MEMBERSHIP GUIDE

PREMIER CARE

INDEX

YOUR HEALTH FIRST.....2
- More than a health insurance company.....3
- Why choose Premier Care.....4
- Your coverage.....5
- Supplementary options.....6
- Manage your policy online.....7
- USA Medical Services.....8
- Contacting us.....9

YOUR REIMBURSEMENT.....10
TABLE OF BENEFITS.....12
POLICY CONDITIONS.....16
GLOSSARY.....26

YOUR HEALTH FIRST

What would happen to your family, career, and financial situation if you had an unexpected illness?

Our experience shows that long-term illness may have serious financial and social consequences.

Bupa puts your health first by offering insurance plans suitable for customers requiring international health coverage and advise on health and wellbeing.

To make sure that customers with special needs are not excluded in any way, we offer the choice of Braille, large print, or audio for your letters and literature. Please let us know should you require one of these.

A COMPANY YOU CAN TRUST

Bupa is a leading and experienced health insurer, providing a variety of products and services to residents of Latin America and the Caribbean. Bupa began as a provident association in the United Kingdom in 1947 with just 38,000 members. Today, Bupa looks after the health and wellbeing of millions of individuals around the world, giving us a unique global advantage for the benefit of our members.

Since its inception more than 70 years ago, Bupa has maintained a sustained financial growth and continues to consolidate its credentials as a healthcare leader. Bupa has no shareholders, which allows for the reinvestment of all profits to optimize products and services in synergy with accredited healthcare providers. Trust in healthcare personnel and services is critical for everyone. Our commitment to our members for over half a century is testament of our capacity to safeguard your health as the most important patrimony.

The expertise of our people is essential to deliver the best quality healthcare. Bupa employs over 85,000 people worldwide who live up to the highest quality standards of care, service, and expertise. Bupa Insurance Limited is authorized by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. The Financial Conduct Authority does not regulate the activities of Bupa Insurance Limited that take place outside of the United Kingdom.

MORE THAN A HEALTH INSURANCE COMPANY

With Premier Care you can feel confident that you and your family have the best health insurance and support should you need it.

BENEFITS

- Complete freedom of choice concerning specialists, hospitals, etc. in the Caribbean and Latin America (excluding Mexico)
- Full coverage regardless of your job, leisure interests and sports activities
- Chronic conditions are covered in full if diagnosed after enrollment or if accepted by the company
- Coverage of accidents resulting from terrorist acts
- Guaranteed renewal of the policy for life, regardless of your age and state of health

SERVICES

- 24-hour multilingual emergency service
- Advice on choice of hospitals and doctors
- Access to Bupa's highly qualified medical consultants for advice and second opinion
- Access to a broad range of online services, the possibility of managing your policy on our website

WHY CHOOSE PREMIER CARE?

Our solutions and advice are recognized all over the world. Regardless of where you live or where you are travelling, we prioritize your health above all.

With a Bupa insurance plan you do not need to look for all the snags in the small print. All agreements are worded in such a way that they can be understood.

GEOGRAPHICAL COVERAGE

With Premier Care you are covered in the Caribbean and Latin America, excluding Mexico. If you are travelling outside this region you have the possibility of taking out a supplementary travel plan or one of our products covering worldwide.

LIFETIME COVERAGE

You can be insured regardless of most conditions that you have suffered from before taking out the insurance. If accepted, all pre-existing conditions known at the time of acceptance are excluded from coverage. In very rare cases a previous medical history may result in your application being rejected. People of all nationalities, residents in the Caribbean and Latin America, excluding Mexico, who have not reached 75 years of age are eligible to apply. Once accepted, you are guaranteed that the policy will be renewed for the rest of your life – regardless of your age and changes in your health. Even if you develop a long-term chronic illness, your coverage will remain unchanged.

YOUR COVERAGE

Premier Care is a major medical plan, with benefits for hospitalization services, childbirth, out-patient surgery and other out-patient services, e.g. doctor's consultations, physiotherapists, etc.

The insurance will also cover your expenses for emergency air ambulance transportation to the nearest appropriate location, if you have a serious or acute illness or injury and there is no qualified place of treatment locally.

In case Premier Care is not exactly the coverage you need, we have other plans available. Please feel free to contact us or our local representative for further information regarding our exclusive line.

INSURANCE SUM

There is an annual maximum of US$1,000,000 in Premier Care coverage per person, per policy year. There is no lifetime limit, and the maximum overall coverage is renewed every policy year regardless of the number of claims you have presented.

CHOICE OF DEDUCTIBLE

We offer a range of annual deductible options to help you reduce the price you pay for your coverage. You can choose to pay the first US$500, US$1,000, US$2,500, US$5,000 or US$10,000 of your claims for the policy year. There is only one deductible per person per policy year and this applies to all services. There is a maximum of two deductibles per family: the sum of the two highest deductibles on the policy.

The premium level is determined by the deductible chosen. The higher the deductible, the lower the premium will be.

CHILDREN

A child who is born of parents who are eligible for maternity coverage is automatically enrolled in the parents' policy regardless of the child's state of health at birth, provided that both parents are insured on the policy and that a birth certificate is sent to Bupa no more than three months after the birth. Even congenital and hereditary conditions will be covered.

Children who are born before commencement of the policy, or before the insured parents are eligible for maternity coverage, must go through the normal application procedure.

For a complete description of the Premier Care coverage, please see the Table of benefits and the Policy conditions.

