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Frequently Asked Questions

▲ **How many members do I need to open the Community Plan?**

Currently, the minimum number of members required to open a Community Plan is five.

▲ **What is the pricing by age?**

Standard Plan: price per month for each age band

0-17: \$50

18-39: \$80

40-49: \$120

50-59: \$190

60-74: \$350

Premium Plan

0-17: \$85

18-39: \$130

40-49: \$200

50-59: \$310

60-74: \$575

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60-74: \$740

▲ What is covered in the base package common to all plans?

The base package includes a \$1,500,000 maximum limit per policy year and covers emergency room care, hospital stays, surgeries, prescription medications (in-patient), and lab tests or diagnostic studies when you are in the hospital.

▲ Can members in a group plan choose their own plans?

Yes, members can choose the plan that works best for their needs!

▲ Can you upgrade your plan mid-policy year? Also, can we cancel the plan mid-policy year?

No, you'll have to wait to upgrade at the next renewal. This is because it protects insurance companies from people upgrading only when they "need" the insurance (for example, you get pregnant and then buy the upgrade).

You also can't cancel the plan mid-policy year unless you have a qualifying life event. Qualifying life events would be something like your new spouse putting you on their insurance instead.

▲ Can I switch between the Standard Plan and Premium plan?

Switching plans mid-policy year (twelve months) is not currently an option. You will have to wait until the policy renewal.

▲ When someone leaves my team, when does coverage end? For example, if they leave on the 21st, does it end that day, and will we receive a credit of the amount back to the company? Or will coverage remain active through the end of the month?

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your next invoice for the unused premium.

- ▲ **In the standard plan, there's a \$5,000 limit for outpatient benefits per year. Can that money be used for medical visits to a general practitioner, and does it include ophthalmologists, gynecologists, dentists, etc.?**

You can visit any specialist you wish for any medically necessary visits.

For example, you could visit your ophthalmologist if you have an eye injury. But for your annual eye exam, you would need the Premium or Premium Plus Maternity Plan with routine vision coverage.

Same with the gynecologist. Any medically necessary visits because you have symptoms and need treatment would go under your outpatient. A routine gynecological visit would only be approved under screenings, for which you would need the Premium or Premium Plus Maternity Plan.

In short, any treatment or visits that are routine, annual check-ups, or visits without symptoms or medical need would be covered with the Premium and Premium Plus Maternity plans.

Anything deemed medically necessary requiring a hospital stay would be covered with the Core Plan (on all three plans) or outpatient (all three plans, \$5,000 USD limit; 10% co-insurance on Standard Plan outpatient only).

- ▲ **Where can I see the full policy?**

You can find the most up-to-date versions of all our policies [here](#).

- ▲ **What discount do we get by using the Community Plan model?**

The discount for the Remote Health Community Plan, as opposed to opening individual plans for each member, is over 50%.

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Standard: \$80 per plan; with the add-on, the total would be roughly \$150.

Premium: \$130 per plan; with the add-on, the total would be roughly \$240.

Premium Plus Maternity: \$155 per plan; with the add-on, the total would be roughly \$300.

▲ How does payment for Remote Health work?

When you submit your group policy application, you can choose between a credit card payment or a bank transfer. Paying with a credit card allows you to sign up for auto charges as well, so you don't have to worry about a lapse in coverage due to non-payment. If you have a U.S-based bank account, you can also sign up for an auto-draft.

Please note that when you select bank transfer, you must submit a wire confirmation after each payment is made to ensure your payment is received.

The first payment will be made once the application has been approved. You can choose your preferred billing cycle (quarterly, semi-annually, or annually).

If applicable, you would invoice your members internally. You will get an invoice each month with your members' names and their individual costs.

▲ What is the billing cycle for Remote Health? Can we pay for our insurance using different company accounts?

Companies can pay quarterly, semi-annually or annually for Remote Health. The payment can come from whatever account you choose.

