# Plan

# Viva Vital

Individual Health Insurance Policy

Effective
**September**

**2024**

Trawick International, Inc
300 Fairhope Ave. Suite G.
Fairhope, AL 36532 USA

TRAWICK International

Plan

# VIVA VITAL

Valid

## September 2024

It is our pleasure to welcome you to Trawick International, and thank you for allowing us the opportunity to serve you. We understand that choosing the right international health insurance policy is an important decision, and we want to assure you that we are committed to providing you with access to the best possible service and treatment anywhere in the world.

We take pride in our innovative products and have created a program that not only covers you in case of an unforeseen medical event, but also rewards you when you do not need to make use of your policy.

This guide was created in order to explain all of your policy coverages, limits and conditions in greater detail. We urge you to carefully review this document and reach out to your insurance agent, or to us, with any questions. Our team of experienced professionals are available to guide you through any questions you may have.

We look forward to building a long-lasting relationship with you. Once again, thank you for choosing Trawick International.

Sincerely,

**Daryl Trawick**

**CEF/Founder**

CONTENTS

## OVERVIEW OF COVERAGES

Below please find a Summary of Benefits offered in plan options VIVA VITAL. Please refer to your selected plan options, Schedule of Benefits, and Certificate of Coverage in order to find your specific covered benefits. Unless otherwise stated, the benefits are offered on a per Insured/per Policy Year basis in which the chosen Deductible applies. All amounts are in U.S. Dollars (USD). The benefits are limited to the medical expenses covered under the Policy and are subject to Usual, Customary and Reasonable (UCR) expenses for the geographic area where the expenses were incurred. All benefits with **100% (√)** coverage are up to the specific Policy limit. Benefits with established coverage will be up to the limits stated in your relevant Policy. Please refer to your Policy's Schedule of Benefits for your applicable established benefits, including applicable deductibles Capitalized words are defined terms of special relevance and meaning in this document.

# Viva Plan Vital

## SUMMARY OF BENEFITS

| Viva Plan Maximum Annual Benefit | VIVA VITAL (Hospitalization Plan) |
|---|---|
| USD | **$3,000,000.00** & $1M |
| **Viva Plan Deductibles** | **VIVA VITAL (Hospitalization Plan)** |
| Outside USA | $500, $1,000, $2,000, $3,000, $5,000, $10,000, $20,000 |
| In USA | $1,000, $2,000, $3,000, $5,000, $10,000, $20,000 |
| **Viva Plan US Hospital Networks** | **VIVA VITAL (Hospitalization Plan)** |
| | ○ **Free Choice (Worldwide)** |
| **Viva In-Patient Benefits** | **VIVA VITAL (Hospitalization Plan)** |
| Private and Semi-Private Room | ○ In network – Standard 100% UCR |
| Intensive Care Unit | ✓ |
| Surgery (Including Outpatient Surgery) | ✓ |
| Emergency Room | ✓ (if admitted immediately as an inpatient) |
| Hospital Accommodation for Companion of Hospitalized Child under 18 years | $175 per night, max. of 30 nights |
| Hospital Accommodation for Companion of Hospitalized Insured 18 years and older | ✓ max. of 21 nights |
| Surgeon and Anesthetist Fees | ✓ |
| Major Diagnostic Services (Inpatient) | ✓ |
| Inpatient Consultation by a Physician or Specialist | ✓ |

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# VIVA VITAL

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|---|---|
| Prescribed medications while hospitalized | ✓ |
| Oncology: cancer tests, treatment (chemotherapy and/or radiotherapy) and medication | ✓ |
| Dialysis | ✓ |
| Congenital and Hereditary Conditions<br>The benefit can never exceed the policy's maximum benefit | ✗ |
| Organ Transplant Procedures, Maximum per organ/ tissue, per lifetime | $1,000,000 per organ or tissue, lifetime per Insured, after deductible, including $60,000 for living donor |
| Surgical treatment for symptomatic disorders of feet<br>24 month waiting period applies | ✓<br>(Surgical treatment only) |
| Emergency Dental Coverage | ✓ |
| Reconstructive surgery in case of Illness or Accident | ✓ |
| Surgical Implants or prosthesis (Excluding dental) | ✓<br>(as a follow up to a covered hospitalization) |

| Viva Out - Patient Benefits | VIVA VITAL (Hospitalization Plan) |
|---|---|
| Outpatient Diagnostic Testing - Echocardiography, Ultrasound, CAT Scan, PET Scan or MRI, Endoscopy (e.g., gastroscopy, colonoscopy, cystoscopy), X-Rays and Laboratory | $15,000<br>(Pre-surgical testing only, Pre-authorization required) |
| Nurse or Therapist care at home | $10,000 |
| Physician and Specialist Visit | $6,000 for up to 10 months from the date of the discharge<br>(visit for pre-hospitalization and as a follow up to a covered hospitalization) |
| Physical Therapy & Rehabilitation | ✓<br>max. of 60 visits (following a covered Hospitalization) |
| Durable Medical Equipment, Special Devices, External prosthesis, Orthotic devices | ✓<br>(as a follow up to a covered hospitalization) |
| Prophylactic surgery for cancer risk reduction | ✗ |
| Bariatric Surgery, gastric bypass and any type of surgical procedure for loss of weight, its complications, treatments and/or medications | $10,000 Lifetime<br>(after a 24-month Waiting Period) |
| Refractive Surgery (Lasik) Lifetime maximum | ✗ |
| Prescribed Medications | ✓<br>up to 6 months after discharge, max. of $3,500 per Policy Year |

| | |
|---|---|
| Treatment of Allergies | Acute allergies that result in hospitalization |
| HIV/AIDS | $50,000 per Lifetime<br>(after a 24-month Waiting Period) |
| Routine Health Checkup<br>No deductible applies<br>No waiting period | ✗ |
| Preventive Care<br>No deductible applies<br>No waiting period<br>* Deductible inside/outside the U.S. $5,000 or less - Worldwide<br>* Deductible inside the U.S. $10,000 or more and outside the U.S. $5000 or less - Outside the U.S. | ✗ |
| Hearing aid | ✗ |
| HPV (treatment and vaccine) | ✗ |
| Specialized Treatments (occupational therapy, speech therapy, autism, sleep apnea and other sleep disorders) | ✗ |
| Complementary Therapy; (Chiroprator, psychologist, psychiatrist, osteopathy, and/or acupuncture). | ✗ |

| **Viva Maternity Benefits** | **VIVA VITAL (Hospitalization Plan)** |
|---|---|
| Maternity - normal delivery or c-section<br>(10 month waiting period applies) | ✗ |
| Maternity and Birth complications<br>(10 month waiting period applies) | ✗ |
| Extraction and storage of Stem Cells | ✗ |
| Inclusion of the newborn within 90 days after the birth | ✗ |

| **Additonal Benefits** | **VIVA VITAL (Hospitalization Plan)** |
|---|---|
| Emergency Transportation Air Ambulance * | ✓<br>(to the closest hospital, if admitted immediately as an inpatient)<br>o deductible applies |
| Emergency Transportation Ground Ambulance | ✓<br>(to the closest hospital of qualified treatment)<br>No deductible applies |
| Cost of return ticket for the Insured and one companion after an Evacuation by Air Ambulance (combined) | ✗ |

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# VIVA VITAL

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|---|---|
| Coverage Alzheimer disease | ✓ (Hospitalization & RX) |
| Dementia | ✓ (Hospitalization & RX) |
| Repatriation of Mortal Remains or Cremation Services | $25,000 |
| Palliative/Hospice Care | ✓ |
| Coverage for Accidents While Practicing Professional Sports | ✗ |
| Deductible will be waived up to $5,000 maximum in case of an Emergency or Accident that occurs while the Insured is travelling outside of country of residence | ✗ |
| In case of a Serious Accident, as defined in this Policy, no deductible will apply for the first Medically Necessary Hospitalization immediately following said Serious Accident. | ✗ |
| In the event of death of the Primary Insured, his/her Insured Dependents will have free coverage after the last paid period | ✗ |
| Deductible reduction for no claims for 3 years [1] | Reduction of 50% of the Deductible for 1 year after the 3rd year without claims |
| Deductible carry-over | ✓ |
| Second Medical Opinion | ✓ |

[1] Routine medical checkups and claims where the Insurer does not issue payments to a Provider or to the Primary Insured will not be taken into account to qualify for this discount.

* Emergency transportation on Air Ambulance to the nearest suitable medical facility, for treatment of a Covered Condition for which treatment cannot be provided locally and when transportation by any other method would result in loss of life or limb.
* **All arrangements must be pre-approved and coordinated by The Company for this coverage to take effect.**

## OUR AGREEMENT

Trawick International LLC PIC, (hereinafter the “Company”), undertakes to pay the Primary Policyholder the benefits detailed in this Policy related to the covered expenses incurred by him/her or his/her eligible Dependents, as a result of any medical treatment, medical service and/or medical supply as of the Effective Date of the coverage of this Policy.

Trawick International LLC PIC is a segregated portfolio company licensed as an insurance company in the Cayman Islands and supervised by the Monetary Regulatory and Advisory Body of the Cayman Islands. Third Party Administrator (TPA), a designed entity (Trawick International LLC) by the Insurer for the purposes of providing administration services of this policy on behalf of the Company, hereafter referred to, sometimes collectively, as the “Plan Administrator”.

All compensable benefits are subject to the terms and conditions of the Policy, including the applicable Deductibles, maximum benefits and the limits detailed in the Table of Benefits and the Certificate of Coverage, which are an integral part thereof.