SUPPLEMENTARY OPTIONS

WORLDWIDE TRAVEL OPTIONS

Worldwide Travel Options offers the best possible protection if you suffer a sudden, unexpected illness or injury when travelling outside your country of residence. Worldwide Travel Options covers worldwide and there is no deductible: if treated within the Caribbean and Latin America (excluding Mexico), but outside your country of residence, the deductible chosen on Premier Care will be covered by Worldwide Travel Options. You are also covered for next-of-kin companion and repatriation if relatives at home get seriously, and acutely ill. If you take out Worldwide Travel Options in addition to Premier Care you will get a discounted rate on the travel plan.

The Policy conditions for Worldwide Travel Options are described in a separate brochure.

ONLINE TO MAKE YOUR LIFE EASIER!

Log in to www.bupasalud.com, search for "My Bupa" in our display options and follow the registration steps with your email to manage your policy from the comfort of your home or office. Enjoy our online services:

- Access to your policy documents and ID cards
- Payments
- Changes request
- Claim request and update information
- Pre-authorization services request
- Costumer Service
- Blua (digital health)

You are responsible for checking all documents and correspondence online.

USA MEDICAL SERVICES

YOUR DIRECT LINE TO MEDICAL EXPERTISE

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

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

WHEN THE WORST HAPPENS, WE ARE JUST A PHONE CALL AWAY

IIn the event of an emergency evacuation, USA Medical Services provides advanced alert of patient arrival to the medical facility and maintains continuous critical communication during transport. While treatment and initial care are being provided, USA Medical Services monitors your progress and reports any change in your status to your family and loved ones.

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

CONTACTING US

DO YOU NEED HELP?

Our customer service team is available Monday through Friday from 9:00 A.M. to 5:00 P.M. (EST) to help you with:

- Questions about your coverage
- Making changes to your coverage
- Updating your personal information

Visit My Bupa in our display options
www.bupasalud.com/MyBupa

Tel: +1 (305) 270 3944
Fax: +1 (305) 270 3948

MEDICAL EMERGENCIES

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

Tel: +1 (305) 275 1500
Fax: +1 (305) 275 1518
www.bupasalud.com/MyBupa

Mailing/Claims please submit your request through
Mi Bupa, www.bupasalud.com/MiBupa

YOUR REIMBURSEMENT

Before reimbursement can be paid out, you must meet the deductible you have chosen. Therefore, when presenting a claim, the reimbursable expenses up to the current maximum benefits will be first applied to your deductible. After that, reimbursements will be paid to you in accordance with the Table of benefits.

Please note that all reimbursements are paid in accordance with the Usual, Customary, and Reasonable (UCR) fees for the specific service. UCR is the maximum amount the company will consider eligible for payment, adjusted for a specific region or geographical area.

Please see the Policy conditions for a comprehensive description of the covered benefits and of the conditions that apply to the insurance.

WAITING PERIOD

In the event of an acute and serious illness or injury, the coverage will start immediately from the policy commencement date. For other conditions, there will be a waiting period of 4 weeks, with the following exceptions:

If you switch to Bupa from another international health insurance plan with another company, the coverage will come into effect immediately on the policy commencement date.

The waiting period in connection with pregnancy and childbirth is 10 months.

HOSPITALIZATION

For many years, we have worked with hospitals throughout the world and therefore, are thoroughly aware of the practical circumstances that must be in place prior to a hospital admission. If you wish, we can take care of the details in connection with planned or non-acute admissions.

If you are hospitalized, we can issue a payment guarantee, matched to the coverage you selected. The bill can then be sent directly to us, enabling you to concentrate on getting better. In the event of emergency admission, we should be notified as soon as possible in order to avoid misunderstandings about the insurance coverage. Please state the date of admission, diagnosis, treatment and expected date of discharge.

Expenses in connection with the notification of a hospital admission will be refunded by Bupa (for example, your call to Bupa from another country).

OTHER TREATMENT

Out-patient treatment, such as medical consultations and exams, should be paid by the policyholder before claiming reimbursement.

To claim reimbursement for out-patient treatment expenses, you must submit the official, original, and itemized bills and receipts together with a completed claim form, indicating the diagnosis and your policy number.

Upon receipt of the completed claim form, we will process your claim and reimburse you in U.S. dollars (US$).

AIR AMBULANCE

Regardless of the circumstances, you must inform us before transportation takes place either directly or through the treating physician. Air ambulance services must be pre-approved by Bupa. In consultation with the treating physician, our medical consultants will choose an alternative place of treatment. We will take care of every detail to ensure that the transportation and the hospitalization are managed as efficiently as possible.

TABLE OF BENEFITS

Expenses will be reimbursed according to the following rates. Benefits will be paid when the total reimbursable amount exceeds the selected deductible. The Table of benefits forms part of the Policy conditions. Please read both the Table of benefits and the Policy conditions carefully and review the glossary at the end of this Membership guide, where certain terms are defined or explained further.

All amounts are expressed in U.S. dollars (US$).

All reimbursements are paid in accordance with the Usual, Customary, and Reasonable (UCR) fees for the specific service. UCR is the maximum amount the company will consider eligible for payment, adjusted for a specific region or geographical area.

