Remote Health
by SafetyWing | VUMI

Global health insurance

Community Plan 5.0 Standard

Policy Document — Remote Health VIP



SafetyWing

Your health taken care of *wherever* you live, work or travel.



We make it simple for remote workers around the world to stay healthy. Welcome to your global health plan.

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No reimbursement stress with prepaid cards and direct payments to providers

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VUMI®

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

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

In partnership with SafetyWing, with Remote Health you will have the peace of mind of knowing that your health is in the best hands 24 hours a day, 365 days a year.

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Summary of benefits

Unless otherwise stated, the benefits are offered on a per Insured/per Policy year basis. All amounts are in U.S. Dollars (USD). The benefits are limited to the medical expenses covered under the Policy and are subject to the Usual, Customary and Reasonable expenses (UCR) for the geographic area where the expenses were incurred.

Plan summary | Standard benefits

Maximum cover per Policy year: US$1,500,000

Age limit to apply: 74 years

Geographical cover options: Worldwide; or Worldwide excluding US/SG/HK

Base plan coverage

Unless otherwise stated, the following benefits are for inpatient treatments.

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

Plan summary | Standard benefits

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

Plan summary | Standard benefits

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

Plan summary

Standard benefits

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

Plan summary | **Standard benefits**

Outpatient

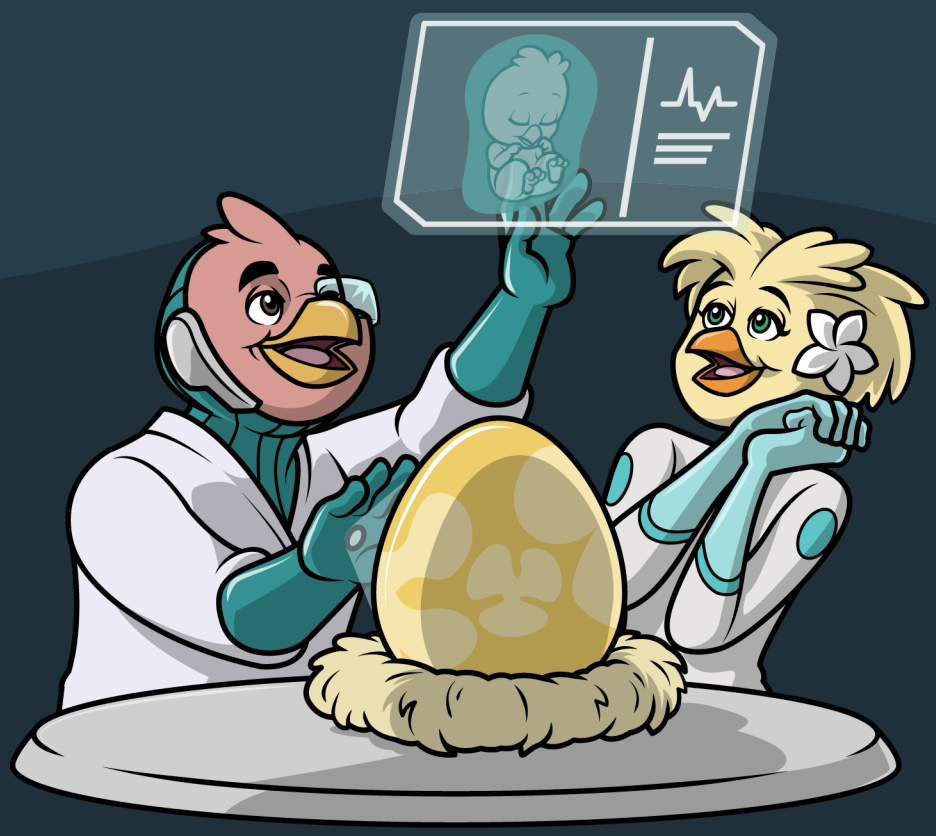
The maximum allowable amount for all combined outpatient benefit expenses is up to five thousand dollars (US$5,000) per Policy Year. — US$5,000

Emergency room care	100% UCR
Physician and specialist visits	100% UCR
Medications	100% UCR
Physical therapy	100% UCR
Allergy treatments	100% UCR
Diagnostic study services Laboratory tests, pathology, X-rays, MRI/CT/ PET scans	100% UCR
Complementary therapies Massages, osteopaths, chiropodists and podiatrists, chiropractors, homeopaths, dietitian and acupuncture	Up to US$60 per visit per visit, up to a max. of 15 visits per Policy Year
Mental health visits	100% UCR Up to a max. of 10 visits per Policy Year

Plan summary | **Standard benefits**

Screenings and vaccines	Routine health checks including consultation for cancer screening,cardiovascular and basic vital signs exams, as well as all basic immunization and booster injections.* * COVID-19 vaccines are not included.	US$350
Maternity	Covers Medically Necessary costs incurred during pregnancy and childbirth up to US$2,500, including pre and post-natal check-ups for up to 30 days following discharge. This benefit is subject to a ten (10)-month Waiting Period.	Up to US$2,500
	Complications of Pregnancy and Childbirth	Up to US$50,000

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



Remote Health
by SafetyWing | VUMI

Health Insurance

Remote Health VIP Standard 5.0



SECTION 1

Agreement

VUMI® Group, I.I. (VUMI®), hereinafter the “Company” or the “Insurer,” issues a group Policy in the name of the Contracting organization and undertakes to pay to the Policyholder of the corresponding Certificate of Coverage as a member of the Community Policy, the benefits detailed in this Policy related to the covered expenses incurred by him/her or his/her eligible Dependents under his/her certificate, as a result of any treatment, service or medical supply anywhere in the world where the plan offers coverage, after the Effective Date of this Policy, while it is in effect.

All benefits are subject to the terms and general and particular conditions of this Community Policy, including the applicable co-insurance, maximum benefits and the limits detailed in the Table of Benefits and the Certificate of Coverage which are an integral part thereof.

1.1 RIGHT TO EXAMINE THE POLICY

The Policyholder understands that this Policy is an international health insurance plan that is not subject to regulations and/or mandatory coverage required by the laws of his/her Country of Residence or other, therefore, it may not comply with coverage, underwriting, and other insurance regulatory provisions of the Insured’s Country of Residence. This insurance Policy is not subject to and does not provide certain benefits required by the United States Patient Protection and Affordable Care Act (PPACA). The Contracting Party or the Policyholder must review the terms of the coverage to verify he is/they are in agreement with the coverage offered, and otherwise request the cancellation of this Policy and return it to the Company within a fifteen (15)-day period after receiving it. If during that period no claims have been made, the Company will reimburse the total premium paid and the Policy will be null and void, as if it was never issued.

Reimbursement of the unearned premium

If the Contracting Party or the Policyholder cancels the Policy after the fifteen (15)-day reviewing period, or after being reinstated or renewed, the Company

will reimburse the Contracting Party the unearned portion of the premium up to a maximum of sixty-five percent (65%) of the total amount of the premium. The administrative fees and a thirty-five percent (35%) retention by the Company will not be reimbursed. In case of rescission of the Policy, the Company will apply the premium received to any payment made for a claim against the Policy.

1.2 IMPORTANT NOTICE ABOUT THE APPLICATION FOR A GROUP POLICY

This Policy is issued based on the statements provided in good faith by the Contracting Party and/or the participating members in the Application, and/or in the proposal agreed by all parties ("Application") and the complete payment of the corresponding premium. The Company reserves the right to accept or reject any Application for group Policies.

If any of the information disclosed in the census of the Applicants or in the Application is false, incorrect, incomplete, had the intent of misleading or deceiving, or was omitted, resulting in worsening the risk, it may result in the cancellation or the modification of the Certificate of Coverage of the member involved in any of the aforementioned behaviors; or the entire group Policy may also be cancelled or rescinded, will have no effect, and the Company will not be responsible for any payments of the benefits offered under this Policy, releasing the Company of any responsibility for the payment of benefits stipulated hereunder, as the case may be.

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

Any payments made unduly by the Company as a result of an omission, incorrect disclosure or negligence by the Contracting Party, any of its Insureds, or due to an administrative error of the Company, shall be reimbursed to the Company at the first request.

SECTION 2

Coverage duration

The coverage has a duration period of twelve (12) months and could be renewed for the same period of time, as long as the Contracting Party fulfills its payment commitment of the established premium, subject to the previous analysis of the Contracting Party's claim history, which will be indicated at the time of renewal, as long as the Applicants meet the eligibility requirements, and subject to the terms, conditions and other provisions of the Policy that are in effect at the time of renewal.

Start of coverage

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

SECTION 3

Eligibility

3.1 ELIGIBILITY REQUIREMENTS

The Contracting Party must meet the following requirements to be eligible to qualify for a Policy:

A. Be a legally incorporated entity;

B. Have a minimum of five (5) people working directly or indirectly full time or a minimum of thirty (30) hours per week;

C. The Member must be directly employed by the Contracting Party or meet the Community Plan and Associated Persons definitions;

D. The Member and eligible Dependents must reside outside of the United States of America (USA);

E. The Member's eligible Dependents are the Policyholder's Spouse or Domestic Partner, biological children, legally adopted children, and step children or minors to whom the Policyholder has been designated as legal guardian by a court of competent jurisdiction

F. Applicant Members must be under seventy-four (74) years old;

There is no limitation on this plan restricting it to employees or Associated Persons of the specific subsidiary only, except for those who permanently reside in United States of America (USA). This plan is not available for U.S. residents.

3.2 ENROLLMENT PERIOD

Plan subscriptions are open for new Members during the first thirty (30) days from their hiring date only. After the thirty (30)-day period, for new Members to be added to the contract of the group plan, and for Members who rescinded the plan to re-apply, a satisfactory proof of insurability must be submitted to the Insurer. The Insurer reserves the right to request additional information and/or modify the conditions of coverage for the Applicant. Subscriptions of established Members in the Contracting Party, must be supported by the appropriate documentation that verifies their eligibility to the plan, at the discretion of the Insurer, such as certification, payroll tax receipts from the Department of Labor of their jurisdiction, tax collector or any similar institution that proves eligibility to the plan.The Insurer will determine if the Application to add a Member must go through an individual medical evaluation and/or will be subject to a Waiting Period.

3.3 EFFECTIVE COVERAGE FOR ELIGIBLE DEPENDENTS OF THE POLICYHOLDER (MEMBER) (FOR AN ADDITIONAL PREMIUM)

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

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

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

3.4 ADDITION OF A NEWBORN

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

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

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

SECTION 4

General information

4.1 ISSUANCE OF THE POLICY

The Policy is deemed solicited, issued and delivered when the Agent or the Administrator appointed by the Contracting Party receives the Certificate of Coverage.