***Important notice about the Application***

This Policy has been issued based on the statements provided in good faith by the Primary Policyholder. If any of the information disclosed in the Application is false, incorrect, inaccurate, incomplete, is or had the intent of misleading or deceiving, or was omitted, resulting in worsening the risk, the Policy will be rescinded, will have no effect, and the Company will not be responsible for any payments of the benefits offered under this Policy. Likewise, if a Provider or any other individual or entity who has rendered medical services to the Policyholder and/or to one of the Insureds should submit false statements in collusion with the Policyholder and/or one of the Insureds with the purpose of claiming payments against this Policy, this Policy, its articles and/or Amendments will be, at the discretion of the Company, rescinded or canceled, will have no effect, and the Company will not be responsible for any payment of the benefits offered under this Policy. The Policyholder and/or the Insured(s) would have to reimburse the Company on first demand, for any payments it may have made as a result of an omission, incorrect disclosure or Negligence by the Policyholder and/or the Insured(s). In case of cancellation or rescission, the Company will apply the amount of the unearned premium to the total payments made for any of the aforementioned causes.

***Your right to examine the Policy***

The Policyholder understands that this Policy is an international health insurance plan that is not subject to regulations and/or mandatory coverages required by the laws of his/her Country of Residence or other jurisdictions. Therefore, it may not comply with coverage, underwriting, or other insurance regulatory provisions of the Insured's Country of Residence. This insurance Policy is not subject to and does not provide certain benefits required by the United States Patient Protection and Affordable Care Act (PPACA). The Policyholder must review the terms of the coverage to verify he/she is in agreement with the coverage offered or otherwise request the cancellation of this Policy and return it to the Company within a ten (10)-day period after receiving it (the "Examination Period").

***Right to Reimbursement of the unearned premium***

If during the Examination Period no claims have been made, the Company will reimburse the total premium paid by the Insured (minus a seventy-five dollar (US$ 75.00) administrative fee), and the Policy will be nullified and void as if it was never issued.

If the Applicant, the Policyholder or the Company cancels the Policy after the Examination Period, or after it has been reinstated or renewed, the Company will reimburse the unearned portion of the premium, minus the seventy-five dollar (US$75.00) administrative fee, up to a maximum of sixty-five percent (65%) of the total amount of the premium. The administrative fee and a thirty- five percent (35%) retention by the Company will not be reimbursed. In case of rescission of the Policy, the Company will apply the premium received to any payment made for a claim against the Policy

***Components of the entire contract***

The entire contract between the Policyholder and the Company includes:

A. The Policy (this document);
B. The Application signed by the Applicant which was used for underwriting to evaluate the risk;
C. Any medical exam that may have been required by the Company, as well as any other document that may have been needed at the time of application, including but not limited to the results of the telephone interview done by the underwriter (if any), medical records, and any other relevant information for the evaluation of the coverage;
D. Table of benefits
E. Any form or document that may be required to add new eligible Dependents to the Policy or to modify the Coverage;
F. The Certificate of Coverage (including any Amendments thereto (if applicable)), which modify the terms and conditions of this Policy; and Amendments (if applicable) which modify the terms and conditions of this Policy

## DURATION OF COVERAGE

The coverage lasts twelve (12) months and will renew automatically for the same period of time upon receipt of full payment of premium, subject to the definitions, conditions and other provisions of the Policy that are in effect at the time of renewal. The coverage begins at 00:01 Eastern Standard Time on the Effective Date of this Policy and ends at midnight 24:00 three hundred and sixty-five (365) days later.

## ELIGIBILITY

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

A. Reside in a country other than the United States of America (USA);
B. The Policyholder and his/her Spouse, concubine, or Domestic Partner must be at least eighteen (18) years old and no greater than seventy-four (74) years old, except for minors authorized by one of their parents or legal guardian;
C. Dependent children are eligible up to:
    a. Eighteen (18) years old if they are single; or
    b. Twenty-four (24) years old if they are single and full-time students ("Full-Time Student" defined as a student enrolled at accredited academic college or university taking a minimum of twelve (12) credits per semester at the time the Policy is issued or renewed;
D. Pay the total applicable premium.

Applicants over sixty-four (64) years of age must submit additional medical information for evaluation. The Company may reimburse them up to a maximum of fifty dollars (US$ 50) to cover the cost of requested the medical information once the coverage is approved and the premium has been paid. There is no maximum age for the renewal of this Policy.

Coverage is available for the Policyholder's Dependent children until the day before they turn eighteen (18) years old if they are single, or until the day before they turn twenty-four (24) if they are single and Full-Time Students.

The Company reserves at any moment during the duration of the Policy the right to request a student certification issued by a representative of their university. Additionally, there will be an adjustment of the premiums if the Dependent remains outside his/her Country if Residence for a period of more than one hundred and eighty (180) total days within a twelve (12) month period. When Dependents no longer qualify as such under a Policy, they will be eligible to obtain coverage under their own Policy without underwriting by paying a corresponding premium in a plan with the same or a higher Deductible under the same conditions and/or restrictions of the previous Policy. The Dependent's Application must be received by the Company before the end of the Grace Period of the Policy under which he/she had coverage with the Company.

## HOW IS MY DEDUCTIBLE APPLIED?

Deductible in Policies with only one (1) Insured: Each Insured is obliged to cover the amount equivalent to one (1) Deductible per Policy Year, whether within or outside the United States, depending on where the benefit is received.

Deductible in family Policies or two (2) or more Insureds: For Policies with two (2) or more Insureds, or family policies, the maximum amount of two (2) Deductibles per Policy, per Policy Year must be covered.

Services both inside and outside the United States*: When the Insured has already covered the Deductible outside the United States and other medical services have been provided in the United States, the Insured will be responsible for the payment of the difference between the total amount of both Deductibles. That is, the remaining total of the amount of the Deductible outside the United States minus the amount of the Deductible within the United States.

Services both inside and outside the United States in family Policies: When the two (2) Deductibles have already been covered outside the United States and other medical services have been provided inside the United States, the Insured will be responsible for the payment of the difference between the total amount of both Deductibles (the two (2) amounts from outside and the two (2) amounts from within the United States). That is, the remaining total of the amount of the Deductibles outside the United States minus the amount of the Deductibles within the United States.

The amounts applied to the Deductible by different family members within the same family Policy will be taken into account to reach the payment of the amount of the two (2) Deductibles required per Policy Year.

*For Deductible options with different amounts for outside and inside the United States.
Increased Deductible
During the underwriting process, the Company may impose an additional increased Deductible for the coverage of a specific medical condition, which will be stated in the Certificate of Coverage. There are two types of additional Deductibles:

A. Additional Deductible per Policy Year; and
B. Additional Deductible for the life of the Policy.

Additional Deductible per Policy Year: the additional amount the Insured must pay each year if a claim pertaining to the referred medical condition is submitted. This additional Deductible per Policy Year will be applied each year of coverage on a separate accumulator from the annual Deductible of the Policy. Both Deductibles must be met separately if the specific medical condition is the reason for any claim. However, for any other medical service offered by the Policy, not related to the medical condition for which an additional Deductible was imposed, only the regular annual Deductible of the chosen plan and option at the time of application must be met.

Additional Deductible for the life of the Policy: the additional amount the Insured must pay for the life of the Policy if a claim pertaining to the referred medical condition is submitted. This Deductible for the life of the Policy will begin to apply after satisfying the annual Deductible of the plan and option chosen at the time of application. Once the annual Deductible is satisfied, all expenses for medical services pertaining to the specific medical condition for which the increase in Deductible was applied for the life of the Policy will continue to be applied to this additional Deductible until it is fully satisfied (paid in full)

Any amount applied annually to the accumulator of the increased Deductible for the life of the Policy will be added until it is fully satisfied. Once this Lifetime Deductible is satisfied, it will be eliminated, and only the annual Deductible of the chosen plan and option will remain the responsibility of the Insured.

In all cases, the annual Policy Deductible must be covered when making a claim. If the claim pertains to the medical condition for which the additional Deductible was imposed, the Insured must cover both Deductibles.

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

In case of a Serious Accident, as defined in this Policy, no Deductible will apply for the first Medically Necessary Hospitalization immediately following said Serious Accident. Any subsequent treatment will incur the Deductible.

The Deductible will be reduced by fifty percent (50%) to the insured that has not filed any claims for three (3) consecutive policy years. This benefit does not apply in the case of family deductibles. Once a claim has been filed, to qualify for this benefit, a new period of three (3) policy years begins at the next Anniversary date.

Change to another deductible or plan that has this benefit does not interrupt the three (3) policy year period without submitting claims.

The lower of the benefits is applied until a new period of three (3) policy years begins.

The benefit applies only to options with a value equal to or less than five thousand (USD $5,000) dollars deductible.

*Routine medical checkups and claims where the Insurer does not issue payments to a Provider or to the Primary Insured will not be taken into account to qualify for this discount.

The deductible will be waived up to a maximum amount of $5,000 per event, in the case of an accident, incident or emergency while the Insured is traveling for business or tourism outside of their country of residence.

The Insured must present evidence of international travel of temporary nature such as a passport, entry / departure dates, copy of the business/tourist (nonimmigrant) visa.

This benefit covers medical treatments incurred or treated in hospital emergency rooms, centers, or health providers such as Emergency or Urgent Centers, Outpatient Clinics and Private Medical Facilities and is subject to the following considerations:

Events related to chronic medical conditions, such as Arterial Hypertension, Diabetes Mellitus, etc.: they only qualify for this benefit if the patient has been stable and without changes in the treatment of the condition in question for at least the six (6) months prior to the event or emergency. The Deductible will be waived only for the medical expenses incurred or indicated during the care of said accident, incident, or emergency. An immediate follow-up medically necessary related to the same event would be also exempt from Deductible.

For any other medical event or further treatment, including but not limited to physical and rehabilitation therapies, the corresponding deductible will apply. In case of deductibles over $5,000, the Insured will cover the difference, after the exoneration of this maximum amount.

Exclusion: All benefits in this Policy related to the Deductible refer only to the annual Deductible of the plan and option chosen. Therefore, the amounts applied to the Deductible increase in the last three (3) months before the Anniversary Date of the Policy will not be taken into consideration for the Deductible carry-over benefit, nor the Deductible elimination or reduction benefit for not submitting claims for three (3) consecutive years.