Maximum coverage per person, per policy year	US$ 1,000,000

Hospitalization and in-patient benefits and limitations	
Private or semi-private room, max. 240 consecutive days	100%
Intensive care room	100%
Room and board at the hospital for a relative accompanying an insured person, per day	US$200
Surgery	100%
Anesthesia	100%
Medical treatment, laboratory tests, x-rays	100%
Medicine treatment during a hospital stay	100%
Mental Health while in-patient (psychiatric and/or psychological treatment a as a result of a covered illness). Must be pre-approved / 90 visits per life time	100%
Chemotherapy/medicine and radiation for treatment of cancer	100%
Dialysis for treatment of kidney failure	100%
Prostheses, corrective devices and medical appliances which are medically required and implanted during surgery	100%
Transplant procedures Coverage for human organs, tissue, and cells only. Both the transplant procedure and the procurement of the organ must be pre-approved by the company.	100%
Acute emergency dental treatment due to serious accident up to 30 days after discharge from hospital In case of doubt the decision will be left with the company's dental consultant.	100%

Hospital/clinic day-case benefits and limitations	
Out-patient surgery in hospital/clinic	100%
Pre-surgical analyses preparing for anesthesia in connection with a scheduled surgery	100%
Emergency room treatment in connection with acute illness or accident	100%
Chemotherapy/medicine and radiation for treatment of cancer and dialysis for kidney failure	100%
Prosthetic limbs (lifetime max. US$120,000)	US$30,000

Prescribed rehabilitation benefits and limitations	
Medically prescribed in-patient rehabilitation at an authorized rehabilitation center following hospitalization due to serious accident/illness, all inclusive, max. per day, max. 30 days per incident Must be pre-approved by the company.	US$300

Home nursing benefits and limitations	
Medically prescribed home nursing by a registered nurse following hospitalization due to serious accident/illness, all inclusive, max. per day, max. 30 days per incident Must be pre-approved by the company.	US$150

Pregnancy, maternity, and birth benefits and limitations	
Normal delivery, complicated delivery, caesarean delivery, Pre-natal care, including vitamins for pregnancy, and non-invasive genetic prenatal screening (free fetal DNA screening); and postnatal care, is reimbursed according to the rates for out-patient benefits.	100%
Delivery following fertility treatment, Pre-and postnatal treatment is not covered. Children born as a result of fertility treatment are not automatically covered – an application must be submitted to include them under their parents' policy.	US$5,000
These benefits are subject to the selected deductible. Benefits only apply if both parents are covered on the policy.	

Congenital conditions benefits and limitations	
Congenital conditions manifested before age 18, lifetime maximum	US$300,000
Congenital conditions manifested after age 18	100%

Out-patient benefits and limitations	
Doctor, specialist and psychiatrist visits, max. 30 visits per policy year	80%
Surgical intervention	80%
Adult Health check-up, max. per policy year	US$250
Pediatric Health check-up, max. per policy year	US$250
Vaccines (medically required as a part of national immunization programs) • No deductible applies • Subject to 20% of coinsurance	US$800
Chiropractor, osteopaths, and physiotherapist visits, including treatment Max. 40 consultations per policy year.	80%
Prescribed medicine, max. per person, per policy year A prescription must be enclosed with the claim form.	US$1,000
Echocardiography, ultrasound, etc., max. per exam	80%
CAT scan, max. per scan	80%
MRI/PET scan, max. per scan	80%
Endoscopy (gastroscopy, colonoscopy, cystoscopy) max. per exam	80%
X-rays, max. per exam	80%
Laboratory, max. per exam	80%

Ground transportation benefits and limitations	
Emergency transportation to hospital by ground ambulance	US$1,500

Air ambulance benefits and limitations	
Emergency air ambulance transportation services, max. per person, per policy year Includes: • Air ambulance transportation to the nearest suitable location in the event of a serious and acute illness or injury where no qualified treatment can be obtained locally. • Expenses for a family member or friend accompanying the insured during transportation. • Expenses for the return journey home upon completion of the treatment Air ambulance services must be pre-approved by the company.	100%

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

Worldwide Travel Options (supplementary option not automatically included)	
Annual insurance sum	US$300,000
• Coverage for sudden unexpected illnes or injury when travelling outside your country of residence • Next-of kin companion • Repatriation in case of a relative falling seriously, acutely ill • No deductible is applied	
The conditions regulating Worldwide Travel Options are found in a separate brochure.	

POLICY CONDITIONS

ART. 1 ACCEPTANCE OF THE INSURANCE

1.1 Bupa Insurance Limited, hereinafter called the company, shall decide whether the insurance can be accepted. In order for the insurance to be accepted and the company to become your insurer, the application must be approved by the company and the necessary premium paid to the company.

1.2 In order for the insurance to be accepted by the company, an application must be submitted prior to the applicant attaining the age of 75 (seventy-five). The company has the right to waive this requirement in exceptional cases.

1.3 In order for the insurance to be accepted by the company on standard terms, the applicant must be of sound health at the time of acceptance and must not suffer nor have suffered from any recurring disease, illness, injury, bodily infirmity or physical disability, please see Art. 8.2 a. The decision as to whether a preexisting condition exists shall rest entirely with the company's medical consultants.

1.3.1 If the conditions in Art. 1.3 are not met, the company may offer the insurance, however, excluding coverage for treatment of a preexisting condition, and any related symptoms, or a disease, illness, or injury which results from or is related to a preexisting condition. If the company decides to offer the insurance, the policyholder will receive a policy schedule in which the terms of coverage are stated. After a period of two years, the insured may make a written request to the company to reevaluate coverage for any preexisting conditions against an additional premium or on special terms. Such decision to be entirely at the company's discretion.

1.4 In the event of a change in the applicant's state of health after the application has been signed and before the company's approval thereof, the applicant shall be under the obligation to notify the company of such change immediately.

ART. 2 COMMENCEMENT DATE

2.1 The insurance shall be valid as of the date on which the application is approved by the company. The commencement date is stated in the policy schedule. The company may agree on another date with the policyholder.