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

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

Any translations of this Policy into other languages are provided as a courtesy for the Insured's convenience. However, the English version will prevail and will be

the controlling contract in case of any doubt or dispute regarding any provision of this Policy. The Policyholder may request a copy of their Policy documents directly from the Company at any time.

4.2 AUTHORITY

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

4.3 ADMINISTRATIVE ERRORS

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

4.4 ENTIRE CONTRACT

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

4.5 CURRENCY

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

4.6 COVERAGE START

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

4.7 DELIVERY OF MEDICAL INFORMATION TO THE REGISTERED AGENT OR ADMINISTRATOR OF THE CONTRACTING PARTY

The Contracting Party, through its representative designated in the Application, by accepting the coverage that this corporate plan offers to its members and Dependents, expressly states that all Insured, understand and accept that the registered Agent may access all confidential and private medical information (past, present and future) submitted to the Insurer, any of its affiliates or subcontractors, as well as the private medical information issued by the Insurer.

The Contracting Party, therefore, accepts that the Insurer makes this information available to the Agent and/or administrator in order to facilitate the transfer of

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

4.8 NOTIFICATION OF LEGAL SEPARATION OR DIVORCE

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

4.9 MEDICAL NOTIFICATIONS

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

4.10 CLAIMS

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

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

4.11 MEDICAL RECORDS

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

4.12 COVERAGE UNDER ANOTHER INSURANCE/COORDINATION OF BENEFITS

If another group health insurance has been contracted, including government-

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

The coverage under this Policy will act as secondary to any other Policy or healthcare plan. The Company will provide benefits after the claims have been submitted to the primary insurance plan first, and only when benefits payable under the primary Policy have been satisfied. When filing a claim subject to coordination of benefits, proof of the other insurance coverage must be submitted along with copies of the medical records, the itemized invoices, Explanation of Benefits (EOB) of the primary insurer, as well as proof of the payments made by the other insurance company.

The total amount of payments is not to exceed the total of the expenses incurred; the Company shall not pay any amount reimbursed by the other company.

4.13 CANCELLATION OR NON-RENEWAL OF THE POLICY OR OF AN INSURED CERTIFICATE OF COVERAGE

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

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

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

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

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

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

by OFAC or similar entities or asset control agencies in other jurisdictions; or

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

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

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

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

4.14 FRAUD

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

4.15 CHANGE OF PLAN

A. Policy Cancellations: Mid-year cancellations are not permitted unless a qualifying life event occurs. The following are considered qualifying life events:

- Change of employment
- Relocation outside of the 175+ countries of coverage
- Change in relationship status

B. Plan Changes: Mid-year plan changes are not allowed, even if no claims have been submitted.

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

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

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

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

SECTION 5

Rates and premium payments

5.1 PREMIUM PAYMENT MODE

This Policy is considered an annual Policy. The premium can be paid monthly, annually, semi-annually, quarterly or according to the payment mode established by the Company. Changes in payment mode will be made only on the Policy Anniversary Date.

5.2 GRACE PERIOD

The Company grants a thirty (30)-day Grace Period to pay the annual renewal premium of the Policy, which begins the day after the Expiration Date of the Policy, according to the selected payment mode. If the premium is not paid within the Grace Period, the Insurer will terminate the Policy at 23:59 on the last day for which the premium had been paid. If the full premium is not received by the Company before the Grace Period ends, this Policy shall be deemed expired as of its Expiration Date. During the Grace Period, no benefits or payments will be provided for expenses incurred after the Expiration Date. If the premium is paid during this period, the Policy will be renewed.

5.3 PREMIUM PAYMENT

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

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

5.4 PAYMENT NOTICES

The premium is payable on the Expiration Date of the Policy. Renewal notices are issued as a courtesy and the Company does not guarantee delivery. If the Contracting Party does not receive a payment notice thirty (30) days before the Expiration Date, and the Contracting Party does not know the premium amount, it must contact the Agent or the Insurer. The collection efforts of the premium made by the Insurer does not imply the resignation of the Company of its right to terminate this Policy for lack of payment. Failure to pay the renewal premium on or before the Expiration Date will be interpreted as the expressed will of the Contracting Party to not renew this Policy.

5.5 RATE CHANGES

The Insurer reserves the right to change the premium rates on the date of each anniversary of this Policy, according, to the inflation of medical costs and/or the loss ratio of the group.

5.6 PREMIUM REIMBURSEMENT

If the Contracting Party or the Insurer cancels or rescinds the Certificates of Coverage of this Policy for any of the Insureds, the Insurer will reimburse the unearned portion of the corresponding premium to said Insured of the Contracting Party, following the provision 1.1.

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

SECTION 6

Benefits and provisions

Unless stated otherwise, benefits are offered per Insured, per Policy year. All amounts are expressed in US dollars (USD). The benefits are limited to the medical expenses that are covered under the Policy, and are subject to the Usual, Customary and Reasonable (UCR) costs for the geographical area where the expenses were incurred.

6.1 GEOGRAPHICAL COVERAGE

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

6.2 STANDARD PRIVATE HOSPITAL ROOM

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

6.3 INTENSIVE CARE UNIT

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

6.4 SURGEON, ASSISTING SURGEON AND ANESTHESIOLOGIST FEES

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

6.5 ONCOLOGY

Coverage for tests, treatments (chemotherapy and/or radiotherapy), and oncology medications, for both inpatients and outpatients, is 100% UCR.

6.6 ORGAN AND TISSUE TRANSPLANT

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

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

B. Every pre-Transplant care, which includes those services directly related to the evaluation that established the need for the Transplant, the evaluation of the Insured to receive the Transplant procedure, and the preparation and stabilization of the Insured for said procedure;

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

D. The cost of obtaining the organ and tissues, its harvesting and transportation, and the medical expenses of the Donor;

E. The procedure to Transplant the organ;

F. The coverage of an artificial heart, or mono or bi-ventricular devices to allow the patient to be viable until he/she receives the final Transplant;

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

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

The following requirements are indispensable for this Transplant coverage:

A. It is Medically Necessary;

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

C. No other procedures and/or treatments are available that will lead to the same level of results and care to treat the medical condition or Illness that caused the need for the Transplant;

D. It is not originated as a result of a Transplant where the receiver obtains a mechanical artifact or artificial equipment aimed to replace human organs, or when the organ to be Transplanted is an animal's; and

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

The Company must receive a Preauthorization request as soon as it is determined that an Insured is a candidate for a Transplant, so that it can be managed, coordinated, and preauthorized by the Company. To optimize this benefit for the Insured, the Company will recommend the use of special Transplant Providers. To make use of this benefit, the Insured must authorize the Company to submit all medical documentation related to the Transplant for a VIP® Second Medical Opinion to determine the Medical Necessity and appropriateness thereof.

6.7 CONGENITAL DISORDERS

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

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

6.8 HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

The coverage for this benefit is up to a maximum of fifty thousand dollars (US$50,000) per Insured, per Policy Year.

This coverage is subject to the fact that the Human Immunodeficiency Virus's antibodies or the AIDS virus has not been detected before the Effective Date of the Policy nor in the first thirty-six (36) months from the Effective Date of this Policy (for teams under 5 people), and/or when is a result of a proven occupational Accident (such as being a member of an Emergency services, medical or dental practitioner where the Insured may have contracted the infection accidentally while carrying out normal duties) or a blood transfusion when received as inpatient as part of a Medically Necessary treatment. This benefit includes pre and post diagnosis consultations, routine check-ups for this condition, Medication and dressings (except experimental or those unproven), Hospital accommodations and nursing fees. This benefit must be coordinated and approved in advance by the Company.

6.9 ADULT COMPANION ACCOMMODATION EXPENSES OF A HOSPITALIZED INSURED

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

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

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

6.10 RECONSTRUCTIVE SURGERY AND NASAL OR SEPTUM DEFORMITY

The reconstructive surgery shall be covered at one hundred percent (100%) UCR if and when it is Medically Necessary and as the result of a medical condition covered by this Policy. In the case of treatment provided for nasal malformations or of the septum, coverage will be provided if caused by trauma received during an Accident covered by the Policy or due to the treatment of nasal cancer. The Company may require copy of the reports, tests, films, discs or any other information necessary to evaluate the case.

6.11 DAY PATIENT OR OUTPATIENT SURGERY

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

6.12 REHABILITATION AND SPECIALIZED TREATMENTS

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

In all cases, the Company must receive the treatment plan, together with the estimated fees, as well as evidence of Medical Necessity for said treatment plan. Coverage for this care or treatment must be authorized in advance by the Company.The Company would evaluate the extension of the treatment if it is Medically Necessary.

6.13 NURSE CARE AT HOME

The coverage for this benefit is one hundred percent (100%) UCR, for up to sixty (60) days, and based on the Usual, Customary and Reasonable charges for the particular care of the case, or based on special rates established or contracted in advance by the Company for the geographic area, country or specific Provider with whom the Insured receives such services.

This benefit must be coordinated and approved in advance by the Company and

it includes medical home care that has been prescribed by the treating Doctor.

Medical Home health care includes services that can only be provided by certified professionals (nurses or therapists) and does not include custodial or nursing home care, as defined in this Policy.

6.14 EMERGENCY TRANSPORTATION

Ground Ambulance

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

The Insured, by accepting this service, agrees to hold the Company and any of its affiliates harmless from any negligence resulting from such transportation services, as well as for delays or restrictions caused by mechanical problems or by governmental restrictions, in addition driver errors, omissions or negligence, or due to operational, weather, force majeure or any other adverse conditions.

6.15 EVACUATION AND REPATRIATION

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

Air Ambulance Emergency evacuation

The evacuation benefit applies strictly for Emergencies only.

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

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

A. The required Emergency treatment is for a condition or an Accident covered by the Policy;

B. The Insured's life or the loss of any of his/her limbs is in danger;

C. The required treatment cannot be rendered or is not available in any way in the area or place where the Insured is;

D. The transportation is provided by an entity licensed for such purposes, with the qualified staff and equipment;

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

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

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

of its affiliates harmless from any negligence resulting from such transportation services, as well as for delays or restrictions caused by mechanical problems or by governmental restrictions, in addition to pilot, driver or crew errors, omissions or negligence, or due to operational, weather, force majeure or any other adverse conditions.