▲ Are the premium prices per month?

Yes, these prices listed are monthly, per member.

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Because all members of one policy need to be on the same plan, if you wish to include Maternity coverage, every family member would be on the Premium Plus Maternity plan.

- ▲ **If a member passes to the next age band during their current policy year, do they continue paying the price for the initial age band for the rest of the policy year?**

Members sign up for annual plans with Remote Health. This guarantees that your premium and benefits stay the same for 1 full policy year. If you have a birthday during the policy year and pass into the next age band, this will only be reflected at renewal at the end of the policy year.

- ▲ **Can I cover my contractors and freelancers?**

Yes! You can cover contractors and freelancers with Remote Health.

- ▲ **What happens after sign-up?**

Your account will be assigned to an Account Manager, who will be your go-to person here at SafetyWing to make insurance as easy as possible.

Your Account Manager will schedule a couple of onboarding calls with you. The first call is a one-on-one where your Account Manager will review the benefits you are offering to your team, and they will show you how to manage your team from your SafetyWing admin dashboard and review any questions you have. This call is about 30 minutes.

The second call is a town hall, to which all your members are invited. Your Account

FAQ Case studies**▲ How do I submit a request to add a new member, add a dependent, or cancel the policy?**

Use your SafetyWing admin dashboard to manage your members' policies! This includes adding and removing members.

If a member is allowed to include their dependents, you can make this selection when you add them to your plan, and the member will automatically be prompted to add their dependent's details at the time of their enrollment.

Dependents can be added to a member's plan within the first 30 days from the start date. So, if you didn't give the member access to include their family, please get in touch with your Account Manager.

▲ Do I need to add all my employees or contractors to the policy?

No, you don't. You must, however, offer it to everyone in a given category of your company. For example, if you want "Directors" covered, then all Directors must be offered the plan within your company. But if you only want to cover "Directors," you do not need to also cover "Managers."

▲ How will the activation email look when it goes out to our members?

The activation email will have the company name on it as well as a SafetyWing-branded request for members to activate their health insurance.

▲ What if we have an employee with a start date in the future, can we add them in advance, and will they be covered?

Yes. You can reach out to your dedicated Account Manager any time you wish to add an employee/member.

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- ▲ **If an employee leaves our company but wishes to keep their health plan, will they be able to?**

Employees who leave your company cannot keep their Remote Health coverage.

- ▲ **Are members able to pause their coverage over the 12-month period? What if they move countries?**

Members are not able to pause coverage during the one-year term. If a member moves, they will need to notify the SafetyWing team of their move.

Without the worldwide add-on, members will become ineligible for coverage if they move to Hong Kong or Singapore. [Here](#) is the full list of restricted countries.

- ▲ **What is considered a qualifying reason to cancel a plan for one of our members?**

The annual plan by the company is a twelve-month commitment. Employees can be removed if they leave the company, or if they have a qualifying life event such as being added to their spouse's health insurance.

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We can't specifically advise on misclassification and there are differing rules around this globally. In the US there may be considerable risk of misclassification by providing healthcare to contractors but this risk may not be as high in other countries.

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Frequently Asked Questions

▲ Can you walk me through how this insurance works?

First, you will arrange treatment or doctor's appointments with your preferred doctor or clinic. For all treatments and visits under \$250 USD, you will pay your provider directly after the treatment or visit. Before you leave the office, please collect medical notes detailing what the treatment was for and the date you received treatment.

You will also need to request an invoice or receipt for the amount paid. Then you will log onto your SafetyWing online dashboard, click "make a claim," and fill out the form. It will only take you a few minutes.

The form will ask you for details of why you needed the treatment, what the treatment was, your medical notes and receipts, and your banking information for reimbursement.

Reimbursements should take 21 days or less.

For any treatment over \$250 USD or pre-planned costly procedures, you can contact us and request pre-approval and direct billing.