## PREMIUM PAYMENTS

Premium payment - Payment of the premium is the responsibility of the Contracting Party or the Policyholder, whichever may be the case. The premium is payable on the Renewal Date of this Policy according to the mode of payment selected. Payment of the premium renders the Policy effective during the period for which the premium has been paid. Any excess premium paid will be reimbursed without inclusion of any interest and in the same manner as it was paid. Failure to pay the total premium will result in the termination of the Policy. For compliance reasons, the Company reserves the right to accept advance or future payments for insurance premiums. The renewal of this Policy is guaranteed for life according to the terms and conditions of the effective Policy at the time of renewal, as long as the premium is paid, and the eligibility requirements of this Policy are maintained.

Payment mode - Premiums can be paid annually, semi-annually, quarterly, or according to the payment mode established by the Company. Payment mode changes will be made only on the Anniversary Date of the Policy. The premium is payable on the Expiration Date of the Policy. Renewal notices are issued as a courtesy, and the Company does not guarantee their delivery. Payment of the premium is the responsibility of the Contracting Party or the Policyholder, whichever may be the case, and if the payment notice has not been received, he/she must contact the Company or registered Agent.

Termination of coverage after the Expiration Date - When a Policy is terminated for any reason coverage will cease on the termination date, and the Company will only be responsible for the treatments covered under the terms of the Policy that took place before its termination date. There will be no coverage for any treatment that occurs after the termination date, regardless of when the Injury or medical condition was first presented or how much additional treatment may be required.

Grace Period - The Company grants a thirty (30)-day Grace Period to pay the renewal premium corresponding to the Policy. The Grace period begins the day after the Expiration Date, according to the selected payment mode. If the full premium is not received by the Company before the Grace Period ends, this Policy shall be deemed expired as of its Expiration Date. During the Grace Period, no benefits or payments will be provided for expenses incurred after the Expiration Date. If the premium is paid during this period, the Policy will be renewed.

The Company may coordinate the payment of the pending premium with the Agent or directly with the Policyholder, at its sole discretion. However, the Company’s additional collection procedures are not equivalent to waiving the right to terminate this Policy due to non-payment of the total premium due on its Expiration Date, as established in this Policy.

It is the absolute responsibility of the Policyholder to pay the premium due on time. The fact that there might be claims or administrative requests pending with the Company does not exempt  or extend the term for the payment of the premium on its Expiration Date or the consequent expiration of the Policy.

Failure to pay the total premium due on the Expiration Date shall be understood as the express will of the Policyholder to not renew the Policy. Likewise, the implicit compliance with the registration requirements set by the Company, when applying for insurance coverage again after the renewal deadlines have elapsed, as defined herein, shall be understood as the express will of the Policyholder to renew this Policy.

Rate changes - The Company has the right to change the premium rates annually on the Anniversary Date of the Policy based on the Country, geographical area within the same country and/or Region of residence, age groups c in four (4)-year age band periods, and/or depending on the number of children who qualify as Dependents. In no event will the Company modify the rates of an individual Insured based on his/her claim history.

Policy reinstatement - After the cancellation of a Policy for non-payment of the required premium, this Policy may be reinstated if a new Application is submitted. The Company reserves the right to approve or deny such Application.

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Policy reinstatement - After the cancellation of a Policy for non-payment of the required premium, this Policy may be reinstated if a new Application is submitted. The Company reserves the right to approve or deny such Application.

## WHAT TO DO WHEN YOU NEED TREATMENT/NOTIFICATIONS

Some of the benefits covered by this Policy are subject to advance notice requirements (Notification). Through the notification requirement, the Insurance Company is able to confirm the eligibility of the Insured, authorize the provision of the corresponding services, negotiate better discounts in favor of the Insured, and control the medical cost. Under all circumstances, the Insured must notify the Insurance Company of his/her intention or need for Hospitalization, outpatient surgery, Major Diagnostic Tests, and ground and air ambulance services.

Additionally, the Insured must obtain the necessary pre-authorization and coordination by the Insurance Company for any of the following benefits:

- Hospitalization
- Reconstructive surgery in case of illness or Accident
- Durable Medical Equipment or special devices
- Emergency Transportation by Air Ambulance
- Bariatric Surgery, gastric bypass and any type of surgical procedure for loss of weight
- Ambulatory Physical Therapy, Rehabilitation, and Home Health Care

- Repatriation of mortal remains or cremation services
- Oncology: cancer tests, treatment (chemotherapy and/or radiotherapy) and medication
- Organ and tissue transplants
- Palliative Care
- Prophylactic surgery to reduce cancer risk
- Dialysis

## TIME LIMITS FOR PRE-AUTHORIZATIONS/NOTIFICATIONS

***Pre-Authorization/Notifications***

The Insured must notify the Company at least seventy-two (72) hours prior to receiving any medical services that require notification or pre-authorization. The Company must also be given notice of all medical Emergencies that require notification within seventy-two (72) hours after the event that caused the Emergency. If the Policyholder and/or the

Insureds fail to notify the Company accordingly, they shall then be responsible for thirty percent (30%) of all covered costs after payment of the applicable Deductible.

To notify the Company, the Insured may send an e-mail to precert@trawicklatam.com or fill out the medical notification form on at www.portal.trawicklatam.com or by downloading the mobile app, or on our website www.trawicklatam.com.

***Claims Submission***

Claims or invoices related to expenses covered under this Policy must be submitted to the Company within a period of one hundred and eighty (180) days after the date of service of same to be eligible for coverage.

***Medical records***

The Policyholder, because of the underwriting and/or claims process, must provide the Company with all the medical information required. Additionally, the Policyholder, as well as his/her Dependents, must authorize the Company to obtain any medical report, documentation and/or access to the patient in case deemed necessary to complete the underwriting or claim process, as the case may be. Otherwise, the claim could be denied until the necessary information and authorizations are received.

***Medical notifications***

Insureds must notify the Company prior to receiving those medical services that require notification or pre-authorization by calling the telephone number or via the e-mail listed on the back of their ID card. If the Policyholder and/or Insureds fail to notify the Company accordingly, they will be responsible for thirty percent (30%) of all covered costs, in addition to the applicable Deductible.

***Claims***

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

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

Some of the benefits covered by this Policy are subject to advance notice requirements (Notification). Through the notification requirement, the Insurance Company is able to confirm the eligibility of the Insured, authorize the provision of the corresponding services, negotiate better discounts in favor of the

Insured, and control the medical cost. Under all circumstances, the Insured must notify the Insurance Company of his/her intention or need for Hospitalization, outpatient surgery, Major Diagnostic Tests, and ground and air ambulance services.

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

A. Claim Form duly completed;
B. All itemized bills from the Provider detailing the services rendered, along with proof of payment;
C. A recent medical history or any other medical information that the Company may consider pertinent;
D. For pharmacy expenses, a copy of the medical prescription;
E. In the event of an Accident, the Insured must submit all information related to said Accident, as well as the circumstances surrounding it, pursuant to what is required by the Company. This includes, but is not limited to Accident reports, police reports or other reports when issued by the pertinent authorities, or any other information available from any other third parties involved in the matter;
F. Declare any other medical insurance coverage the Insured may have when submitting a claim.

When simultaneously submitting multiple claims for reimbursement for different Insureds, the expenses for each Insured, Accident, Illness and/or Provider must be separated for each Insured and event. Once the claim process has been initiated, the Insured must send all the information requested by the Company within a period of no longer than ninety (90) days from the first request by the Company to complete their claim. Once this period has expired without receipt of the requested information, the claim will not proceed, and the Company will be relieved of any obligation.

Should the information provided be considered inadequate or incomplete in any manner, a delay in the payment or reimbursement process may be caused, or it may render the claim to be temporarily closed until the necessary information is received within the stipulated deadline. The Company reserves the right to request the original receipts, medical records and/or any other relevant documentation in order to process the claim. The Company will not return original documentation received to process a claim; however, it may offer a copy of such documentation when requested.

In the event that a claim that should have been denied because coverage was excluded from the Policy,  was not compensable for any other reason, or has been paid in error, the Company will not be obligated to continue paying for the expenses of treatments or services related to such claim from the date of the identification of the error and may request the reimbursement of the amounts unduly paid.

***Guarantee of Payment (GOP) letter***

Upon receiving a request from the Insured or a Provider, the Company may issue a Guarantee of Payment, so the Insured begins to receive the required care. If during the treatment or Hospitalization of the Insured the Company receives information that the care or claims are not compensable due to undeclared Preexisting Conditions, Policy exclusions or any other reason that invalidates the coverage, the guarantee issued will be withdrawn, and the Insured must assume the total responsibility for the non-compensable expenses towards the Provider.

The Company will not be responsible for any fees charged by the receiving bank, such as commissions for currency exchange or for incoming wire transfers. These charges will be the responsibility of the recipient of the payment.

## APPEALS

In the event of any disagreement between the Insured and the Company regarding a claim or administrative decision, before any other action is taken, the Insured must begin an appeal about the claim or decision to the Company's Appeals Department for review and analysis. The appeal must be submitted within a period of no more than thirty (30) days from the date the administrative decision or a claim was made.

To appeal, the Insured must submit a letter appealing the claim to service@trawicklatam.com. Said letter must include all relevant information, as well as copies of all documents considered necessary to re-evaluate the decision made.

The Company's Appeals Department will review the appeal in detail and will notify its decision to the Insured in writing within thirty (30) days following receipt of the appeal letter along with all pertinent information and/or documentation. During the process, the Company's Claims Department will have

the right to request additional information or documentation from the Insured or the Providers, third parties or entities, if deemed necessary, to accurately evaluate the arguments of the appeal.