Repatriation

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

Repatriation or cremation of mortal remains

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

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

6.16 ACCIDENT AND EMERGENCY NON-ELECTIVE TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVERAGE

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

6.17 HOSPITAL CASH BENEFIT

The coverage for this benefit is up to one hundred and fifty dollars (US$150) per night, up to a maximum of thirty (30) nights, when an Insured person is admitted for inpatient treatment and is receiving free-of-charge treatment that would have otherwise been eligible for coverage under this Policy. This benefit is only available by reimbursement.

6.18 PASSIVE WAR AND TERRORISM

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

6.19 TERMINAL ILLNESS / PALLIATIVE CARE

The coverage for this benefit is up to a maximum of fifty thousand dollars (US$50,000) for palliative services to patients with a terminal Illness covered by this Policy, with a medical diagnosis certifying that it is a terminal Illness with a life expectancy of the Insured of one hundred and eighty (180) days or less.

This service must be provided by a medically supervised team of professionals, and it must be rendered in an accredited hospice. This benefit must be coordinated and approved in advance by the Company.

6.20 INPATIENT PRESCRIPTION MEDICATION

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

To request approval, a copy of the prescription written by a physician to treat a condition covered by this Policy must be sent along with the claim. The Company will provide the generic Prescription Drug as the first option when available.

Highly specialized Medications

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

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

This benefit excludes inpatient or outpatient Medications that are not scientifically or medically approved for a specific diagnosis or considered as off-label use or Experimental, or the use of combinations, even when a particular Doctor prescribes it, as well as over-the-counter Medication and/or those not approved for the treatment of the condition of the Insured by the U.S. Food and Drug Administration (FDA) or the European Medicines Agency (EMA), or additional government-sponsored medical agency that has jurisdiction over where the member is being treated that VUMI may reference on a per-claim basis at its discretion. If a prescribed medication is approved by the FDA for the specific condition of the Insured, but it is part of an Experimental treatment, that drug is also excluded of coverage.

6.21 DURABLE MEDICAL EQUIPMENT

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

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

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

6.22 INPATIENT PSYCHIATRIC COVERAGE

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

6.23 HEALTH SCREENINGS AND VACCINES

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

6.24 MATERNITY CARE

A. The benefit for maternity care for natural and Medically Necessary cesarean deliveries is up to a maximum of two thousand five hundred dollars (US$2,500) per pregnancy, including pre- and postnatal expenses. Also, any pregnancy resulting from fertility treatments, will be covered up to the maximum maternity care benefit, but will not be considered a Covered Maternity for any other benefits of this Policy like Maternity and Birth Complications and the automatic inclusion of the Newborn in the Policy.

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

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

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

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

Coverage is not provided for a pregnancy not covered by this Policy.

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

6.25 NEWBORN COVERAGE AND MATERNITY COMPLICATIONS

Coverage for Maternity and Birth Complications, as defined in this Policy, is provided up to a lifetime maximum of fifty thousand dollars (US$50,000) per Policy, with no Deductible. This benefit is subject to a waiting period of ten (10) months.

The identification of a complication during pregnancy is based on medical follow-up that detects a deviation from the normal course of pregnancy. There are various indicators used to determine a complication, which result from medical monitoring during pregnancy or childbirth and detail the condition of the fetus, the status of the cervix, and the condition of the mother.

Outpatient treatment of an eligible medical condition that is a direct result of a pregnancy complication, including but not limited to: ectopic pregnancy, hydatidiform mole, retained placenta, placenta previa, eclampsia (coma or seizure occurring during pregnancy and following pre-eclampsia), post-partum hemorrhage, and miscarriage requiring immediate surgical treatment.

This benefit ends upon the discharge of the mother, in cases of Maternity Complications, or upon the discharge of the Newborn, in cases of Birth Complications, or after ninety (90) days, whichever occurs first, if the newborn is not enrolled within the established timeframe.

This benefit does not apply to conditions resulting from fertility treatment or any other type of assisted reproductive procedure, nor to pregnancies that are not covered under this Policy.

Exclusions

Prescribed bed rest and medical leave that do not require hospitalization, as well as any other symptoms that are inherent and typical of pregnancy; elective cesarean section or cesarean section following a prior cesarean; vaginal bleeding; care or treatment of a chronic condition unrelated to pregnancy, even when special or specific care or treatment is required during the gestation period; complications arising from pregnancies resulting from fertility treatments; and complications

of a pregnancy not covered under this Policy shall not be considered Maternity Complications.

This list is not exhaustive. Other situations may need to be considered depending on the medical progression of the pregnancy, childbirth, and additional examinations.

6.26 OUTPATIENT BENEFITS

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

A. **Emergency room care:** The coverage for this benefit is one hundred percent (100%) UCR.
B. **Physician and specialist visits:** The coverage for outpatient physician and specialist visits is one hundred percent (100%) UCR.
C. **Outpatient Prescription Medication:** The coverage for outpatient Medication, not prescribed during a Hospitalization, is one hundred percent (100%) UCR.

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

Highly specialized Medications

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

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

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

has jurisdiction over where the member is being treated that VUMI may reference on a per-claim basis at its discretion.

D. **Physical therapy and rehabilitation:** The coverage for outpatient physical therapy and rehabilitation is one hundred percent (100%) UCR. In all cases, the Company must receive the treatment plan, together with the estimated fees, as well as evidence of Medical Necessity for said treatment plan. Coverage for this care or treatment must be authorized by the Company in advance.

E. **Mental health visits:** The coverage for this benefit is one hundred percent (100%) UCR, up to a maximum of ten (10) visits per Policy Year.

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

   Covered services include treatment for bulimia, anorexia, bereavement, non-medical causes of insomnia, Attention Deficit Disorder (ADD), and Attention Deficit Hyperactivity Disorder (ADHD).

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

   In all cases, the Company must receive a treatment plan, along with evidence of services being Medically Necessary, from either a referring physician, or the licensed practitioner or service that is providing ongoing treatment. This coverage must be coordinated and approved in advance by the Company. Pre-authorization by the Company is mandatory for every ten (10) visits, excluding the first consultation.

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

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

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

6.27 VIP® SECOND MEDICAL OPINION

VUMI®'s VIP® Second Medical Opinion service provides Insured Persons with access to the opinions of top-level medical experts from the comfort of their own homes. The most appropriate physicians for the medical condition will evaluate the case based solely on the Insured Person's medical history and the information that led to the initial diagnosis. This service does not include an in-person consultation with any of the doctors who issue their opinion.

To opt for this service, the Insured must complete, sign, and send the form, along with their medical history, diagnosis, tests performed, a copy of their passport or identity document, and any other documentation relevant to the case, to secondopinionvip@vumigroup.com.

IMPORTANT: The recommendations of Second Medical Opinion VIP® do not alter, modify, or override the terms, conditions, or exclusions of this Policy. All claims and coverage determinations are subject to the specific provisions described in the Policy Coverage Conditions.

SECTION 7

Exclusions

7.1 EXCLUSIONS FOR MEDICAL CARE, NON-AUTHORIZED MEDICATIONS, AND EXPERIMENTAL TREATMENTS

A. **Treatments that are not Medically Necessary and medical care that is not prescribed or recommended by a physician:** Any service, expense, treatment, Injury or Illness, or costs related to services or supplies that are not Medically Necessary; or that are provided or prescribed to an Insured who is not under the care of a Physician or medical professional legally licensed in the Region or country where they practice; or that have not been prescribed by a Physician or medical professional. Not administered within a licensed facility. This to exclude home massages, doctor home visits unless medically necessary.

B. **Alternative medicine:** Homeopathic or alternative care except as specifically provided in this Policy

C. **Investigational or Experimental Procedures:** Treatments that are not scientifically recognized or are still in the investigational or clinical trial phase, as well as those that have not been approved by the United States Food and Drug Administration (FDA) or the European Medicines Agency (EMA) or any additional government-sponsored medical agency that has jurisdiction over where the member is being treated that Company may reference on a per-claim basis at its own discretion.

   Only services, expenses, or Medications approved by the competent authority in the country where they are rendered or prescribed are eligible for reimbursement. Insureds receiving services in regions not subject to the European Union EMA are subject only to U.S. FDA regulations.

D. **Non-medically approved Medications:** Any medication that is not scientifically or medically approved for a specific diagnosis, or that is considered off-label use or Experimental; or the use of combinations that are not generally accepted by the scientific community, even when prescribed by a particular Physician, as well as over-the-counter medications and/or those not approved for the treatment of the Insured's specific condition by the United States Food and Drug Administration (FDA) or the European Medicines Agency (EMA).

E. **Experimental Medications that are part of an Experimental treatment:** Prescription Medications that are approved by the United States Food and Drug Administration (FDA) or the European Medicines Agency (EMA) for the Insured's specific condition, but that are used as part of an Experimental treatment.

F. **Complications caused by Experimental treatments:** Any cost of services or treatments incurred by the Insured due to any complication arising from or resulting from any Experimental treatment received, or any subsequent treatment the Insured may require as a result of undergoing any Experimental treatment or the use of non-authorized medications or drug combinations.

G. **Non-prescription medications:** Any medication, supply, or medical equipment that can be obtained without a medical prescription, known as over-the-counter (OTC) medications, even when recommended by a physician, including but not limited to dietary supplements due to digestive intolerances; appetite suppressants; vitamins; supplements; minerals; herbal based products; teas; or anti-aging or hair-growth medications or products.

H. **Treatments rendered outside the Policy effective period:** Claims and costs for medical services with a date of service after the Policy Expiration Date that are related to Accidents, Illnesses, or maternities originating during the Policy term, unless the Policy has been renewed before the expiration of the Grace Period. This includes any portion of a covered prescription that will be used after the expiration of the current Policy effective period.

I. **Routine examinations:** Any routine examination as part of a preventive screening that is not specified in the Schedule of Benefits; routine hearing and eye examinations; cochlear implants, hearing aids or any other surgical hearing implant; Optometry services, eyeglasses, and contact lenses; refractive surgery or any surgical procedure intended to correct visual acuity or refractive errors, including but not limited to LASIK, PRK, radial keratotomy, or similar procedures performed to correct myopia, hyperopia, astigmatism, presbyopia, or other refractive conditions; prophylactic treatments, including vaccines; hearing loss; and the issuance of medical certificates and/or fitness examinations for work or travel, except as specifically provided in this Policy.

J. **Aesthetic or cosmetic treatments:** Any type of cosmetic or elective surgery, or treatments whose primary purpose is aesthetic, except when necessary due to an Injury or an Illness that caused a deformity affecting a bodily function, provided such deformity or Illness occurred as a result of a covered condition during the Policy term. This includes any treatment for nasal or septal deformities, except as specifically provided in this Policy. Complications resulting from non-covered services, as well as the diagnosis or treatment of any condition arising as a complication of a non-covered service, including but not limited to services rendered for cosmetic purposes, including hair transplant; alopecia treatments; body piercing; and breast reductions and implants.

