicted to the body by an external cause.

MAXIMUM COINSURANCE (stop loss): The maximum coinsurance is the total sum of money for coinsurance that the insured must pay annually, in addition to the deductible, before the company can pay 100% benefits. The maximum coinsurance or "Stop Loss" is reached when the insured has paid the deductible and reached the maximum annual out-of-pocket amount for coinsurance.

MAXIMUM DISBURSEMENT (out of pocket maximum): The out-of-pocket maximum is the maximum amount that the insured must pay for covered medical expenses in a policy year. This amount includes the deductible, coinsurance and copayment.

MEDICALLY NECESSARY: A treatment, procedure, service, or medical supply prescribed by the treating physician and determined by USA Medical Services to be necessary and appropriate for the diagnosis and/or treatment of an illness or injury. A treatment, procedure, service, or medical supply will not be considered medically necessary if:

(a) It is provided only as a convenience to the Member, the Member'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 Member'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.), or

(e) It is custodial in nature.

MEMBER: The insured named in the Membership Certificate. The term "Member" includes the Principal Member and all dependents covered under this membership.

MEMBER ENROLLMENT FORM FOR GROUP HEALTH INSURANCE AND/OR MEDICAL SUPPLEMENT: Documents that contain written statements by applicants about themselves and/or their dependents when applying for coverage, which are used by the insurer to determine acceptance or denial of the risk. This also includes any oral statements made by an applicant during a medical interview held by the insurer, their medical history, questionnaires, and other document provided to, or requested by the insurer prior to the issuance of the membership.

MEMBERSHIP: The policy contracted by the Group Administrator with the insurer to provide coverage for the Members.

MEMBERSHIP CERTIFICATE: Document that specifies the effective date, the particular conditions, deductibles, extent and limitations of coverage, and lists the Principal Member and each covered dependent.

MEMBERSHIP EFFECTIVE DATE: The date stated in the Membership Certificate, on which coverage under this membership begins.

MEMBERSHIP YEAR: The period of twelve (12) consecutive months beginning on the effective date of the Contract and any subsequent twelve (12) month period thereafter.

MULTIPLE TRAUMA: Accidental bodily injuries occurring simultaneously in different parts of the body as a result of a covered serious accident.

NEWBORN: An infant from the moment of birth through the first thirty-one (31) days of life.

NOTIFICATION: The Insured has a mandatory obligation to communicate a notification to the Insurer about the occurrence of an accident or the need to receive emergency treatment. This notification must be made within the first seventy-two (72) hours from the onset of the need for treatment. A third party may provide the notification on behalf of the Insured should the Insured be unable to do so themself. All notifications must be communicated through the accepted support channels, which are specified on the insurance card.

NURSE: A professional legally licensed to provide nursing care in the country where the treatment is provided.

OPTION: The coverage area and maximum annual limit selected by the Group Administrator for the Members of the group.

OUT-PATIENT SERVICES: Medical treatments or services provided or ordered by a physician for the Member 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.

PALLIATIVE CARE: Palliative care will be understood as care provided to patients who do not respond to the curative procedure and are in the terminal stage. They represent an approach to improving the quality of life of patients and their families facing the problems associated with life-threatening diseases. It includes the prevention and relief of suffering through the early identification, assessment and treatment of pain and other physical, psychosocial, and spiritual problems. Palliative radiotherapies or chemotherapies for treatment of pain are not included.

PANDEMIC: An epidemic occurring over a widespread area (multiple countries or continents) and usually affecting a substantial proportion of the population.

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.

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.

PRESCRIPTION DRUGS: Medications whose sale and use are legally restricted to the order of a physician.

PRINCIPAL MEMBER: The named applicant in the Member Enrollment Form for Group Health Insurance, and the first person named on the Membership Certificate, who is entitled to receive reimbursement for covered medical expenses.

PROFESSIONAL OR COMPENSATORY SPORT: The practice of sports professionally or for compensation refers to a voluntary sports practice carried out by athletes, either on their own account or within the organization or direction of a club, league, sports entity or similar, through an established relationship of a regular nature and receiving or with the intention to receive, in exchange, a remuneration derived from this sporting practice in the form of salary, sponsorship or another type of financing or remuneration, and including the respective training even when no compensation is received for it.

PROVIDER NETWORK: A group of hospitals and physicians approved and contracted to treat Members on the insurer's behalf. The list of hospitals and physicians in the insurer's provider network is available from USA Medical Services and may change at any time without prior notice.

RECIPIENT: The person who has received, or is in the process of receiving an organ, cell or tissue transplant.

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.

RIDER: A document added to the membership by the insurer which adds and details an optional coverage.

ROUTINE HEALTH CHECKUP: A medical examination taken at regular intervals to verify a normal state of health or discover a disease in its early stages. A checkup does not include any test or consultation to follow-up on a disease already diagnosed.

SECOND SURGICAL OPINION: The medical opinion of a physician or surgeon other than the current attending physician or surgeon.

SERIOUS ACCIDENT: An unforeseen trauma occurring without the Member's intention, which implies a sudden external cause and violent impact on the body, resulting in demonstrable severe bodily injury that requires immediate hospitalization for twenty-four (24) hours or more 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.

STEPCHILD: Child born to or adopted by the spouse or domestic partner of a Principal Member, whom the Principal Member has not legally adopted.

SURGICAL PROCEDURE: An operation, including consultations immediately before and after the surgery, and all essential aftercare before the patient leaves the hospital.

TERMINAL CONDITION: An active, progressive, and irreversible illness or condition that, without life-sustaining procedures, will result in death in the near future, or a state of permanent unconsciousness from which recovery is unlikely.

TRANSPLANT PROCEDURE: Procedure in which an organ, cell (e.g. stem cell, bone marrow, etc.), or tissue is implanted from one person to another or when an organ, cell, or tissue is removed from the same person and then received back.

TREATMENT: Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve, or cure an illness or injury.

TREATMENT IN URGENCY CARE CENTERS AND CONVENIENCE CLINICS: Are the treatments received in classified Urgent Care Centers in the United States of America. This is a type of medical service center specializing in the diagnosis and treatment of serious or acute medical conditions, which generally require immediate attention; but do not pose an imminent risk to life or health. This service is an intermediate care between the primary doctor and the emergency service. Services in hospital emergency centers or others that are not Urgent Care will not be covered under this benefit.

USUAL, CUSTOMARY, AND REASONABLE (UCR): It is the maximum amount the insurer will consider eligible for payment under a health insurance plan. This amount is determined based on a periodic review of the prevailing charges for a particular service adjusted for a specific region or geographical area.

WAITING PERIOD (SPECIFIC): Period of time that starts on the effective date of the membership during which benefits are not yet payable to the Member.

(a) For pregnancy, maternity, and birth benefits, the Member must have been covered under this membership for a continuous ten (10) month period prior to the actual delivery date.

(b) For HIV/AIDS benefits, the Member must have been covered under this membership for a continuous twelve (12) month period.

(c) For Bariatric Surgery benefits, the Insured must have been covered under the membership for a period of twenty-four (24) continuous calendar months

WELL BABY CARE: Routine medical care provided to a healthy newborn.