***Second instance of appeal***

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

## TERMS AND CONDITIONS OF YOUR COVERAGE

***The plans that you selected are indicated in your Schedule of Benefits, which lists all the benefits you are covered for and any applicable limits, including any applicable waiting periods. For an explanation of how your benefit limits apply to your plan, please see the "Benefit limits" paragraph below.***

Please note that your benefits are also subject to:

- Policy definitions and exclusions (also available in this document).
- Any special conditions indicated on your Insurance Certificate (and on the Special Condition Form issued prior to policy inception, where relevant).

***Geographical coverage***

This plan provides coverage with free choice of Hospitals and Doctors anywhere in the world through direct payment to the Providers or reimbursement to the Policyholder. However, when seeking elective medical treatment within the United States, the coverage is limited to the Company's Networks corresponding to the Region. This rule does not apply for Emergency treatments, meaning that if the Insured receives Emergency treatment in the USA, he/she will have access to any Hospital. If an Insured receives non-urgent services outside the corresponding Networks in USA, the Insured will be responsible for forty percent (40%) of all covered expenses in addition to the Deductible.

This Policy has a Waiting Period of thirty (30) days beginning on its Effective Date. During this waiting period, coverage will only apply to conditions or injuries caused due to an Accident or an Infectious Disease. Any other condition or symptom not caused by an Accident or of infectious origin and that manifests for the first time during this Waiting Period will be permanently excluded for that particular insured for the rest of the time he/she is insured under this Policy, with the exception of a covered pregnancy.

***Waiving of the Waiting Period***

The thirty (30)-day Waiting Period may be waived at the sole discretion of the company if all of the following requirements are met:

A. The prior coverage is disclosed in the Application, and the Company receives a copy of the prior Policy as well as the receipt for payment for its last twelve (12) months;
B. The Application is submitted to the Company within thirty (30) days following the termination of the coverage of the previous Policy; and
C. The Insured was covered by medical insurance equivalent to this Policy which was in force for a consecutive period of at least twelve (12) months immediately after its Effective Date.

If the Waiting Period is waived, the benefits payable under this Policy for any condition that occurs during this thirty (30) day waiting period are permanently limited to the lesser of the benefits offered by this Policy or the prior Policy for the rest of the time that the Insured remains insured under this Policy.

The above waiting period waiver is not applicable for the ten (10)-month Waiting Period for maternity care benefits, as well as other Waiting Periods required for other benefits, as stipulated in this Policy.

***Coordination of Benefits***

When the Insured has other insurance coverage, it must be disclosed to the Company at the time of application or when submitting a claim.

The coverage under this Policy will act as secondary to any other Policy or healthcare plan. The Company will provide benefits after the claims have been submitted to the primary insurance plan first, and only when benefits payable under the primary Policy have been satisfied. Only the benefits offered by this Policy will be considered for this coordination with other insurers.

The Company shall process a coordination of the benefits in which the amounts paid by the other insurance company will be applied to the Deductible in accordance with the benefits and limitations of this Policy. When filing a claim subject to coordination of benefits, proof of the other insurance coverage must be submitted along with copies of medical records, itemized invoices, Explanation of Benefits (EOB) of the primary insurer, as well as proof of payments made by the other insurance company. The total amount of payments is not to exceed the total of the expenses incurred; the Company shall not pay any amount reimbursed by the other company even though it may exceed the Deductible of this Policy.

***Currency***

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

***Non-renewal, rescission, or cancelation of the Policy***

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

A. The information disclosed in the Application is false, incomplete or when fraud has been committed, any of which may have caused the Company to approve the Policy when, had the Company been provided with the correct information, it would have issued the Policy under certain conditions or would have deemed that the Applicant was a non-insurable person;
B. The Insured and/or his/her Dependents change Country of Residence and fail to notify the Company within a thirty (30) day period;
C. The Policyholder or Contracting Party (if applicable), requests the cancellation of the coverage in writing or doesn't pay the premium as stipulated in this Policy;
D. The Insured submits a claim or information deemed fraudulent by the Company. In the event of such fraud, the Policyholder shall be responsible and will have to reimburse the Company for any payments made in reference to the claim in question, whether the payment was made in the form of a reimbursement to the Insured or directly to the Provider;
E. The marital status of the Policyholder changes due to divorce, or separation in case of Domestic Partners. The Insured should notify the Company within thirty (30) days of the date of the divorce or separation. Coverage for the Dependent Spouse will cease at the end of the Policy Year ;
F. The Insured lives in a country that is subject to an embargo or is sanctioned by the Office of Foreign Assets Control (OFAC), or if an Insured is on any of the lists of persons sanctioned by OFAC, or similar entities in the United Kingdom and the European Union; or
G. The Insured spends more than one hundred and eighty-three (180) days out of a three hundred and sixty-five (365)-day period in the United States or any of its territories.

***Policy issuance***

This Policy is deemed solicited, issued, and delivered when the Policyholder receives it in his/her Country of Residence.

The Company does not solicit, sell, or accept applications for any insurance policy to be delivered or issued to any person in any state of the United States. If it is determined that the Policy was solicited, sold and/or delivered in the United States or any of its territories, it must be canceled or rescinded.

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

***The translation of this Policy into other languages is provided as a courtesy for the Insured's convenience. However, the English version will prevail and will be the governing contract in case of any doubt or dispute regarding any provision of this Policy.***

***Coverage for Pre-existing Conditions***

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

Pre-existing Conditions that were not declared will not be covered, and omission of declaration may lead to the modification, rescission, or cancelation of the Policy. The Company, at its sole discretion, may modify, rescind, cancel, or non-renew the Policy due to the omission of a Pre-existing Condition.

## INPATIENT BENEFITS

***Private and Semi-Private Hospital Room***

The coverage for the Hospitalization of an Insured in a Standard Room is one hundred percent (100%) UCR within the corresponding Preferred Provider Network (when applicable). Outside the Preferred Provider Network (when applicable), the coverage will be applied at a rate of 60% of charges.

***Intensive care unit***

The coverage for the treatment of an Insured in an intensive care unit is one hundred percent (100%) UCR within the corresponding Preferred Provider Network (when applicable). Outside the Preferred Provider Network (when applicable), the coverage will be applied at a rate of 60% of charges.

***Surgery (Including Outpatient Surgery)***

The coverage for Surgery in a Hospital, Clinic or medical office is one hundred percent (100%) UCR. Coverage for this care or treatment must be authorized in advance by the Company.

***Emergency Room***

The coverage for Emergency room care to treat an Emergency or Accident, as defined in the Policy, is one hundred percent (100%) UCR.

***Hospital Accommodation for Companion of a hospitalized Insured***

***Under eighteen (18) years old***

The coverage is for an adult companion accommodation of a hospitalized Insured Dependent under the age of eighteen (18) and is limited to the amount per day specified under the elected plans options Schedule of Benefits.

***Over eighteen (18) years old***

The coverage is for an adult companion accommodation of a hospitalized Insured eighteen (18) years of age and older is one hundred percent (100%) UCR, for up to a maximum of twenty-one (21) nights.

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

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

***Surgeon and Anesthesia Fees***

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

***Major Diagnostic Service (Inpatient)***

The coverage for pathology and laboratory medicine, radiology, and nuclear medicine of an Insured is one hundred percent (100%) UCR if Medically Necessary for the diagnosis and treatment of the Illness or injury for which an Insured is hospitalized.

***Inpatient Consultation by a Physician or Specialist***

The coverage for Physician and Specialist visits during a covered Hospitalization is one hundred percent (100%) UCR.

***Prescribed Medications while hospitalized***

The coverage for Prescription Medication, prescribed during a Hospitalization, is one hundred percent (100%) UCR.

To request approval of Prescribed Medications, a copy of the prescription written by a Physician (defined as a board-certified medical professional in the provider's country of residence) to treat a condition covered by this Policy must be sent along with the claim.

***Highly specialized Prescription Medications***

Highly specialized Prescription Medications indicated for a specific use will be covered within the limits of the corresponding benefit indicated in the Table of Benefits, as long as they are coordinated and approved in advance by the Company. The Company will coordinate the delivery of such Prescription Medication directly to the Insured with its Providers. The Insured must accept the conditions of the Company for the supply of such specialized Prescription Medications, by either receiving treatment with the specific Provider designated by the Company or according to the delivery method available. The Company will provide the generic Prescription Medication as the first option when available.

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

***Oncology***

This benefit refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis.

***Dialysis***

This benefit shall be covered if and when it is Medically Necessary and as the result of a medical condition covered under the terms of this Policy, such as but not limited to, Kidney Failure or impaired kidney function.

***Organ Transplant Procedure, Maximum per organ/tissue, per lifetime***

Coverage is provided for the transplant of any human organ or tissue in accordance with percentage and maximum allowable amounts as per Plan election.

A. Every pre-Transplant care, which includes those services directly related to the evaluation that established the need for the Transplant, the evaluation of the Insured to receive the Transplant procedure, and the preparation and stabilization of the Insured for said procedure;
B. Every pre-surgery exam, including laboratory exams, X-rays, CT scans, MRIs, ultrasounds, biopsies, Prescription Medication and supplies;
C. The cost of obtaining the organ and tissues, its harvesting and transportation, and the medical expenses of the Donor;
D. The procedure to transplant the organ;
E. The coverage of an artificial heart, or mono or bi-ventricular devices to allow the patient to be viable until he/she receives the final Transplant;
F. Every post-Transplant care directly related to the Transplant including, but not limited to any follow up, Medically Necessary treatment resulting from the Transplant, and complication that may arise after the Transplant, whether it may be a direct or indirect consequence of the procedure; and
G. Any medication or therapeutic measure used to ensure the viability and permanence of the transplanted organ.