ART. 3 WAITING PERIODS IN CONNECTION WITH NEW INSURANCE CONTRACTS

3.1 When a new insurance contract is entered into, the right to reimbursement under the new insurance contract shall only take effect 4 (four) weeks after the commencement date of the insurance. However, this does not apply when the policyholder can prove simultaneous transfer from an equivalent insurance with another international health insurance company.

3.1.1 In the event of acute and serious illness and serious injury, the right to reimbursement shall, however, take effect concurrently with the commencement date of the insurance.

3.1.2 However, for pregnancy and childbirth and consequences thereof the right to reimbursement shall only take effect 10 (ten) months after the commencement date of the insurance.

3.2 The insured may change his/her insurance coverage to another type of coverage as from a policy anniversary by giving 1 (one) month's written notice to the company and subject to proof of insurability according to Art. 1.

3.3 The company will process an extension of coverage as a new application in accordance with Art. 1.

ART. 4 WHO IS COVERED BY THE INSURANCE?

4.1 The insurance shall cover the insured person(s) named in the policy schedule, including children registered therein.

4.2 Coverage of children shall be subject to: the child being registered with the company, and one of the insured persons having legal custody of the child.

4.3 An application must be submitted for newborn children.

4.3.1 If the insurance of one of the parents has been valid for a minimum of 10 (ten) months, newborn children of the parent can be insured, regardless of Art. 1.3, without submitting an application, please see Art. 8.2 h. A copy of the birth certificate must be submitted within 3 (three) months after the birth. If the birth certificate is not submitted to the company within 3 (three) months after the birth, a medical questionnaire must be submitted for the child, who has to undergo the standard underwriting procedure according to Art. 1. Registration of the child will take place from the date the medical questionnaire has been signed.

4.3.2 In case of adoption, the insured must submit a medical questionnaire for the adopted child.

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

ART. 5 WHERE IS COVERAGE PROVIDED?

5.1 The insurance shall provide coverage in the Caribbean and Latin America (Mexico is excluded from coverage) unless otherwise stated in the policy schedule.

5.2 We and/or our applicable related subsidiaries and affiliates will not engage in any transactions with any parties or in any countries where otherwise prohibited by U.S. law or other law applicable to the company. Please contact USA Medical Services for more information about this restriction.

ART. 6 WHAT IS COVERED BY THE INSURANCE?

6.1 The insurance shall cover the insured's medical expenses in accordance with the coverage chosen and the applicable reimbursement rates. The valid reimbursement rates are stated in the Table of benefits.

6.2 Reimbursement shall be paid following the company's approval of the expenses as being covered by the insurance after a fully completed claim form with original, receipted and itemized bills enclosed has been submitted to the company.

6.3 The deductible shall apply per person, per policy year. There is a maximum of two deductibles per family, per policy year. The sum of the two highest deductibles on the policy is the maximum deductible drawn on the policy per policy year.

6.3.1 When a benefit has a maximum reimbursement rate, the expenses will first be applied to the selected deductible. Once the expenses exceed the deductible amount, the company will pay the difference between the amount of expenses applied to the deductible and the total expenses up to the benefit limit stated in the Table of benefits.

6.3.2 In case of a serious accident that requires immediate hospitalization for 24 (twenty-four) hours or more, no deductible shall apply for the period of the first hospitalization only.

6.4 Physicians, specialists, etc. performing the treatment must have authorization in the country of practice. Furthermore, the method must be approved as being suitable for the given diagnosis by the public health authorities in the country where the treatment takes place. Methods of treatment not yet approved by the public health authorities, but under scientific research will only be covered if approved in advance by the company's medical consultants.

6.5 In no event shall the amount of reimbursement exceed the amount shown on the bill. If the insured receives compensation from the company in excess of the amount to which the insured is entitled, the insured shall be under the obligation to repay the company for the excess amount immediately, otherwise the company will set off the excess amount in any other account between the insured and the company.

6.6 Reimbursements shall be limited to the usual, customary and reasonable charges in the area or the country in which the treatment is provided.

6.7 Any discount, which has been negotiated directly between the company and providers, will be specifically used by the company for the overall benefit of the insured persons within the insurance product as a whole.

6.8 Any ex-gratia payments are entirely at the company's discretion. If the company decides to make a payment to which the insured is not entitled under the insurance, the insured accepts it as a one-time decision only. The company is not waiving any of the policy conditions, and the company is not obligated in any way to continue making payments for similar or identical treatments not covered under the insurance. Ex-gratia payments will still count towards the insured's annual maximum coverage, per person, per policy year.

6.9 Prostheses (excluding prosthetic limbs), corrective devices, and medical appliances will be covered 100% (one hundred percent) when they are medically required and implanted during surgery. Coverage for prosthetic limbs is limited to the maximum benefit described in Art. 6.9.1.

6.9.1 Prosthetic limb devices include artificial arms, hands, legs, and feet, and are covered up to a maximum of US$30,000 (thirty thousand dollars) per person, per policy year, with a lifetime maximum of US$120,000 (one hundred twenty thousand dollars). The benefit includes all the costs associated with the procedure, including any therapy related to the usage of the new limb.

Prosthetic limbs will be covered when the individual is capable of achieving independent functionality or ambulation with the use of the prosthesis and/or prosthetic limb device, and the individual does not have a significant cardiovascular, neuromuscular, or musculoskeletal condition which would be expected to adversely affect or be affected by the use of the prosthetic device (i.e., a condition that may prohibit a normal walking pace).