K. **Mental health treatments:** Services for mental and nervous disorders and related Prescription Medication; neurodevelopmental disorders, except when required to treat a complication of a covered condition, as defined in the terms and conditions of this Policy and except as specifically provided in this Policy.

L. **Maternity or Birth Complications treatments for a non-Covered Maternity:** Any cost for treatment of the mother or Newborn related to a non-Covered Maternity, including any complication, as well as Maternity Complication expenses for dependent daughters. Any voluntary termination of pregnancy (legal or illegal), unless prescribed due to the mother's life being in imminent danger, or in the case of rape that has been legally reported to the relevant authorities.

M. **Medical expenses for sterilization and fertility treatments:** Any portion of medical expenses incurred for male or female sterilization; reversal of sterilization; emergency or experimental birth control; copper IUDs; treatment for males; infertility treatments; artificial insemination; in vitro fertilization services; tests, treatments, and/or procedures of any kind treat fertility/infertility including, but not limited to any type of medications, including medications to regulate the menstrual cycle/ovulation for family planning purposes; artificial insemination; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); surrogate motherhood; and all other procedures and services related to fertility and infertility, unless expressly covered by the plan.

   Any pregnancy resulting from such treatments, complications of that pregnancy, and postpartum care, unless stated in the Policy Schedule of Benefits. Delivery will be covered up to the maximum maternity care benefit specified in the Schedule of Benefits, but it will not be considered a Covered Maternity for any other benefit under this Policy, such as Maternity or Birth Complication services or automatic Newborn enrollment under the Policy.

   Any consequence or condition suffered by the mother or Newborn as a result of any type of fertility treatment; sex reassignment, reproduction, or

modification services, including hormone therapy, intersex surgery, sexual deviations and disorders, or psychosexual dysfunctions.

Any type of Genetic Testing, including but not limited to tests to determine paternity or the sex of a child, except for Genetic Tests required for the treatment of compensable conditions, as previously determined and approved by the Company.

Treatments or prostheses used to enhance or restore potency or other sexual deficiencies; testicular prosthesis and/or insertion of a penile prosthesis, except when necessary for the treatment of neurogenic or vasculogenic impotence caused by a medical condition that has lasted more than one (1) year, including but not limited to a spinal cord Injury/Illness, multiple sclerosis, spina bifida, diabetes, radical prostatectomy, rectal surgery, intrapenile arterial disease, cavernous abscess, Disorders related to the Human Papillomavirus (HPV) or Peyronie's Disease (not associated with an Accident) and genital herpes.

N. **Obesity and weight-control treatments:** Any treatment, expense, or service to prevent obesity or for weight-control purposes, whether for weight loss or gain, and any alteration of normal body growth, including any type of dietary supplement, except as specifically provided in this Policy.

O. **Growth hormones:** Treatments with growth hormones or bone growth stimulators, or any treatment related to growth hormone, regardless of the reason for which it was prescribed.

P. **Dental or orthodontic treatment:** any expense for dental or orthodontic treatment including, but not limited to abnormalities or disorders of the upper jaw, the mandible or the mandibular joint including, but not limited to anomalies and malformations thereof; bruxism; Temporomandibular Joint Syndrome (TMJ); cranio-mandibular disorders; or any other jaw or joint condition connecting it to the skull, as well as other tissues associated with such joints, except as specifically provided in this Policy.

Q. **Sleep disorders, Alzheimer's and autism:** Treatment or services related to any of the following conditions: sleep disorders, Alzheimer's disease, and autism.

7.2 PATIENT SERVICES EXCLUSIONS

A. **Pre-admission to a Hospital for more than twenty-three (23) hours:** Any admission to a Hospital for more than twenty-three (23) hours on the day prior to a scheduled surgery, or admission to a Hospital to receive outpatient medical services, unless pre-approved by the Company.

B. **Additional medical assistants:** The participation of more than one (1) medical, surgical, or assisting-professional in a surgery, unless previously approved by the Company.

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

D. **Extended care:** Treatments in mental health centers or psychiatric institutions; nursing homes; home health care services that extend beyond the reasonable time needed to cure or heal a condition; assisted-living facilities; convalescent centers or hospices; Long-Term Care Centers or extended-care facilities; hydro-clinics; health spas; and gym memberships, except as specifically provided in this Policy.

E. **Counseling services:** Any expense related to recreational or educational therapy; marriage counseling; adoption agency services; pastoral counseling; family, social, occupational, religious, or other maladjustment counseling; chronic behavior disorders; codependency; impulse-control disorders; organic disorders; learning difficulties; hyperkinetic syndromes. This includes any Prescription Medication used for the treatment associated with any of the aforementioned conditions.

F. **Custodial Care:** Assistance with household routines or personal hygiene; any other personal service offered for comfort, including but not limited to beauty and hairdressing services, radio and television, meals and lodging for guests, telephone charges, household supplies, massages, and travel expenses that are not Medically Necessary Emergency Ambulance services, as specifically provided under this Policy.

G. **Charges for treatments rendered by immediate family members:** Charges for medical services rendered by an immediate family member or a member of the Insured's household, even if the bill or claim is submitted by another person or entity such as a professional association or corporation. This exclusion also prevents an Insured who is also a physician from treating themselves and submitting claims for such care. For the purposes of this exclusion, "immediate family member" means any of the following: spouse; biological or adoptive parent, child, or sibling; stepparent, stepchild, stepsibling; father-in-law, mother-in-law, son-in-law, daughter-in-law, or brother-in-law; grandparent or grandchild; spouse of a grandparent or grandchild. The Company reserves the right to authorize treatment provided by a family member or to allow the use of the Provider's facilities.

H. **Podiatric care and orthopedic devices:** routine foot care, as well as any service or supply related to foot care, including but not limited to medical or surgical treatment of bunions, flat feet, weak arches, and chronic foot strain; removal of warts, corns, or calluses; special shoes; pedicures or nail trimming; and orthopedic inserts of any type or form.

I. **Administrative and non-medical fees:**

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

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

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

7.3 MEDICAL EQUIPMENT AND SUPPLIES EXCLUSIONS

A. **Artificial kidney equipment:** Any portable or home-use artificial kidney equipment.

B. **Artificial or animal organs, cryopreservation and storage of tissues and Stem Cells:** Any expense related to the acquisition and implantation of an artificial heart or animal organs; cryopreservation; storage of bone marrow, tissues, Stem Cells, or umbilical cord blood for more than twenty-four (24) hours, except for an examination to establish a diagnosis and except as specifically provided in this Policy.

C. **Duplicate Durable Medical Equipment:** Any expense related to the duplication of functions of a device or Medical Equipment indicated for the same purpose, as well as the loss, repair, or replacement of Durable Medical Equipment, except when its normal life cycle has expired and only when such equipment was originally covered under this Policy.

7.4 EXCEPTIONAL RISKS EXCLUSIONS

A. **Reckless Behavior:** Services, care, and treatment, without limitation, incurred in relation to Injuries that occurred due to Reckless Behavior, Negligence, Gross Negligence, or Intentional Misconduct by the Insured, as determined by the Company.

B. **Encounters with wild animals:** Injuries or expenses that result from or arise out of encounters with wild animals under any circumstance.

C. **Behavior that disturbs public order:** Injuries or expenses arising from participation in fights, including those involving members of the Insured's family, unless the Insured is acting lawfully in self-defense, as determined by a court of law.

D. **Criminal acts:** Injuries and/or Illnesses that result, arise, or occur during the commission or perpetration of a violation of the law by the Insured.

E. **Self-exposure to Injury:** Treatment for any loss or expense of any nature arising directly or indirectly from, contributed to, caused by, resulting from, or related to self-exposure to danger or bodily Injury, or disregard for one's own rights and safety or that of others, except in an attempt to save a human life.

F. **Self-inflicted Illness or Injury:** Treatment for any condition resulting from self-inflicted Illnesses or Injuries, suicide or attempted suicide, whether sane or insane, or Emergency air services related thereto.

G. **Alcohol-related disorders:** Addictive conditions of any kind; alcoholism or alcohol abuse (when the Insured's blood alcohol level is considered to exceed the legal limit in the jurisdiction where the incident occurred).

H. **Substance abuse:** Treatments for solvent abuse, drug abuse, or addictive conditions of any kind, and treatment of any Illness arising directly or indirectly from the abuse of or addiction to alcohol or drugs. This includes, but is not limited to, treatment of any Injury caused by, contributed to, or resulting from the use of alcohol, illegal drugs, or any drug or medication taken by the Insured that is not used in the dose or for the purpose prescribed by the Insured's physician.

I. **Expenses covered by third parties:** Health services resulting from accidental bodily Injuries arising from an automobile, boat, or plane Accident, or any other type of Accident, whether in public or private, business, residential, etc., where the incident that injures the Insured is covered by any type of insurance, private or public, regardless of whether the Insured pursues a liability claim against a third party. Care and treatment for any Injury, Illness or condition for which the Insured receives benefits under any workers' compensation law, employer's liability policy, or any similar policy.

J. **Expenses for medical services or treatments for declared Epidemics or Pandemics:** Any medical treatment subject to management by public authorities, including treatments and services related to infectious Diseases declared as an Epidemic or public health emergency by the World Health Organization (WHO), the United States Centers for Disease Control and Prevention (CDC), or any other government, governmental agency, or governing body of the country in which the Epidemic occurred. In addition, such coverage is also excluded if the U.S. Department of State or similar office, the Embassy(ies) of the affected country(ies), the airline, or another governmental agency has issued an official travel warning against the area or region before traveling to the affected country, except when exposure occurs accidentally or unknowingly while traveling to or from non-declared risk areas, or as a result of visiting the area before the declaration of an Epidemic or Pandemic.

K. **Injuries resulting from active service, war, or participation in riots:** Treatment of Injuries that result when a person is an active member of the police force, army, or military force of any country, or is directly or indirectly* participating in war or military conflict, insurrection, civil or military coup, hostilities, civil war, riot, rebellion, martial law, act of terrorism, or any illegal activity, including possible arrest and imprisonment resulting from such participation, except in cases where the Insured is merely a bystander or innocent civilian.

*"Indirect" participation activities that merely support one of the conflicting parties. Such activities include, among others, selling goods to one or more armed parties. Injuries caused by indirect participation in war or conflict include any support of one of the parties involved in a conflict without directly engaging in combat, such as providing financial assistance, supplying weapons, propaganda, or intelligence, which essentially contribute to the war effort without active combat participation.