* *The Lifetime limit for this benefit includes any other amount previously paid under another plan of the Company or any of its affiliated companies.*

The following requirements are necessary to receive Transplant coverage:

A. It is Medically Necessary;
B. It is not considered elective, Experimental or Investigative;
C. No other optional procedures and/or treatments are available that will lead to the same level of results and care to treat the medical condition or Illness that has caused the need for the Transplant;
D. It is not originated by or as a result of a Transplant in which the receiver obtains a mechanical artifact or artificial equipment aimed to replace human organs, or when the organ to be transplanted is an animal's; and
E. It is not performed due to an initial failed Transplant carried out prior to the Effective Date of this Policy, or a non-covered Transplant that was carried out after the Effective Date of this Policy.

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

***Surgical treatment of symptomatic disorders of feet***

The coverage for surgical treatment of symptomatic foot-related disorders, such as infections, tumors, or trauma, is one hundred percent (100%) UCR, up to the limits of the Policy. Any other non-inherent condition to the feet or Accident that affects the feet, may receive coverage according to the general benefits of the Policy.

This benefit is subject to a twenty-four (24)-month Waiting Period and must be notified to the Company in advance for approval.

This benefit excludes any non-surgical treatment of diseases of the feet, such as: corns, calluses, hallux valgus bunions, hammer toe, Morton's neuroma, flat feet, weak arches and other symptomatic disorders of the feet including, but not limited to pedicures, chiropractic treatments, orthopedic shoes and any other special support of any type or form.

***Emergency Dental Coverage***

The coverage for this benefit is one hundred percent (100%) UCR for Injuries resulting from a covered Accident. The treatment must be rendered within the first one hundred and eighty (180) days after the date of the Accident. This benefit is limited to the treatment necessary to restore or replace sound natural teeth that have been damaged and/or lost in a covered Accident.

***Reconstructive surgery in case of Illness or Accident***

The reconstructive surgery shall be covered if and when it is Medically Necessary and as the result of a medical condition covered under the terms of this Policy. In the case of treatment provided for nasal malformations or of the septum, coverage will be provided if caused by trauma received during an Accident covered by the Policy or due to the treatment of nasal cancer.

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

***Surgical Implants or prosthesis (Excluding dental)***

The coverage for this benefit is one hundred percent (100%), including but not limited to implants, appliances, prosthesis, and other devices or materials used during a surgical procedure but must be pre-authorized in advance by the Company.

## OUTPATIENT BENEFITS

Benefits are covered up to the limits specified in the elected plan options Schedule of Benefits. The coverages for these benefits are based on the Usual, Customary and Reasonable charges for the particular case or based on special rates established or contracted in advance by the Company for the geographic area, country, or specific Provider with whom the Insured receives such services.

This benefit must be coordinated and approved in advance by the Company, and it includes medical home care that has been prescribed by the treating Doctor. The Company will evaluate the need and time required for specialized medical care, in order to adjust it in case of prolonged treatment.

***Outpatient Diagnostic Testing***

The coverage for this benefit is one hundred percent (100%) UCR, including but not limited to, pathologies, X-rays and MRI, CT or PET scans is up to a maximum per Policy Year.

***Nurse or Therapist care at home***

The coverage for this benefit is one hundred percent (100%) UCR as a follow-up care to a covered Hospitalization based on the Usual, Customary and Reasonable charges for the particular care for the services rendered or based on special rates established or contracted in advance by the Company for the geographic area, country, or specific Provider with whom the Insured receives such services. These services need to meet specified medical and circumstantial criteria to be covered.

This benefit must be coordinated and approved in advance by the Company, and it includes medical home care that has been prescribed by the treating Doctor. The Company will evaluate the need and time required for specialized medical care, in order to adjust it in case of prolonged treatment. Must be pre-authorized and coordinated by the Company.

Medical home care includes services from certified professionals (Nurses or therapists) and it does not include Custodial Care, as defined in this Policy. If additional days are medically necessary, the request must include progress notes and must be pre-authorized by the Company.

***Physician and Specialist Visit***

The coverage for Physician and Specialist visits in the physician's office, if Medically Necessary, is one hundred percent (100%) UCR, up to $6,000 for up to 10 months from the date of the discharge. Visit for pre-hospitalization and as a follow up to a covered hospitalization.

***Physical Therapy and Rehabilitation***

An initial period of 30 days for Physical Therapy and Rehabilitation will be covered if pre-authorized. The coverage for outpatient physical therapy and rehabilitation is up to the maximum listed in the Schedule of Benefits, based on the Usual, Customary and Reasonable charges for the particular therapy(ies) of the case, or based on special rates established or contracted in advance by the Company for the geographic area, country, or specific Provider with whom the Insured receives such services. In all cases, the Company must receive the treatment plan together with the estimated fees, as well as evidence of Medical Necessity for said treatment plan for prior approval of same every thirty (30) days. Coverage for this care or treatment must be authorized in advance by the Company. The Company would evaluate the extension of the treatment if it were Medically Necessary.

If additional days are medically necessary, the request must include progress notes and must be pre-authorized by the Company.

***Durable Medical Equipment***

When Medically Necessary, Durable Medical Equipment will be covered by this plan as long as the Insured presents a prescription from a Physician or licensed Provider that justifies (to Company's absolute satisfaction and sole discretion that the equipment is clearly necessary and offers) a therapeutic benefit for the Insured. This coverage must be coordinated and approved in advance by the Company.

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

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

***Bariatric and Gastric Bypass and any type of surgical procedure for Weight Loss, it's Complications or Treatments***

The coverage for this benefit is per Policy, per Lifetime. This benefit is subject to a twenty-four (24)-month Waiting Period.

This benefit includes expenses related to bariatric or gastric bypass procedures, any complications that may arise from this procedure and/or FDA-approved weight loss medications, as well as any complications from prior bariatric surgery performed prior to the Effective Date of the Policy during the time the Insured is covered by this Policy or by any other plan the Insured may have with the Company or any of its affiliates.

The Company must receive notification of the procedure as soon as the Insured is informed that he/she has been selected as a candidate to receive the identified procedures and has, among other requirements, a body mass index (BMI) of forty (40) or more. This benefit, including everything related to the identified procedures, must be coordinated in advance with the Company. If the Insured requests a change to a plan where this benefit is higher, the lower benefit offered in the previous plan will prevail during two (2) years from the date of approval of the change of plan.

Please review your product's Schedule of Benefits.

***Prescribed Medications***

The coverage for outpatient Prescription Medication, not prescribed during a Hospitalization, is up to a maximum selected in the plan option's Schedule of Benefits.

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

***Highly specialized Prescription Medications***

Highly specialized Prescription Medications indicated for a specific use will be covered within the limits of the corresponding benefit indicated in the Table of Benefits, as long as they are coordinated and approved in advance by the Company. The Company will coordinate with its Providers for the delivery of such Prescription Medication directly to the Insured. The Insured must accept the conditions of the Company for the supply of such specialized Prescription Medications, by either receiving treatment with the specific Provider designated by the Company or according to the delivery method available. The Company will provide the generic Prescription Medication as the first option if available.

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

***HIV/AIDS***

The coverage for this benefit is per Lifetime. This coverage is subject to the fact that the Human Immunodeficiency Virus's antibodies or the AIDS virus had not been detected before the Effective Date of the Policy nor in the first twenty-four (24) months from the Effective Date of this Policy. This benefit must be coordinated and approved in advance by the Company.

Please review your product's Schedule of Benefits.

## ADDITIONAL BENEFITS

***Emergency Transportation Air and/or Ground Ambulance***

***Air Ambulance***

The benefit for emergency medical evacuation/transportation by Air Ambulance is covered up to a maximum listed in the respective plans Schedule of Benefits, without Deductible.

If the transportation by Air Ambulance of a patient is merely convenient or recommended, but does not qualify as an Emergency, as defined in this Policy, it will not be covered under this benefit.

The following requirements must be met for the approval of the Emergency transportation by Air Ambulance benefit:

A. The required Emergency treatment is for a condition, or an accident covered by the Policy;
B. The Insured's life or the loss of any of his/her limbs is in danger;
C. The required treatment cannot be rendered or is not available in any way in the area or place where the Insured is at the time of the Emergency;
D. The transportation is provided by an entity licensed for such purposes, with the qualified staff and equipment;
E. The transportation will be authorized to the nearest Hospital where the Insured can receive treatment by qualified entities; and
F. The Air Ambulance transportation must be pre-authorized and coordinated in advance with the Company.

***Ground Ambulance***

The benefit for Emergency transportation by Ground Ambulance is one hundred percent (100%) UCR, without Deductible. The Insured, by accepting these services, agrees to hold the Company and its affiliates harmless from any negligence resulting from such transportation services, as well as for delays or restrictions caused by mechanical problems or by governmental restrictions, in addition to pilot, driver or crew errors, omissions or negligence, or due to operational, weather, force majeure or any other adverse conditions.

***Coverage Alzheimer's disease and Dementia***

The coverage for this benefit is one hundred percent (100%) UCR for all approved hospitalizations related to Alzheimer's disease and Dementia and their complications. This benefit excludes treatments in a Long-Term Care Facility.

Specialized Prescription Medication for this condition must be pre-authorized and coordinated in advance with the Company.

***Repatriation of Mortal Remains or Cremation Services***

In the event the Insured dies outside of his/her Country of Residence, costs for the repatriation of the remains to his/her Country of Residence will be covered, provided that the death resulted from a condition covered by this Policy.

This coverage is limited to all basic costs incurred in the repatriation process or the process of cremation of the remains, including a basic container legally approved for transportation, shipping costs and the necessary government authorizations pursuant to the requirements of the pertinent authorities, and it excludes transportation of the remains by Air Ambulance or any private transportation.

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

***Palliative/Hospice Care***

An initial period of 30 days will be covered if pre-authorized. The coverage for this benefit is one hundred percent (100%) UCR for palliative services to patients with a terminal illness covered by this Policy. A medical diagnosis certifying that patient has a terminal Illness with a life expectancy of the Insured of one hundred and eighty (180) days or less Is required for this benefit to apply. This service must be provided by a medically supervised team of professionals, and it must be rendered in an accredited hospice care facility.