Repair of the prosthetic limb is covered only when anatomical or functional change or reasonable wear and tear renders the item nonfunctional and the repair will make the equipment usable.

Replacement of the prosthetic limb is covered only when anatomical or functional change or reasonable wear and tear renders the item nonfunctional and non-reparable.

Initial coverage, repair, and/or replacement of prosthetic limbs must be pre-approved by the company.

6.10 Coverage for transplantation of human organs, cells, and tissue is provided up to the maximum amount payable stated in the Table of benefits, after the applicable deductible. This transplant benefit begins once the need for transplantation has been determined by a physician, has been certified by a second surgical or medical opinion, and has been approved by the company, and is subject to all the terms, provisions, and exclusions of the policy. This benefit includes:

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

(b) Pre-surgical workup, including all laboratory and X-ray exams, CT scans, Magnetic Resonance Imaging (MRI's), ultrasounds, biopsies, scans, medications, and supplies.

(c) The costs of procurement, transportation, and harvesting of the organ, cells, or tissue, including bone marrow, stem cell, or cord blood storage or banking.

(d) Post-transplant care including, but not limited to any medically necessary follow-up treatment resulting from the transplant and any complications that arise after the transplant procedure, whether a direct or indirect consequence of the transplant.

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

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

ART. 7 AIR AMBULANCE COVERAGE

7.1 For coverage of air ambulance the conditions listed below shall also apply.

7.1.1 The sum insured for air ambulance coverage is stated in the Table of benefits.

7.1.2 Reimbursement shall be paid for reasonable expenses incurred by the insured for air ambulance transportation in the event of acute and serious illness or injury. Transportation shall be to the nearest suitable place of treatment and only if no qualified treatment can be obtained locally.

7.1.3 The expenses for an air ambulance transportation covered under the insurance, but not arranged by the company, shall only be compensated with an amount equivalent to the expenses the company would have incurred, had the company arranged the transportation.

7.1.4 Coverage shall be provided subject to the treating physician and the company's medical consultants agreeing on the necessity of transferring the insured, and agreeing on whether the insured should be transferred to his/her country of residence/home country or to the nearest suitable place of treatment.

7.1.5 The insurance shall cover reasonable and necessary transportation expenses for one person accompanying the insured.

7.1.6 Only 1 (one) transportation is covered in connection with one course of an illness.

7.1.7 Air ambulance coverage shall only apply if the illness is covered under the insurance and if the coverage includes the country to which the insured is being transported.

7.1.8 In the event that the insured is transported for the purpose of receiving treatment, he/she and the accompanying person, if any, shall be reimbursed for the expenses for a return journey to the insured's place of residence. The return journey shall be made at the latest 90 (ninety) days after the treatment has been completed. Coverage shall only be provided for travelling expenses equivalent to the cost of an airplane ticket on economy class, as a maximum.

7.1.9 In the event that the insured has received treatment covered by the insurance, but has reached the terminal phase, he/she and the accompanying person, if any, shall be reimbursed for the expenses of the return journey to the insured's place of residence.

7.1.10 The company cannot be held liable for any delays or restrictions in connection with the transportation caused by weather conditions, mechanical problems, restrictions imposed by public authorities or by the pilot or any other condition beyond the company's control.

ART. 8 EXCLUSIONS AND LIMITATIONS

8.1 The insurance shall not cover medical expenses incurred for any disease, illness or injury known to the policyholder and/or the insured at the time of application, unless agreed upon with the company.

8.2 Furthermore, the company shall not be liable to pay reimbursement for expenses which concern, are due to or are incurred as a result of:

a) any illness, injury, bodily infirmity or physical disability and consequences hereof which have come into existence, or shown symptoms, before the insurance became effective;

b) cosmetic surgery and treatment unless medically prescribed and approved by the company;

c) treatment of obesity;

d) venereal diseases, AIDS, AIDS-related diseases and diseases relating to HIV antibodies (HIV positive). However, diseases relating to AIDS and HIV antibodies (HIV positive) are covered if proven to be caused by a blood transfusion received after the commencement of the policy. The HIV virus will also be covered if proven to be contracted as the result of an accident occurring during the course of the following occupations only: doctors, dentists, nurses, laboratory personnel, ancillary hospital workers, medical and dental assistants, ambulance personnel, midwives, fire brigade personnel, police officers, and prison officers. The insured shall notify the company within 14 (fourteen) days after such accident and at the same time provide a negative HIV antibody test;

e) abuse of alcohol, drugs and/or medicines;

f) intentional self-inflicted bodily injury;

g) contraception, including sterilization;

h) induced abortion unless medically prescribed;

i) any kind of fertility test and/or treatment, including hormone treatment, insemination or examinations and any procedures related hereto, including expenses for pregnancy, prenatal and postnatal treatments of the newborn child/children. An application must therefore be submitted for children born as a result of fertility treatment and/or born by a surrogate mother. The application will undergo the standard underwriting procedure, according to Art. 1;

j) treatment of sexual dysfunction;

k) any kind of care which is experimental or off-label use (not FDA approved), not part of a medical or surgical treatment, including stays in long-term care establishments, health resorts, convalescent homes and similar institutions;

l) treatment by naturopaths or homeopaths and naturopathic or homeopathic medications and other alternative methods of treatment, unless specified in the Table of benefits;

m) the issuing of medical certificates and attestations and examinations as to suitability for employment or travel;

n) treatment of diseases during military service;