L. **Injuries or Illnesses caused by radiation:** Treatment of Injuries or Illnesses resulting from any loss arising from ionizing radiation, pollution, or contamination by radioactivity from any nuclear fuel waste combustion and radioactive, explosive, or toxic property or other hazardous component, as well as receiving X-ray therapy or radiotherapy without medical prescription or supervision.

M. **Expenses incurred in sanctioned countries:** Any expense or claim arising from treatments, 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 their agencies or asset control bodies.

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

SECTION 8

Definitions

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

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

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

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

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

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

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

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

Assisted or Custodial Care: Services provided that include, but are not limited to personal assistance that does not require professional or training skills, such as routine patient care, surveillance, monitoring of signs, periodic turning and positioning in bed and administration of medications that may be self-administered or administered orally and by non-medically trained persons, as well as preventive or routine care; or care under standard conditions, including assistance in daily activities, for example: washing, feeding or dressing of an Insured, providing assistance for his/her move or mobilization, making the bed and other activities related to daily life, with the purpose of preventing Accidents and providing accompaniment, among others.

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

Associated Persons: Individuals who have a relationship with the Policyholder through the facilitation and/or hire, payment services or any other services it provides from time to time. This includes: 1. Contractors (where they support payments, contracts etc.); 2. Employees from employees of record partners (where they are the middle man between the client company and employee of record partner); 3. Employees of record from their own entities; 4. HQ members; and 5. Users of talent management or hiring facilitation services.

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

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

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

Community: A group of Associated Persons who may be:

A. Contractors (where they support payments, contracts etc.);

B. Employees from employees of record partners (where they are the middle man between the client company and employee of record partner);

C. Employees of record from their own entities;

D. HQ employees; or

E. Users of talent management or hiring facilitation services.

Community Plan: Health insurance policy that's facilitated by a lead Policyholder who will provide voluntary cover for its EOR's and its Associated Persons.

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

Complications of Pregnancy and Childbirth: Morbid conditions that occur during pregnancy, childbirth, or the postpartum period (after birth) and may affect the mother, the baby, or both, as a result of an abnormal course of pregnancy and/or childbirth. Some examples of complications include*, but are not limited to: toxemia; gestational hypertension; eclampsia; ectopic pregnancy; hydatidiform mole; antepartum and postpartum hemorrhage; retention of the placenta and its membranes; fetal death; spontaneous abortion; placental abruption; placenta previa; failure of fetal descent; amniotic fluid embolism; prematurity; umbilical cord injury; fetal distress; perinatal asphyxia; umbilical cord problems; shoulder dystocia; or premature delivery.

*This list is not exhaustive. Other situations may need to be considered depending on the medical course of the pregnancy, delivery, and additional tests.

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 to the Insured Party and/or their Dependents, due to an employment relationship or family ties. The Contracting Party is not an Insured Party and therefore does not enjoy the benefits under the Policy; however, they have the power to request the cancellation of the Policy they have paid for the Insured Party and receive 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.

Newborns who are the result of a fertility treatment don't have automatic inclusion, therefore do not qualify for the benefits associated with this type of addition to the Policy.

Dangerous Activities and Sports: Activities that increase the risk of death or illness for the person practicing them. Examples of dangerous activities and sports include, but are not limited to, scuba diving, rock climbing, mountaineering, skydiving, freefall jumping, paragliding, parasailing, and mountain biking.

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

Domestic Partner: Person with whom the Insured has established a relationship of domestic life.

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

Effective Date: The date when the Policy becomes effective.

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

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

Experimental or Investigative: Any treatment, procedure, equipment, Medication, combination of Medication, device, supply or Hospitalization which, at the time the service or supply is provided, does not meet the generally approved norms for the specific indication or Application to the condition by the FDA or other applicable federal Agency of the government of the USA, or the European Medicines Agency (EMA), or additional government-sponsored medical agency that has jurisdiction over where the member is being treated that VUMI may reference on a per-claim basis at its discretion and whose approval is required regardless of the location where the medical expenses are incurred.

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

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

Genetic Testing: A type of medical test that identifies changes in genes, chromosomes, or proteins. The results of a Genetic Test can confirm or rule out a suspected genetic condition or help determine the likelihood of a person developing or passing on a genetic disorder.

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

Gross Negligence: A lack of attention that demonstrates reckless disregard for the safety or life of others, which is so great that it appears to be a conscious violation of other people's right to safety.

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

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

High Cost Countries:

- Africa and Middle East: Bahrain, Israel, Kingdom of Saudi, Arabia, Kuwait, South Africa, United Arab Emirates, and Qatar.
- America: Brazil, Canada, and United States of America.
- Asia: China, Japan, Singapore, South Korea, and Hong Kong.
- Europe: Austria, Belgium, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Monaco, Netherlands, Norway, Sweden, Switzerland, and United Kingdom.
- Oceania: Australia.

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

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

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

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

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

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

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

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

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

Intentional Misconduct: A deliberate act or omission that is contrary to or exceeds the conduct expected of a person, when that person knows or is reckless as to the fact that such act or omission is contrary to or exceeds the conduct expected of them.

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

Live Donor: A live person who donates an organ, tissue or cell to be Transplanted into the body of another person or recipient.

Long-Term Care Facility: Assisted living institution.

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

Medical Necessity or Medically Necessary: Treatment, medical service or medical supply deemed necessary by the Company, in mutual agreement with the Insured's physician, to diagnose and/or treat an Illness or Injury.

It is not Medically Necessary if the service:

A. Is provided as a matter of convenience to the Insured or his/her family or the Hospital/physician;

B. Is not appropriate for the diagnosis or treatment of the specific condition;

C. Exceeds the level of care required for the diagnosis or treatment of a specific condition;

D. Is outside the scope of the standard practices established for Doctors and Hospitals; or

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

Member(s): An individual named under the group Policy at any given time.

Negligence or Negligent: Failing to behave with the level of care that a reasonably prudent person would exercise in the same circumstances. The behavior usually consists of actions, but it can also consist of omissions when there is a duty to act, or there are rules or precautions to follow.

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

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

Notification: Communication to the Company about a procedure or treatment, requesting assistance with appointments or advice on specialists, providers, etc. A Notification does not count as a mandatory Preauthorization request for a service that requires more information about the use of one of the Policy benefits.

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.

Ophthalmology: A medical specialty that focuses on the eyes, including their anatomy, physiology, and the treatment of complex eye diseases. Ophthalmologists diagnose, treat, and monitor eye disorders, and may perform surgery when necessary.

Optometry: Primary care professionals who perform routine eye exams, prescribe eyeglasses and contact lenses, and treat common eye conditions.

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 Contracting Party are described and which governs the insurance contract.

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

Policyholder or Applicant: The individual who signs the insurance Application, is the main Insured under the Policy, has the authority to request changes in the Policy, and receives the reimbursements for payments of medical services covered under this Policy, as well as any reimbursement of the unearned premium.

Preauthorization or Precertification: Request made by the Insured in order to obtain authorization from the Company to use one of the benefits of the Policy that requires this mandatory request for treatment or procedure.

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 received or recommended 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 some form of treatment would have been received.

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

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

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

Reckless Behavior: Conscious disregard for 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.

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

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

Serious Accident: Violent, sudden, unforeseen and unintentional event that is provoked exclusively by external causes that result, independently of other causes, in bodily Injuries to the Insured, and which require urgent medical care with a Hospitalization of twenty-four (24) hours or more.

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

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

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

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

Suite: Hospital room of a Hospital or Clinic classified by said Hospital or Clinic as a Suite, usually of a larger size than that of a Private Room and which may have a reception area. This includes rooms referred to as “Junior” or “Presidential.”

Team: A group of employees and/or contractors connected to the Policyholder company.

Transplant: Medical procedure to transfer an organ, tissues or cells from a Living or deceased Donor to the recipient, or reimplant it in the same person.

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

United States, US, USA: The United States of America and Territories.

Usual, Customary and Reasonable (UCR): The lower of:

A. The Provider’s usual reimbursement for furnishing the treatment, service or supply; or

B. The amount determined by the Company to be the general rate accepted by Providers of the same category who provides such treatments, services or supplies to persons: (1) who reside in the same geographical area; and (2) whose Injury or Illness is comparable in nature and severity.

The Usual, Customary and Reasonable amount for a service, treatment, or provisions will be determined by the Company based on special rates established or contracted in advance by the Company for the geographic area, country or

specific Provider with whom the Insured receives such services. In some cases, the UCR amount will be determined by direct contracts between the Providers and the Company.

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

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

SECTION 9

Management of the policy

9.1 NOTIFICATIONS AND/OR PRE-AUTHORIZATIONS

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

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

A. All Hospital admissions;

B. All Hospital or outpatient surgeries;

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

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

E. Nasal or reconstructive surgery;

F. Emergency transportation by Air Ambulance;

G. Durable Medical Equipment or any special medical device; and

H. Repatriation or cremation of mortal remains.

I. Any medical service or acquisition of specialized medications, such as those related to the Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS);

J. Organ and tissue transplants, bone marrow transplants, stem cell transplants, and any other similar procedures;

K. Oncological treatment;

L. Long-term care / inpatient rehabilitation; and

M. Dialysis.

To obtain services, a Prior Authorization request must be submitted to the Company at least five (5) business days prior to the scheduled date of the procedure or treatment, unless the services constitute medically justified Emergencies. The Company must also be given notice of all medical Emergencies that require notification within seventy-two (72) hours after the event that caused the Emergency. If the Policyholder and/or the Insureds fail to notify the Company accordingly, they shall then be responsible for thirty percent (30%) of all covered costs.

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

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

Email address: rhpreapproval@safetywing.com

Phone number: +1.214.276.6376

9.2 CLAIMS

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

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

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

A. Claim Form duly completed;

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

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

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

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

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

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

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

If the information provided should be considered inadequate or is incomplete, it may create a delay in the payment or reimbursement process, or it may cause the claim to be temporarily closed until the necessary information is received within the stipulated time limit. The Company reserves the right to request the original receipts, medical records and/or any other relevant documentation in order to process the claim. The Company will not return original documentation received to process a claim; however, it may offer a copy of such documentation when requested. In the event that a claim that should have been denied because coverage was excluded from the Policy has been paid in error, the Company will not be obligated to continue paying for the expenses of treatments or services related to such claim from the date of the identification of the error, and may request the reimbursement of the amounts unduly paid.