This benefit must be coordinated and approved in advance by the Company. If additional days are medically necessary, the request must include progress notes and must be pre-authorized by the Company.

Covered services are available in home, outpatient, and inpatient settings up to the amount listed on the Schedule of Benefits. Admission to a Hospice program is made based on patient need. The Palliative/Hospice care:

- Must relate to a covered medical condition that has been the subject of a prior valid claim with the Insurer, with a diagnosis of terminal illness from physician.
- Benefits are provided as outlined in the Schedule of Benefits per Insured.
- Benefit is payable only in relation to care received by a recognized Hospice.

***Deductible reduction for no claim for 3 years***

The Insured who does not present claims for a period of three (3) consecutive Policy Years will be entitled to the elimination of the annual Deductible as of the fourth (4th) year in option I of this Policy, or to a reduction of the annual Deductible by fifty percent (50%) for one (1) year after the third (3rd) year when submitted claims did not reach the Deductible in any of the years. Under options II, III and IV of this Policy, the Insured will be entitled to a reduction of the Deductible by fifty percent (50%) per Insured for one (1) year after the third (3rd) year without claims. This benefit can be used in any subsequent year, from the fourth (4th) year after having satisfied the requirements to qualify for the benefit.

During any subsequent Policy Year after receiving this benefit, payment of the Deductible will be required, and the Insured will have to wait another three (3) consecutive Policy Years free of claims in order to have the right to the Deductible elimination or reduction again. The claims that were not covered, as well as the Preventive medical Checkup and maternity coverage, will not be taken into consideration as a claim for the purposes of this benefit.

This benefit only applies to the annual Deductible of the Policy and not to any other additional Deductible that the Insured may have.

***Deductible carry-over***

Any covered expense incurred by the Insured during the last three (3) months of the Policy Year, used to satisfy the Deductible for said Policy Year, shall be transferred or carried over to the next Policy Year and used to satisfy the Deductible for that Insured for said year.

If the Insured has an additional Deductible, the amounts applied to the additional Deductible in the last three (3) months before the Policy Anniversary Date will not be taken into consideration for the carry-over to the following Policy Year.

## MANAGING CHANGES IN YOUR POLICY

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

If, for any reason, an Insured stays outside his/her Country of Residence for more than one hundred and eighty-three (183) days in a Policy Year, they must pay the special premium established for expatriates, according to the region where they stay the longest.

Once the notification of change of Country of Residence is received or the Company has determined the change of Country of Residence occurred, the expatriate rate will be applied retroactively to the date on which the change of Country of Residence occurred.

The Company reserves the right to request, at any time, additional information to verify the permanent or temporary residence of anyone Insured under the policy.

Failure to notify the Company about the change of Country of Residence of any of the Insureds, as indicated, may result in modification, cancellation, or non-renewal of this Policy, at the Company's discretion.

***Addition of a Newborn under a covered pregnancy*** - The inclusion as a Dependent of a Newborn born from a pregnancy covered by this Policy (that has not been the result of a fertility treatment) will take place without the need for an underwriting evaluation. The Company must receive copy of the birth certificate or a written notice with the Newborn's name, gender, and date of birth, within the first ninety (90) days of the birth. Coverage for the child will become effective from the date of birth without a Waiting Period.

If the Newborn is not enrolled within the ninety (90) day period, an application will have to be completed and submitted for an underwriting evaluation.

Newborns from a non-covered maternity or who are the result of fertility treatment do not qualify for the automatic inclusion benefit. They must complete an application and go through underwriting.

***Change of Deductible*** - Before the Anniversary Date, the Insured can request to change the Deductible within the same plan. The Company reserves the right to approve or deny the change of Deductible or plan or approve it under conditions and/or restrictions that it considers appropriate.

If the change is for a higher Deductible, it will be approved under the same conditions of the current plan. If the change is for a lower Deductible, it will be subject to an underwriting evaluation.

Once the change is effective, during the first thirty (30) days from the Effective Date, the highest of the Deductibles will be applied toward any Illness or Injury not caused by an Illness of Infectious Origin or an Accident that occurred as of the date of the change. If the new Deductible option includes maternity care benefits, these will be subject to a ten (10)-month Waiting Period. The benefits that did not exist in the previous Deductible option must

meet the corresponding Waiting Periods.

***Change of plan*** - Before the Anniversary Date, the Insured can request a change to any of the other plans offered by the Company, available in the Insured's geographic Region and subject to underwriting. The Company reserves the right to accept or deny the change for any reason and request that a new insurance Application be completed. For changes to plans considered by the Company as specialty plans, additional requirements may be needed for underwriting when submitting the new Application.

If the change is approved, during the first thirty (30) days following the Effective Date of the new plan, the lesser of the benefits shall be applied. If the new plan includes maternity care benefits, these will be subject to a ten (10)-month Waiting Period. The benefits that did not exist in the previous plan must meet the corresponding Waiting Periods.

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

***Policyholder's death*** - In the event of the death of the Policyholder, the Company will pay the Beneficiary listed in the Application (if applicable), or the heir(s)/ heiress(es) or inheriting entity(ies) of the deceased Policyholder the unearned premium or any reimbursement for benefits that remained unpaid while the Policyholder was alive.

## TOOLS AND RESOURCES FOR POLICYHOLDER/INSURED

Insured's have access to their online Member Portal, offering access to:

A. View Policy information, such as Dependents, exclusions, Amendments and upcoming premium payments;
B. Download Policy documents such as the Welcome Letter, Certificate of Coverage and ID cards;
C. Access the Plan Overview and Conditions of Coverage of the plan;
D. Download the Claim and Payment Forms;
E. Submit a claim or medical notification;
F. Contact Trawick Latam; and
G. Obtain Agent's contact information

Insured's have access through www.portal.trawicklatam.com

## ADDITIONAL PROVISIONS

***Denial of liability***

The Company is not responsible for the quality of the medical services provided under this Policy. The Insured agrees to defend, indemnify, and hold the Company harmless from any claim, demand, cause of action, obligation, loss, damage, and/or Injury resulting from Negligence by a Provider or a Hospital.

***Clerical errors***

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

***Medical information privacy notice***

The Company handles the privacy and confidentiality of the personal information of its Insureds with strict adherence to the laws and regulations in force on the matter. All confidential information will be protected by the available electronic means, which have all the appropriate security guarantees.

It is understood that the Insured has given his/her consent for the transfer of said information as necessary and in order to comply with any contract or

agreement for the provision of services, including to his/her registered insurance agent or when required by law or the procurement or administration of justice.

***Limited liability***

The Company will not be responsible for any loss, damage, or Illness that the Insured may suffer which was caused by the provision of services for covered expenses by a medical service Provider or any person who provides such services. In this case, the Insured will have to present his/her complaint directly to the medical service Provider or the person who has offered the service.

***Disputes and Governing Law***

The parties to this agreement recognize that disputes or disagreements may arise between them regarding, among other things, the interpretation, performance, or enforcement of this agreement. The Parties hereby agree to engage in mandatory mediation as a prerequisite to any formal legal action in an effort to resolve such disputes in a timely and cost-effective manner. The Parties agree to submit any dispute arising out of or in connection with this agreement to mediation administered by JAMS (Judicial Arbitration and Mediation Services), unless otherwise agreed upon by the Parties in writing. The mediation shall be conducted in accordance with the JAMS Comprehensive Mediation Rules and Procedures in effect at the time of the dispute, except to the extent modified herein. ***Selection of Mediator***: Within 14 calendar days after either party gives written notice to the other party of its desire to mediate a dispute, the Parties shall jointly select a qualified mediator from the JAMS panel. If the Parties fail to agree on a mediator within the specified time, JAMS shall appoint a mediator from its panel in accordance with its rules. ***Location***: The mediation shall take place in Miami, Dade County, Florida at a location mutually agreed upon by the parties. If the Parties are unable to agree on location, then the location will be designated by the mediator. ***Language***: The language of the mediation shall be English. Mediation Costs: The Parties shall share equally the mediator's fees and any administrative fees charged by JAMS. Each party shall be responsible for its own attorneys' fees, costs, and expenses incurred in connection with the mediation. ***Confidentiality***: All communications, oral or written, made during the mediation process shall be confidential and without prejudice to the rights and positions of the Parties in any subsequent legal proceedings. The Parties and the mediator shall not disclose or use any information or documents obtained during the mediation for any purpose outside the mediation process, except as required by law or with the express written consent of the Parties.

***Good Faith Participation***: The Parties agree to participate in the mediation process in good faith and to make reasonable efforts to resolve the dispute. If a Party fails to attend the mediation session without a showing of good cause or refuses to engage in the mediation process in good faith, the other Party may seek appropriate remedies, including but not limited to, reimbursement of costs and attorneys' fees incurred as a result of the non-compliant Party's actions. In that event, the Mediator will determine what, if any, remedies are to be assessed.

***Limitations on Legal Proceedings***: Mediation is mandatory and neither party shall initiate any legal action or proceeding related to the dispute until the mediation process has been completed, unless otherwise agreed upon by the Parties in writing.

***Binding Nature***: The Parties acknowledge and agree that any settlement reached through mediation shall be binding upon them and enforceable in a court of competent jurisdiction.

***Governing Law and Venue***

The parties agree to grant to the State and Federal courts located in Miami-Dade County, Florida (or if there is exclusive federal jurisdiction), exclusive jurisdiction and venue over any disputes, action or proceedings arising out of or in connection with this insurance Policy involving the parties, and the parties hereby consent to the jurisdiction of such courts. The parties further agree that any legal action shall be commenced by filing such action in a court of competent jurisdiction in Miami-Dade County, Florida.

***Subrogation of third parties and indemnity***

The Company has the right of subrogation or reimbursement of payments made if the Insured has recovered all or part of said payments from a third party.

The Company will subrogate up to the amount paid, under all its rights and actions, against third parties that, due to the damage suffered, the Insured is entitled to. The Policyholder shall have the obligation to cooperate with the Company to recover from the damage caused by third parties or to obtain reimbursement of the expenses covered by it.