o) treatment for sickness or injuries directly or indirectly caused while actively engaging in: war, invasion, acts of a foreign enemy, hostilities (whether war has been declared or not), civil war, terrorist acts, rebellion, revolution, insurrection, civil commotion, military or usurped power, martial law, riots or the acts of any lawfully constituted authority, or army, naval or air services operations, whether war has been declared or not;

p) nuclear reactions or radioactive fallout;

q) treatment performed by the spouse, parent, sibling, or child of any insured under this policy, or any enterprise owned by or connected with one of the aforesaid persons;

r) treatment for or arising from any epidemic and/or pandemic disease, and vaccinations, medicines, or preventive treatment for or related to any epidemic and/or pandemic disease;

s) psychologists, unless specified in the Table of benefits;
t) medicine, whether given by injection or otherwise, medical articles and auxiliary appliances, such as but not limited to cast and crutches, which have not been administered during hospitalization unless specified in the Table of benefits;
u) hospitalization if the sole purpose is administration of medicine when this treatment could take place as day-case treatment;
v) treatment for or related to learning difficulties, such as dyslexia, or behavioral problems, such as attention deficit hyperactivity disorder (ADHD) or developmental problems such as shortness of stature;
w) treatment outside Latin America and the Caribbean;
x) treatment in Mexico;
y) custodial care.

ART. 9 HOW TO SUBMIT A CLAIM

9.1 A fully completed claim form must be submitted to the company for each claim. The claim form must be completed and signed by the treating physician and accompanied by the official, original and itemized bills and receipts for the treatment received. Bills received in currencies other than U.S. dollars (US$) will be processed in accordance with the exchange rate determined on the date of service at the insurer's discretion. Additionally, the insurer reserves the right to issue the payment or reimbursement in the currency in which the service or treatment was invoiced.

9.2 Written proof of claim must be submitted to the company immediately and at the latest within 180 (one hundred eighty) days of the insured event for which the claim is brought.

9.2.1 Complaints regarding the company's claims handling shall be filed not later than 30 (thirty) days after receipt of the reimbursement amount.

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

9.3 The company shall be notified immediately of any stays in hospital, and such notification must include the physician's diagnosis. All notifications should be made by telephone, fax or e-mail; the company shall defray all expenses incurred in this connection.

ART. 10 COVERAGE BY THIRD PARTIES

10.1 Where there is coverage by another insurance policy or healthcare plan, this must be disclosed to the company when claiming reimbursement.

10.2 In these circumstances the company will coordinate payments with other companies and will not be liable for more than its ratable proportion.

10.3 If the claim has been covered in whole or in part by any scheme, programme or similar, funded by any government, the company shall not be liable for the amount covered.

10.4 The policyholder and any insured person undertake to cooperate with the company and to notify the company immediately of any claim or right of action against third parties.

10.5 Furthermore, the policyholder and any insured person shall keep the company fully informed and shall take any reasonable steps in making a claim upon another party and to safeguard the interests of the company.

10.6 The insurer has a right of subrogation or reimbursement from or on behalf of an insured to whom it has paid any claims, if such insured has recovered all or part of such payments from a third party. Furthermore, the insurer has the right to proceed at its own expense in the name of the insured, against third parties who may be responsible for causing a claim under this policy, or who may be responsible for providing indemnity of benefits for any claim under this policy.

ART. 11 PAYMENT OF PREMIUM

11.1 Premiums are determined by the company and shall be payable in advance. The company adjusts the premiums once a year as from the anniversary date on the basis of changes in the coverage and/or the loss experience in the insurance class during the previous calendar year.

11.2 The premium is age-related and will be adjusted on the first anniversary date after the insured's birthday.

11.3 The initial premium shall fall due for payment on the commencement date. The policyholder may choose between quarterly, semi-annual and annual premium payments.

11.4 Changes in the term of payment can only be made at 30 (thirty) days' written notice prior to the policy anniversary.

11.5 There are 10 (ten) days of grace on each premium due date.

11.6 The policyholder shall be responsible for punctual payment to the company and, if a premium is not received by the company within the 10 (ten) days' grace period at any premium due date, the company's liability shall lapse.

11.7 In the event of the death of a policyholder, who is also insured on the policy, the premium on the policy may be waived for a period of 12 (twelve) months from the upcoming premium due date. The death must have been caused by a condition which would have been covered under this policy had the policyholder survived. The waiver applies only to the spouse or partner and their children under the age of 24 (twenty-four) who remain insured under the existing policy and will automatically terminate in the event of marriage of the remaining spouse or partner. The waiver does not apply to any supplementary insurance.

11.8 The policyholder's attention is drawn to Art. 6.5 regarding payment of outstanding amounts.

11.9 Depending on your country of residency and type of policy purchased, you may be subject to applicable taxes or other charges which may be collected and included as part of your total invoiced premium.

ART. 12 INFORMATION NECESSARY TO THE COMPANY

12.1 The policyholder and/or the insured shall be under an obligation to notify the company in writing of any changes of name or address and changes in health insurance coverage with another company, including a consolidated company. If the policyholder and/or the insured change address to a different premium zone, the premium applicable to the new zone will apply from the first comming anniversary date. The company must also be notified in the event of the death of the policyholder or an insured. The company shall not be liable for the consequences if the policyholder and/or the insured fail to notify the company of such events.

12.2 The insured shall also be under the obligation to provide the company with all obtainable information required for the company's handling of the insured's claims against the company.

12.3 In addition, the company is entitled to seek information about the insured's state of health and to contact any hospital, physician, etc. who is treating or has been treating the insured for physical or mental illnesses or disorders. Furthermore, the company is entitled to obtain any medical records or other written reports and statements concerning the insured's state of health.