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

9.3 CLAIMS APPEALS

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

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

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

Second instance of appeal

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

9.4 ARBITRATION AND LEGAL ACTIONS

Any dispute, controversy or claim arising out of or relating to this contract, including the formation, interpretation, breach or termination thereof, including whether the claims asserted are arbitrable, will be referred to and finally determined by arbitration in accordance with the JAMS International Arbitration Rules.

The place of arbitration will be in Miami, Florida. The language to be used in the arbitral proceedings will be English. Each party will bear its own fees and costs (including all Arbitration Costs, as that term is used in the JAMS International Arbitration Rules) incurred in connection with any dispute subject to this provision.

Judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

Governing law

This agreement shall be governed by and construed in accordance with the law of Florida, excluding Florida's choice of law rules.

WAIVER OF JURY TRIAL

THE PARTIES HEREBY KNOWINGLY, INTENTIONALLY AND IRREVOCABLY WAIVE ANY AND ALL RIGHT TO A TRIAL BY JURY IN ANY LEGAL PROCEEDING DIRECTLY OR INDIRECTLY ARISING OUT OF OR IN ANY WAY RELATED TO THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED HEREIN.

9.5 SUBROGATION AND INDEMNITY

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

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

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

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

9.6 ASSIGNMENT AND SUBCONTRACTING

The Company may not assign this Contract, nor the credits, rights, and obligations arising therefrom, nor subcontract the provision of the services in whole or in part, without the prior and express written authorization of the Contracting Party. The Contracting Party may assign this Contract to its successors, assignees, legal successors, and/or to any company in general, without requiring any consent from the Company, by means of a simple written notice. Even when the Contracting Party authorizes partial subcontracting, the Company shall remain liable to the

Contracting Party for the acts of the subcontractor, as if such acts had been performed by the Company itself.

SECTION 10

Language

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

SECTION 11

Agreement

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

SECTION 12

Amendments

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

Data Protection

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

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

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

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

Contact us

remotehealth@safetywing.com

Website

safetywing.com/remote-health



VUMI GROUP, I.I. ORGANIZED UNDER CHAPTER 61 OF THE PUERTO RICO INSURANCE CODE. NO COVERAGE ISSUED BY THIS INSURER IS PROTECTED BY ANY GUARANTEE OR INSOLVENCY FUND IN PUERTO RICO.
Administration services provided by VIP Administration Services, LLC.

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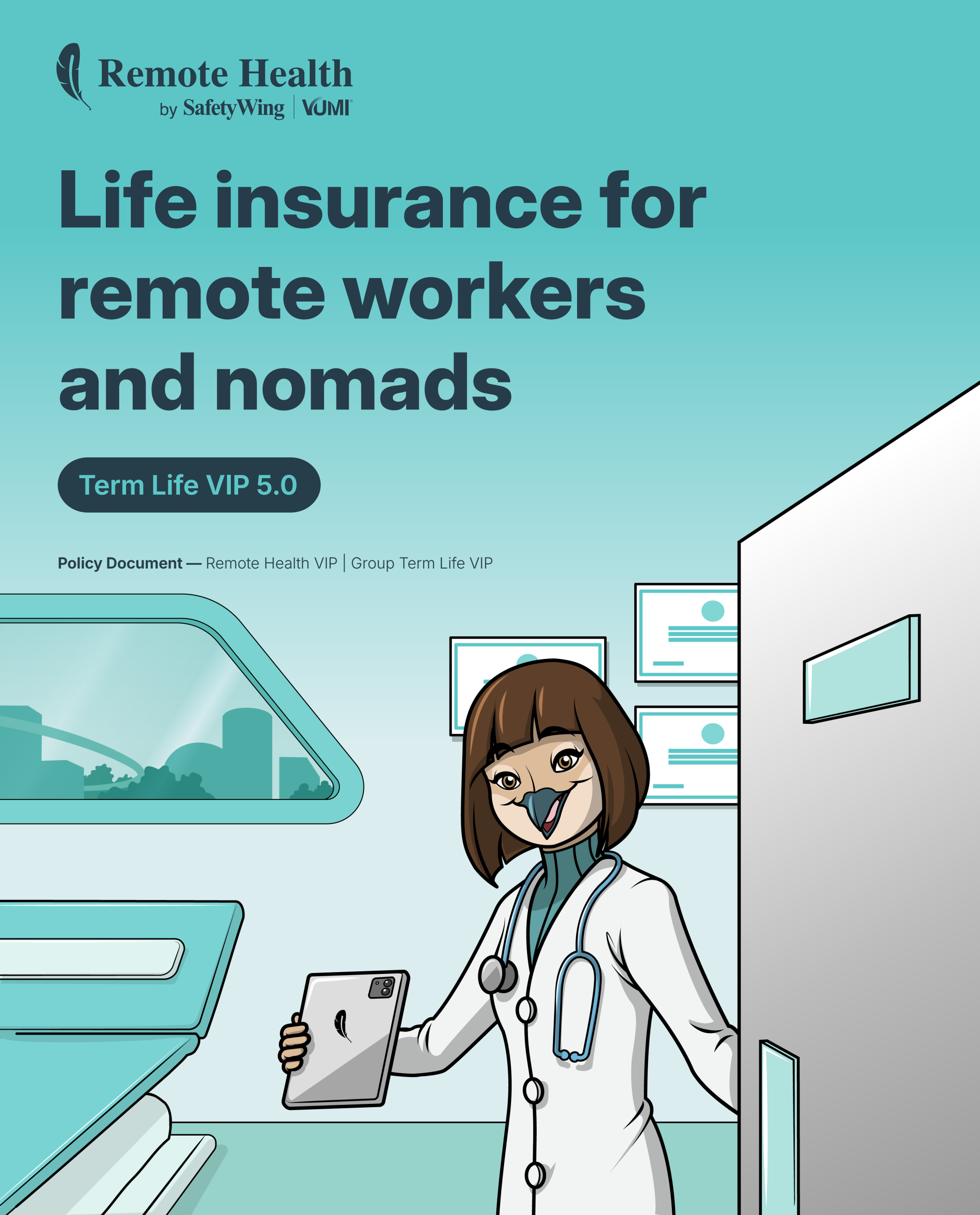
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Remote Health
by SafetyWing | VUMI

Life insurance for remote workers and nomads

Term Life VIP 5.0

Policy Document — Remote Health VIP | Group Term Life VIP



SafetyWing

Your health taken care of *wherever* you live, work or travel.



We make it simple for remote workers around the world to stay healthy. Welcome to your global health plan.

Go to any doctor or hospital at home and while traveling

No reimbursement stress with prepaid cards and direct payments to providers

24/7 human support with response time of less than a minute

VUMI®

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

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

In partnership with SafetyWing, with Remote Health you will have the peace of mind of knowing that your health is in the best hands 24 hours a day, 365 days a year.

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For notifications and pre-authorizations:
rhpreapproval@safetywing.com

For reimbursement of claims:
rhclaims@safetywing.com

General Telephone: +1 214 276 6376

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

Remote Health
by SafetyWing | VUMI

Health Insurance

Remote Health VIP | Group Term Life VIP



SECTION 1

Agreement

This Group Term Life VIP and Accidental Death and Dismemberment (AD&D) insurance Policy (Master Policy) is underwritten and issued by VUMI® Group, I.I., hereinafter the “Company”, based on the insurance group application and group census submitted by the Policyholder or Contracting organization, along with the corresponding premium.

This group Policy is a contract between the Company and the Policyholder or Contracting organization, it may be changed or ended without any of the Insured’s consent or notice, and it is effective for all Insureds for whom the annual premium has been paid.

The Insured, as an Employee, may only acquire this Policy for him/herself only.

The Company will pay a death benefit to the named Beneficiary or Beneficiaries listed in the Certificate of Coverage of the Employee, according to the term insurance coverage when an Insured dies, and in the event the Insured suffers an Accident, the Company will pay the designated amount on the Accidental Death and Dismemberment benefit. The benefits of this Policy will be subject to the terms, provisions, exclusions and restrictions described in this Conditions of Coverage and the Certificate of Coverage, which are an integral part thereof.

Capitalized words are defined terms of special relevance and meaning in this document, and they include the plural as well as the singular. To help Insureds understand insurance terms, they can refer to the definitions described at the end of this Policy.

1.1 RIGHT TO EXAMINE THE POLICY

The Insured must review the terms of the coverage to verify he/she is in agreement with the coverage offered, or otherwise request the cancellation of his/her Certificate of Coverage to the Policyholder or Contracting organization in writing, and return it to the Company within a fifteen (15) day period after receiving it.

The Company will reimburse the Policyholder or Contracting organization the net premium corresponding to this Certificate of Coverage, and it will be null and void, as if it was never issued.

The Policyholder or Contracting organization's decision to cancel this Policy, or the Insured's decision to cancel his/her Certificate of Coverage is their prerogative.

Once the Company processes the requested cancellation, all Company's obligations and liabilities under this Policy and/or each Certificate of Coverage issued will end. The cancellation is binding on the Insureds and any Beneficiary or person entitled to make a claim under this Policy, whether their entitlement is revocable or irrevocable.

To request a cancellation of the Policy or any individual Certificate of Coverage, the Policyholder or Contracting organization must send a written request to the administrator of services, an affiliated company of the Company via email to: remotehealth@safetywing.com or support@safetywing.com

1.2 CONTESTING THE POLICY

Limit on contesting

The Company can't challenge the validity of any individual Certificate of Coverage issued under this Group Term Life Policy, after it has been in effect continuously for two (2) years from the Effective Date, or the date it was last reinstated, whichever comes last. If any particular Certificate of Coverage is amended to increase coverage or change a Beneficiary, the Company can't challenge the validity of the Amendment after it has been in effect continuously for two (2) years from the date the Amendment took effect, or the date the Master Policy was last reinstated, whichever comes last.

Exception to the limit on contesting

The Company can challenge the validity of the Master Policy and all Certificates of Coverage, or any particular Certificate of Coverage or an Amendment, at any time, in cases of fraud.

1.3 IMPORTANT NOTICE ABOUT THE APPLICATION PROCESS

This Policy is issued based on the statements provided in good faith by the Policyholder or Contracting organization and each of the Insureds to be covered under the Policy. If the age or gender of any of the applicants is incorrect or inaccurate in the group application or the group census, the Company will retroactively adjust the premiums based on the correct age and/or gender of the Insured. If any of the other information disclosed by any applicant under the group is false, incorrect, inaccurate, incomplete, had the intent of misleading or

deceiving or was omitted, resulting in worsening the risk, coverage for that Insured will be rescinded, will have no effect, and the Company will not be responsible for any payments of the benefits offered under this Policy. In any of these cases, the Company reserves the right to modify, cancel or rescind the Master Policy in its entirety.