Failure to comply with this obligation entitles the Company to consider cancelling this, Policy. The required cooperation includes, but is not limited to, providing all relevant documentation or testimonial evidence, and undergoing medical examinations, if necessary. The Company may make any claim on his/her behalf, before or after having made payments for expenses covered under this Policy.

The Policyholder must refrain from taking any action, reconciling, or accepting agreements that may adversely affect the Company's subrogation rights in accordance with the provisions of this article. The Company must be notified immediately of any claim action initiated by the Insured in relation to damages that were covered by this Policy, in order to assert its subrogation rights on any payment related to the expenses covered by the incident that originates the claims.

## DEFINITIONS

Accident - A violent, sudden, unforeseen, and unintentional event, produced exclusively by external causes that result, independently of other causes, in bodily Injuries to the Insured.

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

Agency or Agent - Individual or company authorized by the Company to distribute its products and provide administrative services to the Insureds. The Agent shall have access to the Insured's health and medical information, which can be sent to the Company or any of its affiliates. No Agent has the authority to modify the Policy or remove any of its terms and conditions.

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

Amendment - A declaration added to the Policy by an authorized official of the Company to explain, modify and/or restrict the coverage of this Policy for a particular Insured or for the Policy in general.

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

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

Applicant - Natural person applying for an insurance Policy. The Applicant is usually the intended Policy owner or Policyholder after a Policy is issued.

Application - A written declaration designed by the Company which is completed and signed manually or electronically by the Policyholder and contains information about himself or herself and his/her Dependents. This form is used by the Company to determine the insurability of the Applicant and his/her Dependents. Any information or questionnaire submitted to the Company with the Application is considered part of the Application.

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

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

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

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

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

Company – The insurer, Trawick International LLC PIC

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

Contracting Party - Natural or legal person who pays the premium of the Policyholder and/or his/her Dependents, due to a work relationship or family affinity. The Contracting Party is not an Insured and therefore does not enjoy the benefits under the Policy, but he/she has the power to request the cancellation of the Policy paid for by the Policyholder and receive the unearned premium. The Policyholder may pay the corresponding premium to maintain the current coverage when the Contracting Party requests the cancellation and refund of the unearned premium.

Country of Residence - The country in which the Insured resides for a period of more than one hundred and eighty-three (183) days within a year while this Policy is in effect.

Covered Maternity - A pregnancy ending by natural or cesarean delivery after the Waiting Period of ten (10) months after the Effective Date of the mother's coverage. Only option I of this Policy has Covered Maternity. Newborns who are the result of fertility treatment do not have automatic inclusion, therefore do not qualify for the benefits associated with this type of addition to the Policy.

Deductible - The portion of covered expenses that must be paid by the Insured before the benefits of this Policy become payable.

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

Domestic Partner - Person of the opposite sex or the same sex with whom the Policyholder has established a relationship of domestic life.

Durable Medical Equipment - Equipment that provides therapeutic benefits to the patient and allows him/her to perform tasks that otherwise and due to medical conditions or Illnesses he/she could not perform. The Medical Equipment must be durable for continuous use, used for a medical purpose, approved for home use, and able to be transported, such as wheelchairs, crutches, and Hospital beds.

Effective Date - Start date of the term of the Policy.

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

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

Experimental or Investigative - Any treatment, procedure, equipment, medication, combination of medications, device, supply or Hospitalization which, at the time the service or supply is provided, does not meet the approved norms for the specific indication or application to the condition by the FDA or other applicable federal or government agency of the U.S., and whose approval is required regardless of the location where the medical expenses are incurred.

Expiration Date - The date on which the term of the Policy ends according to the selected payment mode.

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

Gross Negligence or Gross Negligent - Lack of care that demonstrates reckless disregard for the safety or lives of others, which is so great it appears to be a conscious violation of other people's rights to safety.

Ground Ambulance - Ground transportation equipped with medical equipment and medically trained personnel to transport individuals who are injured or ill.

Hazardous Hobbies and Sports - Activities that increase the risk of Accidents or even the death of the person who practices them. Examples of Hazardous Hobbies and Sports include, but are not limited to, diving, rock climbing, mountaineering, parachuting, bungee jumping, paragliding, parasailing, motor sports or mountain biking.

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

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

Hospitalization - Admission to an inpatient medical center for a period of twenty-four (24) hours or more to receive medical or surgical care. The severity of the medical condition justifies the need for a Hospital admission. The medical care limited to an emergency room or urgent care is not considered a Hospitalization for the purpose of this Policy.

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

Illicit Substances - Pharmaceuticals, psychoactive substances or similar chemicals defined by the federal government of the United States of America as illegal, such as cocaine and heroin.

Illness - Condition or disorder of internal or external cause that affects the human body, and which requires medical attention.

Illness of Infectious Origin - A medical condition caused by pathogenic agents such as bacteria, virus, fungi, and parasites.

Injury - Damage inflicted to the human body due to some cause.

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

Insured Dependents - Spouse, concubine or Domestic Partner of the Policyholder, his/her biological children, legally-adopted children, stepchildren or children under eighteen (18) years for whom the Policyholder has been named legal guardian by a court of competent jurisdiction.

Lifetime - The maximum amount that the Company will pay for a specific benefit during the life of the Policy.

Live Donor - A live person who donates an organ, tissue, or cells to be transplanted into the body of another person or recipient.

Long-Term Care Facility - Assisted living institution.

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

Medical Necessity or Medically Necessary - Treatment, medical service or medical supply prescribed by the treating physician and approved by the Company as deemed necessary to diagnose and/or treat an Illness or Injury.

It is not Medically Necessary if the service:

A. Is provided as a matter of convenience to the Insured, his/her family or the Hospital/Physician;
B. Is not appropriate for the diagnosis or treatment of the specific condition;
C. Exceeds the level of care required for the diagnosis or treatment of a specific condition;
D. Is outside the scope of the standard practices established for Doctors or other health professionals and Hospitals; or
E. Is a substitution of a Standard or Private Room for a Suite if the Policy doesn't offer this benefit

Negligence or Negligence - Failure to behave with the level of care that someone of ordinary prudence would have exercised under the same circumstances. The behavior usually consists of actions but can also consist of omissions when there is some duty to act or rules of care to follow.

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

Nurse or Therapist - An individual legally licensed according to the regulations where he/ she provides services and who offers patient care services according to the indications of a physician.

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

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

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

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

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

Primary Policyholder - Individual who signs the insurance Application, is the main Insured under the Policy, has the authority to request changes in the Policy, and receives the reimbursements for payments of medical services covered under this Policy, as well as any reimbursement of the unearned premium

Pre-existing Condition - A condition which was diagnosed by a physician prior to the Effective Date of this Policy or its reinstatement; or for which medical advice or treatment was recommended or received by a physician; or for which symptoms and signs presented and, had a physician been consulted, a diagnosis of an Illness or medical condition, or specific treatment, would have been received.

Preferred Provider Network - List of Hospitals contracted by the Company and approved for this Policy for the maximum of the benefits if services are within the United States

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

Private Hospital Room - Hospital room equipped to accommodate only one (1) patient. Professional Sports - Training and practice of sports for which a person receives compensation.

Provider - Hospitals, Clinics, physicians, diagnostic centers, pharmacies and other entities or individuals legally authorized to provide medical services. Reckless Behavior - The conscious disregard of a substantial and unjustifiable risk.

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

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

Serious Accident - An unforeseen trauma occurring without the Insured's intention, which implies a sudden external cause and violent impact on the body, resulting in demonstrable bodily injury that requires immediate Inpatient hospitalization for 24 hours or more within the next few hours after the occurrence of the severe injury to avoid loss of life or physical integrity. A severe injury shall be determined to exist upon agreement by both the treating physician and the Insurer's medical consultant, after review of the triage notes, emergency room and Hospital admission medical records.

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

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

Suite - Hospital room in a Hospital or Clinic classified by the same as a Suite, usually of a larger size than that of a Private Room and which may have a reception area. This includes rooms referred to as "Junior" or "Presidential."

Transplant - Medical procedure to transfer an organ, tissue, or cells from a Living or deceased Donor to the recipient or reimplant it in the same person. US$, U.S. Dollars - Currency of the United States of America.

United States, U.S., USA - The United States of America.

Usual, Customary and Reasonable (UCR) - The lower of: A The Provider's usual reimbursement for furnishing the treatment, service or supply; or B The amount determined by the Company to be the general rate accepted by Providers of the same category who provide such treatments, services or supplies to persons: (1) who reside in the same geographical area; and (2) whose Injury or Illness is comparable in nature and severity.

The Usual, Customary and Reasonable amount for a service, treatment or provisions will be determined by the Company based on special rates established or contracted in advance by the Company for the geographic area, country, or specific Provider with whom the Insured receives such services. In some cases, the UCR amount will be determined by direct contracts between the Providers and the Company.

Benefits covered at one hundred percent (100%) are subject to Usual, Customary and Reasonable costs. It should not be understood that they will be covered for the total amount of the invoice submitted.

Waiting Period - A period of time defined by the Company during which the coverage of some benefits is excluded.

Willful Misconduct - Deliberate act or omission which is contrary to or goes beyond the conduct to be expected of a party, where such party knows that or is reckless to the fact that such act or omission is contrary to or goes beyond the conduct to be expected of them.