To do so, submit a treatment plan, medical notes, and estimated costs using [this form](#). The information will go directly to our medical team to get the claim pre-approved and direct payment arranged with your provider. Whenever possible, please start this

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- ▲ **Is a 'gap cover' applicable to these plans, or will that be dependent on the gap cover provider?**

This would be dependent on the gap cover provider. On the Remote Health plan, any expensive treatments or visits can be pre-approved and have direct billing arranged.

If the charges are outside of what is considered 'reasonable' for the area (UCR), you can choose another provider and we will get pre-approval and direct billing set up with them. Or you can choose to pay the difference in cost, though this is relatively rare.

- ▲ **Remote Health provides worldwide coverage. Does that include any accidents that may happen during vacations, or are we covered only while in our home country?**

Yes, you are also covered while you travel! Travel can be for any reason, business or pleasure. The only exceptions are Hong Kong, Singapore, and the United States. In those three countries, coverage is limited to 30 days per trip, not to exceed 183 days per year. The coverage is limited to emergency or non-elective coverage only.

There are a few countries where we cannot arrange direct billing for hospital stays. They are listed [here](#).

For all other countries, your full coverage will stay the same.

- ▲ **Do you do a health checkup prior to the start of the insurance? Do you exclude pre-existing conditions?**

No health checkups are required! We do not exclude pre-existing conditions as long as they are not listed as a general exclusion. So, for example, if you have a pre-existing case of TMJ, it would not be covered only because it is excluded in the overall policy.

- ▲ **What are the benefit amounts?**

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plan, no co-insurance with other plans).

The following benefits are included only in Premium and Premium Plus Maternity:

- Dental max \$1,500,
- Vision max \$500,
- Screening & vaccines max \$500,
- Maternity max \$7,500.

These amounts are in USD per policy year.

▲ How do I know when my coverage is active?

The coverage will start on the date you request in the Activate Member form. After we initiate your policy and create your online SafetyWing dashboard, then you will receive a second email from us letting you know your policy is active!

▲ Can I travel to Hong Kong and/or Singapore without the add-on?

Yes! You can travel to Hong Kong and Singapore for up to 30 days and have coverage. It is not possible to add more days, and it is for emergency coverage only (not routine).

▲ Do I need to notify Remote Health if I need to have surgery?

All inpatient and outpatient surgeries must be pre-authorized in advance.

If you plan to pay and claim for your surgery, please provide 72 hours notice.

Please provide two weeks' notice if you want Remote Health to pay your provider directly.

FAQ Case studies**► What is the difference between Remote Health and Nomad Insurance?**

The main difference is that Remote Health is comprehensive medical insurance but without non-medical travel benefits. Therefore, it is not a direct alternative.

Remote Health will cover more medical needs than Nomad Insurance, such as elective treatment, pre-existing conditions, cover for cancer treatment, etc. Remote Health has a \$0 deductible and includes added benefits like outpatient, dental, vision, and screenings and vaccines (depending on your plan). It can be used as your primary health insurance and has a maximum coverage limit of \$1.5 million USD.

Remote Health does not have a network! This means that you are free to see any licensed provider or hospital, public or private. We can also provide direct billing when your claim is \$250 USD or more.

Remote Health can also provide you with health coverage while you are travelling outside of your home country.

Nomad Insurance does provide medical and travel benefits. The medical maximum benefit is \$250,000, including a \$250 deductible. You can use this coverage for hospital care, urgent care, and more while you are travelling outside of your home country. Nomad insurance cannot cover cancer treatment or pre-existing disease or illness.

Nomad Insurance also provides travel benefits, such as trip interruption coverage, travel delays, and lost checked luggage.

► I noticed that the United States, Hong Kong, and Singapore are outside of the geographical area of coverage. Can I still visit these countries? Will I have any coverage if I need medical attention during my stay?

You can visit the United States, Hong Kong, and Singapore, and be covered for accidents and emergency non-elective treatment.