ART. 13 ASSIGNMENT, CANCELLATION AND EXPIRATION

13.1 Without the prior written consent of the company, no party shall be entitled to create a charge on or assign the rights under the insurance.

13.2 The insurance is automatically renewed on each policy anniversary.

13.2.1 The insurance can be cancelled by the policyholder as from the anniversary date with 3 (three) months' written notice. The insurance shall be effective for 12 (twelve) months as a minimum.

13.3 Where upon taking out the insurance or subsequently, the policyholder and/or the insured has fraudulently changed original documents or disclosed incorrect information or withheld facts which may be regarded as being of importance to the company, the insurance contract shall be void and shall not be binding on the company.

13.4 Where upon taking out the insurance or subsequently, the policyholder and/or the insured has disclosed incorrect information, the insurance contract shall be void, and the company shall not be liable if the company would not have accepted the insurance if the correct information had been disclosed. If the company would have accepted the insurance but on other terms, the company shall be liable to the extent to which the company would have undertaken the obligations in accordance with the agreed premium.

13.4.1 In the event that the insurance contract is considered void, according to Art. 13.3 or Art. 13.4, the company shall be entitled to a service charge which is set as a specified percentage of the premium paid.

13.5 Where upon taking out the insurance, the policyholder or the insured neither knew nor should have known that the information disclosed by him/her was incorrect, the company shall be liable as if such incorrect information had not been disclosed.

13.6 The company's liability shall automatically cease at the end of the insurance period, including liability for ongoing treatment, consequential damages and after-effects of an injury or illness incurred during the insurance period. Accordingly, upon expiration of the insurance, the right to compensation shall cease, including the right to compensation for claims which are filed later than 6 (six) months after the termination of the insurance.

13.7 The company's liability shall automatically cease at the end of the insurance period, including liability for ongoing treatment, consequential damages and after-effects of an injury or illness incurred during the insurance period. Accordingly, upon expiration of the insurance, the right to compensation shall cease, including the right to compensation for claims which are filed later than 6 (six) months after the termination of the insurance.

ART. 14 COMPLAINTS

14.1 If we have not met your expectations, we have a simple procedure to ensure your concerns are dealt with as quickly and effectively as possible. If you have any comments or complaints, you can call Bupa's customer service through Mi Bupa, www.bupasalud.com/MiBupa or calling at +1 (305) 398 7400. If we are not able to resolve the problem and you wish to take your complaint further, please contact the Complaints Manager at +1 (305) 398 7400.

14.2 It is very rare that we cannot settle a complaint, but if this does happen, you may be entitled to refer your complaint to an independent organization for review. The organization will depend on the nature of the complaint and the location of the Bupa office where the cause of the complaint occurred. We will provide you with that information when needed. In most cases this will either be the Danish Insurance Complaints Board or the UK Financial Ombudsman Service.

If you would like further information about the Danish Insurance Complaints Board you can write to them at Anker Heegaards Gade 2, DK-1572 Copenhagen V, Denmark, call them at +45 (0) 33 15 89 00, or find details on their website at www.ankeforsikring.dk. If you would like further information about the UK Financial Ombudsman Service you can write to them at South Quay Plaza, 183 Marsh Wall, London E14 9JR, UK, call them at +0845 080 1800 or +44 (0) 20 7964 1000, or find details on their website at www.financial-ombudsman.org.uk. Please let us know if you want a full copy of our complaints procedure. None of these procedures affect your legal rights.

ART. 15 CONFIDENTIALITY

15.1 The confidentiality of patients and customer information is of paramount concern to the companies in the Bupa group. To this end, the insurer fully complies with the data protection legislation and medical confidentiality guidelines. The insurer sometimes uses third parties to process data on our behalf. Such processing, which may be undertaken outside the European Economic Area (EEA), is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the United Kingdom's Data Protection Act.

ART. 16 APPLICABLE LAW

16.1 Your insurance policy is governed by Danish law. Any dispute that cannot otherwise be resolved will be dealt with by courts in Denmark. If any dispute arises as to the interpretation of this document, the English version of this document shall be deemed to be conclusive and taking precedence over any other language version of this document. You can obtain a copy at any time by contacting our Customer Service at +1 (305) 270 3944.

GLOSSARY

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

ACUTE AND SERIOUS ILLNESS: An acute and serious illness requires immediate in-patient hospitalization for twenty-four (24) hours or more within the next few hours after the onset of the illness to avoid loss of life or physical integrity. It shall be determined to exist upon agreement by both the treating physician and the company's medical consultants after review of the triage notes and the emergency room and hospital admission medical records.

ANNIVERSARY DATE: 12 (twelve) months from the commencement date and the same date in each year thereafter.

APPLICANT: A person named on the application form and the medical questionnaire as an applicant for insurance.

APPLICATION: The application form and medical questionnaire.

CLAIM: The financial demand covered in whole or in part by the insurance. In the company's evaluation/determination of the claim, the time of treatment is decisive, not the time of the occurrence of the injury/illness.

COMMENCEMENT DATE: The date indicated in the policy schedule on which the insurance commences, unless otherwise stated in the Policy conditions.

COMPANY: Bupa Insurance Limited, a company registered in England No. 3956433. Our address is 1 Angel Court, London, EC2R 7HJ, United Kingdom.

CONGENITAL CONDITION: Any abnormality, deformity, disease, illness or injury present at birth whether diagnosed or not.

CUSTODIAL CARE: Assistance with the activities of daily living that can be provided by non-medical /nursing trained personnel (bathing, dressing, grooming, feeding, toileting, etc.).