## EXCLUSIONS AND LIMITATIONS

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

1. ***Medical care not prescribed or recommended by a physician, non-Medically Necessary, Alternative, Investigative or experimental procedures***

   Any service, treatment, Injury or Illness, or charges related to services or supplies that are not Medically Necessary, or related to daily care staff, or provided to an Insured who is not under the care of a physician or medical professional who is legally qualified in the area or country in which he/she practices; or has not been prescribed by a physician or medical professional; or is considered homeopathic or alternative care; or is not scientifically recognized or is still in an Investigative phase or clinical trial, as well as those that have not been approved by the U.S. Food and Drug Administration (FDA). Any medication that is not scientifically or medically approved for a specific diagnosis, or considered as off-label use or Experimental, or the use of combinations that are not generally accepted by the scientific community, even when a particular Doctor prescribes it, as well as over-the-counter medication and/or those not approved for the treatment of the specific condition of the Insured by the FDA. Prescription Medication that is approved by the FDA for the specific condition of the Insured, but that is part of an Experimental treatment, is also excluded from coverage.

2. ***Substance abuse, self-inflicted Illness or Injury, or criminal acts***

Self-inflicted Illnesses or Injuries, whether the individual is sane or insane; suicide; failed suicide; addictive conditions of any kind; alcoholism, alcohol abuse (when the Insured's blood alcohol level is considered in excess of the legal limit, in the place where the incident occurred); treatment for any Injuries caused by, contributed to, or resulting from drug use or abuse; use of Illicit substances or illicit use of controlled substances or any drugs or medicines that are not taken in the dosage or for the purposes prescribed by the Insured's doctor; encounters with wild animals in any circumstances; participating in fights, including when members of his/her family take part in it, unless the Insured is acting, legitimately, in self-defense, as determined by a court of law; Injuries and/or Illnesses resulting or arising from or occurring during the attempt or perpetration of a crime or a violation of law by an Insured; as well as any incident or Accident resulting from or related to any of the criteria previously mentioned.

The services, care, or treatment are excluded whether or not the Insured is charged with or convicted of any criminal offenses.

Treatment for any loss or expense of any nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily Injury, disregard for the rights and safety of himself/herself or others, except in an endeavor to save human life. Care and treatment, without limitations, incurred in connection with Injuries that occurred from a Negligent, Gross Negligent or Reckless Behavior, or Willful Misconduct of the Insured, as determined by the Company.

3. ***Routine exams***

Routine examinations of the ear and eyes, cochlear implants, or any other surgical implant for hearing; eyeglasses and contact lenses; procedures to correct eye refraction, including radial keratotomy; prophylactic treatments including vaccinations; and the issuance of medical certificates and physical exams for work or travel.

4. ***Illnesses during the thirty (30)-day Waiting Period***

Any medical expense that is not related to an Infectious Disease or Accident that takes place within the first thirty (30) days of the Effective Date of this Policy, unless the Waiting Period has been exonerated.

5. ***Aesthetic treatments***

Any type of elective or cosmetic surgery, or treatments whose principal purposes are aesthetic, except when it is necessary due to an Injury, deformity or Illness occurred during the effective period of this Policy. This includes any treatment for nasal or septum deformities, except as specifically provided in this Policy. Complications resulting from non-covered services, as well as the diagnosis or treatment of any condition which arises as a complication of a non- covered service including, but not limited to services rendered for cosmetic purposes, including hair transplants; alopecia treatment; ear or any other body piercing; breast reductions and breast implants.

6. ***Podiatric care and orthopedic devices***

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

8. ***Expenses covered by third parties***

Healthcare services resulting from accidental bodily Injuries arising out of a motor vehicle, watercraft, or aircraft Accident, or any other type of Accident on public transportation where the Insured is covered under any type of insurance, private or public, regardless of whether or not the Insured sues a third party for liability. Care and treatment for any Injury, Illness, or condition for which the Insured is paid benefits under any workers' compensation law, employer's liability policy, or any similar policy.

9. ***Epidemics or Pandemics***

Any medical treatment subject to the management of public authorities, including treatment and services related to infectious diseases declared as an Epidemic or public Emergency by the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), or any other government or governmental agency or governing body of the country where the Epidemic occurred. In addition, such coverage is also excluded if there has been an official warning issued against travel to the area by the State Department or similar office, the embassies of the affected countries, the airline or another government agency, before traveling to the affected country, except when the exposure occurs accidentally or

unknowingly while traveling to or from undeclared risk areas, or as a result of visiting the area prior to the declaration of an Epidemic or Pandemic.

10. ***Treatments for mental health***

Services for mental and nervous disorders and related Prescription Medication; neuro-developmental disorders, except if they are required to treat a complication of a covered condition, as defined in the terms and limits of this Policy.

11. ***Excessive expenses***

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

12. ***Sterilization, fertilization treatments and sexual reassignment***

Any portion of a medical expense incurred in male or female sterilization; sterilization reversal; birth control; infertility treatments; artificial insemination; in vitro fertilization (unless expressly covered by the plan); any condition suffered by the mother or the Newborn as a result of any type of fertilization treatment; sexual reassignment, reproduction or modification services, including hormone therapy, intersex surgery, sexual deviations and disorders; psychosexual dysfunctions; genetic tests to determine paternity or the sex of a child; treatments or protheses used to improve or restore potency or other sexual deficiencies; testicular prosthesis and/or the insertion of a penile prosthesis, except when necessary for the treatment of neurogenic or vasculogenic impotence resulting from a medical condition greater than one (1)-year dur ation including, but not limited to spinal cord Injury/ disease, multiple sclerosis, spina bifida, diabetes, radical prostatectomy, rectal surgery, fractured pelvis, intra-penile arterial disease, status post cavernosal infection, Peyronie's disease, penile contusion, or penile fracture.

13. ***Obesity and weight control treatments***

Any treatment, expense, or service to prevent obesity or to control weight, whether weight reduction or weight gain, and any alteration in body size, including any type of dietary supplement, unless included in your plan's Summary of Benefits.

14. ***Growth hormones***

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

15. ***Maternity or Newborn Complications under a non-Covered Maternity***

Any expense for the treatment of the mother or the Newborn related to a non-Covered Maternity, including any complication, as well as maternity and Maternity Complication expenses for Dependent daughters. Any voluntary termination of a pregnancy (legal or illegal), unless it is prescribed because the mother's life is in imminent danger, or in the case of a rape, legally reported to the corresponding authorities.

16. ***Dental or orthodontic treatment***

Any expense for dental or orthodontic treatment, except as provided in this Policy including, but not limited to abnormalities of the upper maxillary, disorders of the mandible or the mandibular articulation including, but not limited to its anomalies and malformations, the Temporomandibular Joint Syndrome (TMJ), cr aniomandibular disorders or any other mandibular condition, or any condition of the articulations that join the mandible and the cranium, as well as other tissues that are linked to said articulations.

17. ***Active duty, war, and disturbances***

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

18. ***Hospital pre-admission for more than twenty- three (23) hours***

Any admission to a Hospital for more than twenty-three (23) hours the day before a programmed surgery, or the admission to a Hospital to receive Outpatient medical Services, unless said admission was approved by the Company.

19. ***Treatments provided by immediate relatives***

Charges for physicians' services imposed by an immediate relative or member of the Insured's household; even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation, are excluded from coverage. This exclusion also precludes an Insured who is also a physician from treating himself/herself and submitting claims for such coverage. For the purpose of this exclusion, immediate relative means any of the following: husband or wife; natural or adoptive parent, child or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law, mother- in-law, son in-law, daughter-in-law, brother-in-law or sister-in-law; grandparent or grandchild; spouse of grandparent or grandchild. The Company reserves the right to authorize the treatment provided by the family member or the use of the Provider's facilities.

20. ***Over the counter medication***

Any medication that may be acquired without a physician's prescription including, but not limited to food supplements needed as a result of digestive intolerance; hunger suppressants; vitamins (other than pre-natal as described under maternity); anti-aging or hair growth medications or products, smoking cessation drugs, cosmetic and beauty aids, acne and rosacea drugs (including hormones and Retin-A) for cosmetic purposes, sexual enhancement devices, supplements, herbs or drugs, for any reason.

21. ***Artificial kidney equipment***

Any portable or home-use artificial kidney equipment.

22. ***Artificial or animal organs, cryopreservation and storage of tissues and Stem Cells***

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

23. ***Injuries or Illnesses caused by radiation***

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

24. ***Duplicate Durable Medical Equipment***

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

25. ***Additional medical assistants***

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

26. ***Extended and Custodial Care, and counseling services***

Treatments in mental health centers or psychiatric institutions; nursing homes for the elderly; assisted living facilities; hospices; Long-Term Care Facilities; hydro-clinics; health spas; and memberships to gymnasiums, except as provided in this Policy.

Any expense related to recreational or educational therapy; marriage relationship counseling; services of adoption agencies; pastoral counseling; family, social, occupational, religious, or other social maladjustment counseling; chronic behavior disorders; codependency; impulse control disorders; organic disorders; learning disabilities; hyperkinetic syndrome. This includes any Prescription Medication for treatment associated with any of the above conditions.

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

27. ***Professional Sports***

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

28. ***Expenses incurred in sanctioned countries***

Any expense or claim incurred for the treatment, services or supplies rendered in countries, by or for the benefit of persons and/or companies subject to economic or political sanctions, trade restrictions, and/or embargoes imposed by the government of the United States, the United Kingdom, the European Union, or any of its entities or asset control agencies.

29. ***Health check-ups***

Health check-ups, inoculations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.).

30. ***Genetic Exams***

Genetic counseling, screening, testing or treatment, unless stated on the Schedule of Benefits.

31. ***Elective abortions***

Elective abortions, any voluntarily induced termination of pregnancy, unless the mother's life is in imminent danger.

The company's International Health Insurance products are underwritten by Trawick International Ltd. PIC on behalf of Trawick International Inc. and registered in Grand Cayman, Cayman Islands.

Trawick International Ltd. PIC is a policy issuing company licensed as an insurance company in the Cayman Islands and supervised by the Monetary Regulatory and Advisory Body of the Cayman. The policy is issued through a Trust, AMD Trust and the Primary Insured receives a Certificate of Coverage with respect to the International Health Plan.

# Plan
# Viva Vital

Individual Health Insurance Policy

Effective
**September**
**2024**

## CONTACT INFORMATION


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