Likewise, if a Provider or any other individual or entity who has rendered medical services to one of the Insureds should submit false statements in collusion with the Policyholder and/or one of the Insureds or a third party, with the purpose of claiming payments against this Policy, its articles and/or Amendments, the Insured's coverage 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 Insured(s) and/or the Beneficiary(ies) 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 Insured(s) or a third party.

1.4 ENTIRE CONTRACT

This Master Group insurance Policy is issued under an agreement with the Policyholder or Contracting organization, it includes:

A. The group Policy (this document);

B. The group application and census signed by the Policyholder or Contracting organization;

C. Any medical exam of the Insureds 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 medical records and any other relevant information for the evaluation of the coverage;

D. Any form or document that may be required to add any of the Insureds or certificate holders to the Policy or to modify the coverage;

E. All Certificates of Coverage issued to the Insureds, at any time; and

F. Amendments (if any) which modify the terms and conditions of this Policy, or modify any individual Certificate of Coverage.

All of the Company's obligations to the Insureds are contained in the documents described above. Any other document or oral statement does not form part of this contract. This Policy or any part of this Policy may not be amended or waived except by a written Amendment signed by two (2) authorized signing officers of the Company.

SECTION 2

Policy Term

The coverage lasts twelve (12) months and may be renewed for the same period of time upon receipt of payment of the corresponding premium, subject to the previous confirmation of the Company, eligibility, definitions, conditions and other provisions of the Policy that are in effect at the time of renewal. The coverage starts one (1) minute after midnight (00:01) Eastern Standard Time on the Effective Date of this Policy, and ends at midnight (00:00) three hundred and sixty-five (365) days later.

This Policy may be renewed annually on the Anniversary Date of the group Policy, as long as the Insured has not reached seventy-five (75) years of age. The Insured's maximum age for the renewal of this Policy is seventy-four (74) years old.

The coverage for the Insured ends on the date he/she dies or on the next renewal day after the Insured turns seventy-five (75) years old, whichever comes first. Benefits are not payable after the Policy ends.

SECTION 3

Eligibility

3.1 ELIGIBILITY REQUIREMENTS

This Policy is available to any Insured of the Policyholder or Contracting organization, as long as the following requirements are met at the time of the application:

A. Be an active, full-time employee of the Policyholder or Contracting organization working at least twenty (20) hours per week;

B. Be at least twenty-five (25) years old and up to fifty-five (55) years old; and;

C. The corresponding premium has been paid.

SECTION 4

Obligations of the Insured

4.1 PREMIUM PAYMENT

Payment of the total premium is the responsibility of the Policyholder or Contracting organization. The premium is payable on the Renewal Date of this Policy, according to the mode of payment selected. Payment of the premium makes the Policy effective during the period for which the premium has been paid.

Any premium paid in excess will be refunded without adding interest and in the same way it was paid. Failure to pay the total premium will result in the termination of the Policy.

4.2 CLAIMS

Claims for the natural death, Accidental Death or Dismemberment benefit of an Insured must be submitted to the Company with all the necessary documentation

to start the claim process. All claims must be a result of causes not excluded by this Policy.

Every action or proceeding against the Company for the recovery of insurance money payable under the Policy is absolutely barred unless commenced within the time set out by the Company.

4.3 DOCUMENTATION AND/OR MEDICAL RECORDS

The Insured, Beneficiary or next of kin, must provide and/or authorize the Company to obtain all the medical information required and/or documentation necessary to validate the claim and pay the benefits. Otherwise, the claim could be put on hold until the necessary information and authorizations are received.

4.4 NOTIFICATION OF LEGAL SEPARATION OR DIVORCE

In case of legal separation or divorce, the Insured must notify the Company within thirty (30) days of the event. The Spouse or Domestic Partner could have coverage until the end of the Policy Year

SECTION 5

General Information

5.1 CURRENCY

All currency values shown in this Policy are expressed in US dollars.

5.2 TERMINATION OR CANCELLATION

As appropriate, this Group Policy or an individual Certificate of Coverage terminates on the earliest of:

A. The death of the Insured;

B. The date the voluntary termination of the term of the Policy or the Certificate of Coverage takes effect, without the need of Beneficiary consent, irrevocable or not;

C. The date the Group Policy or any individual Certificate of Coverage is canceled by the Company;

D. On the next Renewal Date after the Insured reaches the age of seventy-five (75);

E. The end of the period for which the last premium has been paid for the Insured;

F. The last day of the calendar month in which the Insured's employment ends;

G. The last day of the calendar month in which the Insured retires in accordance with the Policyholder or Contracting organization's retirement plan; or

H. The Company receives a written request from the Policyholder or Contracting organization to cancel the Master Policy or any individual Certificate of Coverage.

If this Policy is canceled for any reason, coverage ends on the Effective Date of cancellation, and the Company shall only be liable for the payment of the benefit if the death of the Insured, or any compensable event under this Policy, occurs before the Effective Date of the cancellation of the Policy.

5.3 POLICY ISSUANCE

This Master Policy and its Certificates of Coverage are deemed issued or delivered when the Policyholder or Contracting organization receives them in his/her Country of Residence.

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

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

5.4 COVERAGE FOR PRE-EXISTING CONDITIONS

The company will not be responsible for any claim related to Pre-Existing Conditions: 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. Any disease related directly or directly to the use of tobacco products or body max index outside the normal range, overweight is considered or considered a contributing factor to a health condition will not be covered under this policy.

If the Insured dies as a result of a Pre-existing medical Condition that was disclosed in the application, the death benefit may be compensable, unless it has been permanently excluded by the Company. If the Insured dies as a result of a Pre-existing Condition that was not declared, its omission will lead to non-payment of the death benefit.

The Company, at its sole discretion, may modify, rescind, cancel, or not renew the Insured's Policy due to the omission of a Pre-existing Condition on any particular Certificate of Coverage.

5.5 REQUEST CHANGES IN COVERAGE

At the time of the Anniversary Date, the Insured, through the Policyholder or Contracting organization, can request to change the covered amount.

The Company reserves the right to accept or deny any change.

Insureds over forty-five (45) years of age must get the medical exams required by the Company at the time of the change request. The exams must be performed in one of the preferred Providers designated by the Company and the Company will cover the costs of the required exams.

The Application must be submitted to the Company and the Insured must satisfy the eligibility requirements on the date of the application and at the time of renewal.

If the Insured requests a change, the Company may require new evidence of insurability. The premium amount for the Insured for the new coverage will be based on the corresponding rates of the Company at the time of the requested change.

If the Company approves the Insured's request, the new coverage will take effect on the Effective Date of the change approval.

5.6 PAYMENT MODE

Premiums can be paid annually, semi-annually, quarterly, according to the option chosen by the Policyholder or Contracting organization for the payment of the group insurance Policy premium. Payment mode changes will be made only on the Anniversary Date of the Policy.

The premium is due on the Expiration Date of the Policy. Renewal notices are issued as a courtesy and the Company does not guarantee delivery.

Payment of the premium is the responsibility of the Policyholder or Contracting organization, and if the payment notice has not been received, they must contact the Company or his/her registered Agent.

5.7 GRACE PERIOD

The Company grants a thirty (30)-day Grace Period to pay the premium corresponding to the Policy, which begins the day after the Expiration Date, according to the selected payment mode.

If the full premium payment is not received by the Company before the Grace Period ends, this Policy shall be deemed expired. If an event occurs during the Grace Period, the unpaid premium amount will be deducted from the benefit payable.

5.8 RATE CHANGES

The Company reserves the right to change the rates of this Policy on the date of each anniversary.

5.9 POLICY REINSTATEMENT

This Policy may be reinstated when a new group application is submitted for evaluation. The Company may consider a Policy reinstatement if:

A. The Policy lapsed;

B. The Policyholder or Contracting organization applies within twelve (12) months of the date the Policy lapsed;

C. The Policyholder or Contracting organization and its Employees are still insurable based on the Company's eligibility criteria; and

D. All eligible applicants are alive at the time of application, and continue to be alive on the date the Policy is reinstated.

The Company reserves the right to approve or reject an application. The Company will not reinstate the Policy or any particular Certificate of Coverage, if the Policyholder or Contracting organization or any particular Insured has canceled it.

5.10 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.

5.11 PARTICIPATION RIGHTS

This Policy is a non-participating insurance contract. It does not entitle the Policyholder or Contracting organization and/or the Insured to receive dividends from the surplus or profit declared by the Company.

5.12 CONVERSION

The v and/or the Insured cannot convert this insurance Policy into a permanent insurance or any other type of insurance policy.

5.13 CASH VALUE

This insurance Policy has no cash value and does not permit the Policyholder or Contracting organization and/or the Insured to obtain paid-up or extended insurance.

SECTION 6

Benefits and provisions

Subject to all provisions contained in this Policy, benefits payable will be:

A. The death benefit amount;

B. The accidental death benefit amount (minus any dismemberment benefit previously paid), if any.

The insurance benefit will be granted only in case of death of the insured, or in case of dismemberment. However, it is important to clarify that a death benefit will only be paid in the event of death, and double compensation is not applicable in situations of dismemberment and death.

In the event that the insured survives an accident and experiences the loss of one or more limbs, only the benefit corresponding to a single loss of limb will be paid. It is important for the insured and his beneficiaries to understand that, in situations of dismemberment without death, the coverage is limited exclusively to the loss of an affected limb and does not accumulate with other coverages; therefore, this benefit is not considered an additional payment

6.1 DEATH BENEFIT

In the event of the death of the Insured, the Company will make a lump sum payment to the Beneficiary indicated by the Insured to the Policyholder or Contracting organization, or to the legal Beneficiaries if there is none.

A legally and properly executed Will covering inheritable property usually takes precedence over next-of-kin inheritance rights. The death benefit from this Policy will go to the Beneficiaries designated by these documents, regardless of next-of-kin relationships or even Will bequests.

The benefit payable will be determined according to the term life insurance coverage selected at the time of application, and listed in the Certificate of Coverage, as long as the cause of death is a result of a condition not excluded by this Policy.

The Insured may choose one (1) or more Beneficiaries. If any of the Beneficiaries is a minor, then, a Power of Attorney will be required. The Insured may request a change of the Beneficiary at any time. This request must be in writing on a form that is approved by the Company.

The Beneficiary or Beneficiaries were indicated by the Insured to the Policyholder or Contracting organization. If the information is incorrect, the Insured must contact his/her Policyholder or Contracting organization to request changes.