DAY-CASE TREATMENT: Treatment which, for medical reasons, normally requires a patient to occupy a bed in hospital or clinic for less than 24 hours.

DEDUCTIBLE: The amount of money noted in the policy schedule which each insured agrees to pay each policy year before being compensated by the company.

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

DOCUMENTS: Any written information related to the insurance including original bills, policy schedules, and the like.

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

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

FAMILY: Mother and/or father and children under the age of 24. Children aged 24 and older will be transferred to a separate policy.

HOSPITALIZATION: Surgery or medical treatment in a hospital or clinic when it is medically necessary to occupy a bed overnight.

INSURANCE: The Policy conditions and policy schedule representing the insurance contract with the company and setting out the scope of the insurance terms, the premium payable, deductible and reimbursement rates.

INSURED: The policyholder and/or all other insured persons as listed in the valid policy schedule.

LATIN AMERICA: The geographical designation for the countries of Central and South America (excluding Mexico).

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

POLICY CONDITIONS: The terms and conditions of the insurance purchased.

POLICY DUE DATE: The date on which the premium is due and payable.

POLICY SCHEDULE: Policy details showing the type of insurance purchased, premium, deductible and any special terms.

POLICYHOLDER: The person identified as the policyholder on the application form.

PRE-EXISTING CONDITION: The medical history, including the illnesses and conditions listed in the medical questionnaire, which may affect the company's decision to insure or not to insure or to impose special terms.

REHABILITATION: Medically prescribed rehabilitation at an authorized rehabilitation centre following hospitalization.

REIMBURSEMENT RATES: The maximum amount of money which will be paid by way of reimbursement of medical expenses in one year from the commencement date or from each anniversary date, as further detailed in the Policy conditions.

RENEWAL: The automatic renewal of the insurance as per the anniversary date.

ROUTINE HEALTH CHECKUPS: A medical examination taken at regular intervals to verify a normal state of health or discover a disease in its early stages. A checkup does not include any test or consultation to follow-up on a disease already diagnosed. Pediatric routine health checkups apply to insured dependants from twelve (12) months to seventeen (17) years; adult routine health checkups apply to insured eighteen and up.

SERIOUS ACCIDENT: An unforeseen trauma occurring without the insured's intention, which implies a sudden external cause and violent impact on the body, resulting in demonstrable bodily injury that requires immediate in-patient hospitalization overnight within the next few hours after the occurrence of the severe injury to avoid loss of life or physical integrity. Severe injury shall be determined to exist upon agreement by both the treating physician and the company's medical consultant, after review of the triage notes, emergency room and hospital admission medical records.

SERIOUS INJURY: A serious injury requires immediate in-patient hospitalization for twenty-four (24) hours or more within the next few hours after the occurrence of the serious injury to avoid loss of life or physical integrity. It shall be determined to exist upon agreement by both the treating physician and the company's medical consultants after review of the triage notes and the emergency room and hospital admission medical records.

SPECIAL TERMS: Restrictions, limitations or conditions applied to the company's standard terms as detailed in the policy schedule.

STANDARD TERMS: The company's insurance terms with no special restrictions, limitations or conditions.

SUBROGATION: The company's right to enforce a remedy which the insured has against a third party and the company's right to require the insured to repay the company if it has paid expenses recouped by the insured from a third party.

SURGERY: A surgical treatment/intervention, which does not include endoscopies and scans even though these examinations may require anesthesia.

TERMINAL PHASE: When the advent of death is highly probable and medical opinion has rejected active therapy in favor of relief of symptoms and support of both patient and family. This decision must be confirmed by the company's medical consultant.

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

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

WAITING PERIOD: A period of time from the commencement date where the insurance provides no coverage unless as specified in Art. 3.

WE/US/OUR: Bupa Insurance Limited or USA Medical Services acting on behalf of Bupa Insurance Limited.

EUROPEAN ADDRESSES

Bupa International
Russell House, Russell Mews, Brighton BN1 2NR, UK

Bupa Cyprus
3 Ioannis Polemis Street, PO Box 51160, 3502 Limassol, Cyprus

Bupa Denmark, filial af Bupa Insurance Limited, England
Palaegade, DK-1261, Copenhagen K, Denmark

Bupa France
Nice Etoile 30, Avenue Jean Médecin, F-06000, Nice, France

Bupa Malta
120 The Strand, Gzira, Malta

Bupa Spain
Edif. Santa Rosa 1 D, C/. Santa Rosa 20, Los Boliches,
E-29640 Fuengirola (Málaga) Spain

Bupa Global is a trading name of Bupa Insurance Limited and Bupa Insurance Limited and Bupa Services Limited
Bupa 1 court. London, EC2R 7HJ

Bupa Global is a trading name of Bupa Insurance Limited and Bupa Insurance Services Limited which are registered in England and Wales at Companies House under numbers 3956433 and 3829851 respectively. The offices are 1 Court, London EC2R 7HJ. I-JK. Bupa Insurance Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Bupa Insurance Services Limited is authorised and regulated by the Financial Conduct Authority. The Financial Registration numbers of Bupa Insurance Limited and Bupa Insurance Services Limited are 203332 and 312526 respectively.

Administration
18001 Old Cutler Road, Suite 500
Palmetto Bay, Florida 33157
Tel. +1 (305) 275 1500, Tel. +1 800 321 5187
Fax +1 (305) 275 1518
www.bupasalud.com
service@bupalatinamerica.com

BINS_MG_PRE_eng_V24.01