6.2 ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

In the event of the accidental death of the Insured, the Company will make a lump sum payment of one hundred percent (100%) of the death benefit amount to

the designated Beneficiary. The accidental death benefit amount will be reduced by any accidental dismemberment benefit paid. Any subsequent benefit will be determined by using the reduced amount. The dismemberment benefit amount paid to the Insured, will be determined by the type of Loss and percentage shown below. The amount will be included in the Policy proceeds payable.

Accidental Death	
Loss of life	100%
Accidental Dismemberment (with or without attachment)	
Loss of the entire sight of both eyes	100%
Loss of both hands	100%
Loss of both feet	100%
Loss of one hand and one foot	100%
Loss of one hand and the entire sight of one eye	100%
Loss of one foot and the entire sight of one eye	100%
Loss of the entire sight of one eye	50%
Loss of one hand or one foot	50%

In no case will the compensation amount exceed the Insured's Accidental Death and Dismemberment (AD&D) benefit amount, and payment will be made only one (1) time as the result of a single Accident. The Company must receive proof that the Insured's accidental death or dismemberment:

A. Was directly caused by an Accident covered by this Policy;

B. Occurred within ninety (90) days of the Accident; and

C. Occurred while coverage was still in effect.

6.3 ACCELERATED BENEFIT OPTION

If the certificate holder becomes terminally ill with a life expectancy of twelve (12) months or less, he/she or a legal representative has the option to request the Company an accelerated benefit of up to eighty percent (80%) of the death benefit before the Insured's death. The Company will only pay for an eligible accelerated benefit option benefit once.

A. A completed accelerated benefit claim form;

B. A signed physician's certification of the Insured's terminal illness; and

C. The Company reserves the right to request an examination by a physician of its choice and/or a Second Medical Opinion VIP® coordinated by the

Company. If there is a conflicting opinion with the Insured's physician, the Company reserves the right to have a third physician of its choice make the final determination.

If the Insured chooses to use the accelerated benefit option before his/her death, after receiving the payment of the benefit by the Company, such payment shall constitute the full settlement of the Insured's life insurance under the group Policy.

SECTION 7

Exclusions

The Company will not pay the benefits for the death, Accidental Death or Dismemberment (AD&D) of the Insured if his/her death or Accident results directly or indirectly from, or is caused or contributed to by:

A. Participating in war or an act of war, whether declared or undeclared;

B. Actively participating in an insurrection, rebellion, riot or terrorist act;

C. Being an active member of the police force, the army or other military force of any country;

D. Being a Politically Exposed Person (PEP);

E. Engaging in any activity that constitutes a felony under the laws of the jurisdiction in which the activity occurred;

F. Self-inflicted Illnesses or Injuries, whether the individual is sane or insane; suicide; or failed suicide;

G. Addictive conditions of any type; alcohol abuse; drug use or abuse; use of narcotics or Illicit Substances, or illicit use of controlled substances or medication; or being under the influence of alcohol or drugs (legal or illegal);

H. Traveling or flying in any aircraft, except when the Insured is a fare-paying passenger on a regularly scheduled charter or commercial flight;

I. Any Pre-Existing Condition;

J. Any declared epidemic, pandemic and/or COVID-19 related Illness;

K. Participating in Hazardous Hobbies and Sports, such as parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation; riding in or driving any motor-driven vehicle in a race, stunt show or speed test; any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received; bungee jumping, base jumping, hang gliding, sail-gliding, para-kiting, scuba diving deeper than one hundred and thirty (130) feet; spelunking; or mountaineering*, including rock climbing using ropes and any other climbing equipment; and

L. For Accidental Bodily Injuries, infections not occurring as a direct result or consequence of the Injury or disease.

*For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running. The examples provided above have an enunciative not limitative character to any other risk activities the Insured practices.

The company will not provide coverage to persons working in any of the following activities or industries, which are considered high-risk and non-insurable activities:

- Security;
- Arms sales and production;
- Active members of police, firefighters, military;
- Aviation;
- Minning and quarry workers;
- Oil and natural gas;
- Electric powerlines construction; or
- Construction workers.

The Company reserves the right to evaluate professions that are considered high-risk and non-insurable.

The Company shall not be deemed to provide coverage and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such coverage, payment of such claim or provision of such benefit would expose the Company to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, the United Kingdom or the United States of America.

SECTION 8

Management of the benefits

8.1 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 in the Company's offices and by the available electronic means, which have all the security guarantees.

It is understood that the Insured, by signing the application, has given his/her consent for the use of said information when necessary, 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.

8.2 CLAIMS

The Company shall receive all medical and non-medical information required for the claim process to begin:

A. Claim Form duly completed. If there is more than one (1) Beneficiary, each Beneficiary must submit a Claim Form in order to receive payment. The Company will make separate payments to each of the Beneficiaries;

B. The Insured's certified death certificate as proof the Insured died while his/her coverage was still in effect;

C. A recent medical history or any other medical information that the Company may consider pertinent that indicates the cause and circumstances of the Insured's death;

D. If the Insured died in an Accident or has any Accidental Loss covered under this Policy, 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 an attending physician's statement, autopsy reports, toxicology reports, Accident reports, police reports or others, when issued by the pertinent authorities, or any other information available from any other third parties involved in the matter;

E. Proof indicating the Insured's age or date of birth; and

F. Proof confirming the Beneficiary's right to receive the death benefit payable.

Once the claim process has been initiated, the person submitting the claim must send all the information requested by the Company to complete the process in a period of no longer than one hundred and eighty (180) days from the first request received by the Company. Once this period has elapsed without receiving the requested information, the claim will be put on hold until the Insured or Beneficiary(ies) complete the required information.

If the information provided should be considered inadequate or incomplete, it may create a delay in the payment process, or it may cause the claim to be temporarily closed until the necessary information is received. The Company reserves the right to request the original 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. The Company will not be responsible for any fee physicians may charge to complete or provide certain forms.

Before the Company pays the death benefit, the Insured's date of birth must be verified. If the date of birth provided on the census during the application process is incorrect, the Company will adjust the death benefit to the amount that would have been payable based on the premiums paid and the correct date of birth. If the Insured was not eligible for insurance based on his/her true age, coverage

will be voided and the Company will reimburse the total premiums paid by the Policyholder or Contracting organization, without adding any interest.

In the event that a claim that should have been denied because coverage was excluded from the Policy, has been paid in error, the Company may request the reimbursement of the amounts unduly paid. If a payment is made, 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.

8.3 CLAIMS APPEALS

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

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

The Company's Appeals Department will review in detail the arguments and information provided and will notify its decision to the Policyholder or Contracting organization, Insured or Beneficiary 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 Policyholder or Contracting organization, Insured or Beneficiary 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 Policyholder or Contracting organization, Insured or Beneficiary of its decision, the Policyholder or Contracting organization, Insured or Beneficiary will have the opportunity to express his/her opposition to that decision within ten (10) days from the date of the notification. If the Policyholder or Contracting organization, Insured or Beneficiary 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.

8.4 ARBITRATION AND LEGAL ACTIONS

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

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

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

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

Governing Law

The parties agree to grant to the State and Federal courts located in the borough of Manhattan, County of New York, State of New York (or if there is exclusive federal jurisdiction), exclusive jurisdiction and venue over any disputes, action or proceedings arising out of or in connection with this insurance Policy involving the parties, and the parties hereby consent to the jurisdiction of such courts.

SECTION 9

Definitions

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

Accidental Bodily Injuries or Accidental Injuries: Physical damage to the Insured when:

A. Sustained in an Accident on or after the Effective Date of this Policy;

B. This Policy was still in effect; and

C. Is the direct cause of a Loss and not the effect of a disease, bodily infirmity or any other cause;

All Injuries sustained in any one Accident and its complications and recurrence, shall be deemed to be a single Injury.

Accidental Death: Unnatural death that is caused by an Accident such as a slip and fall, traffic collision, or accidental poisoning. Accidental deaths are distinguished from death by natural causes and from intentional homicides and suicide.

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

Beneficiary(ies): Person(s) designated in writing by the Insured to the Policyholder or Contracting organization.

Certificate of Coverage or Group Certificate: Document provided to all members of a group plan that shows the benefits provided under the insurance contract. It is issued by the Company to certify that the Policy has been bought for a specified group of people. This document names the Insured members, Dependents (if any) and the type of Policy, as well as the limits of their coverage. It also identifies exclusions, but it never provides all the contract terms, which are in the Master Policy.

Company: The insurer, VUMI® Group, I.I.

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

Effective Date: Date the insurance Policy becomes active and which it’s shown in the Certificate of Coverage.

Evidence of Insurability: Personal health information provided to the Company to obtain coverage. It may include medical, financial, lifestyle, tobacco usage, family medical history information and other personal history information needed to approve an application for life insurance.

Expiration Date: The date on which 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.

Group Life Insurance: Insurance offered by a Policyholder or Contracting organization or another large-scale entity, such as an association or labor organization, to its workers or members. The Policyholder or Contracting organization is the owner of the Master Policy and the Insureds receive a Certificate of Coverage or group certificate.

Full-Time Employee: Employee of the Policyholder or Contracting organization working at least twenty (20) hours a week.

Hazardous Hobbies and Sports: Activities that increase the risk of Accidents or even the death of the person who practices them.

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.

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

Insured: An Employee who is insured under the group Policy for the coverage described in this Conditions of Coverage.

Loss:

- **A.** Severance of a hand at or above the wrist; or
- **B.** Severance of a foot at or above the ankle; or
- **C.** The irrevocable loss of the entire sight of one or both eyes; or
- **D.** Loss of life.

Master Policy or Group Policy: Insurance Policy that provides coverage to eligible Insureds or members on a group basis and contains all the terms and conditions of the group coverage. A group member of a Master Policy receives a Certificate as evidence of coverage, which summarizes the benefits provided under the Policy.

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

Politically Exposed Person (PEP): Individual with a high-profile political role, or who has been entrusted with a prominent public function. PEP also includes the individual immediate family members, and close associates.

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.

Premium: Amount of money the Policyholder or Contracting organization pays for the insurance Policy.

Renewal Date: Date the Policy must be renewed.

Term Life Insurance: Insurance that provides death protection for a stated time period or term.

Contact us

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VUMI GROUP, I.I. ORGANIZED UNDER CHAPTER 61 OF THE PUERTO RICO INSURANCE CODE. NO COVERAGE ISSUED BY THIS INSURER IS PROTECTED BY ANY GUARANTEE OR INSOLVENCY FUND IN PUERTO RICO.
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