You're covered up to 100% UCR for injuries up to a maximum of USD \$50,000 and up

FAQ Case studies**▲ Does the age limit of 74 apply to all plans?**

Yes, the age limit is 74 for all of our plans. However, this only applies to new members—if you are 73 and enrolled in the plan, you will be eligible for coverage for as long as you wish.

▲ Can you cover members in the USA or Canada?

Unfortunately, we currently cannot offer coverage to members who reside in the United States or Canada.

▲ What counts as one's home country?

Your home country is where you plan on spending the most time in the next 12 months.

▲ Can citizens of the United States enroll in Remote Health?

There is a restriction that prevents a US citizen from being eligible for Remote Health if they are a resident of the United States when they apply for coverage. You can view the entire list of countries with restrictions [here](#).

▲ Can you please explain what the 10% outpatient co-insurance means on the Standard Plan?

This is a cost-sharing insurance term. 10% co-insurance means that if you have a \$100 invoice for an outpatient service, you will be responsible for \$10 (10% of the total invoice).

▲ Is there a deductible?

FAQ Case studies**▲ What does a 5K outpatient limit mean?**

A maximum limit is the maximum amount of money that Remote Health will cover for eligible claims during the policy year (\$5,000 for all outpatient benefits). This amount restarts on the renewal date of your policy.

For example: if your Remote Health policy ends on July 1, 2022, your benefits will renew on August 30, 2023. In other words, when the policy renews, your benefit maximums are reset.

▲ I'm located in Germany, and we are legally obliged to prove that we have health insurance. Do you know if Remote Health qualifies in this case?

This depends on if you're a local German national or an expat.

Remote Health can be bought as a top-up to the local plan if you're a local German national.

Here are some reasons why members use Remote Health as top-up insurance:

- Faster treatment: reduced wait times to get the treatment you need by not joining public waiting lists.
- Freedom to choose the hospital you want: using a public health service can often restrict the hospitals you can visit. Remote Health gives you access to any public or private hospital.
- Eligible for cash payout: get paid up to \$150/night when staying in a free public hospital or when your treatment is covered by different insurance.
- Global coverage: use this coverage wherever you live, move, or work, so if you are a nomad or traveling, you don't need another insurance to cover your medical care.
- A referral from your general practitioner is not required before seeking care with a specialist.

If you're an expat, you may buy this as a primary plan only after the local immigration office approves your visa.

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If Remote Health is considered secondary insurance in your country, the primary insurance would cover first, and Remote Health would work as a top-up.

For any dispute, the insurance company will attempt to solve this with the other insurance company without requiring anything from the member.

▲ Are there any waiting periods?

Remote Health coverage begins the same day as your start date! There are no waiting periods if your plan is provided and **paid for by your employer**.

If you are paying for your own plan as an **individual**, there is a 10-month waiting period for maternity benefits and a 36-month period for HIV/AIDS treatment.

▲ Does Remote Health qualify as travel health/emergency insurance when traveling to countries that might require it for entry?

Remote Health is not travel insurance. However, if you are traveling, we can provide you with your certificate of coverage, a benefits letter, and a letter explaining your COVID-19 coverage.

▲ What is a policy year?

The policy year is 364 days, beginning on your policy start date. For example, a policy year could be from May 12, 2022 - May 11, 2023. On the 365th day your policy will renew.

▲ What is a deductible?

The amount of money you have to pay before your insurance benefits start covering your treatment.

Having a \$0 deductible means you don't need to pay anything out of pocket before your insurance kicks in.

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Remote Health is different from a local or state-run insurance, as it is a global insurance plan. We provide members with worldwide coverage where members can go to any clinic or hospital.

In contrast, local plans may be subject to networks and restrictions. You may need to buy separate private insurance for extra benefits, and these plans tend to be inflexible and bureaucratic.

With Remote Health, you can go to any clinic or hospital without worrying about eligibility requirements. Your treatment options remain consistent wherever in the world you travel and in 185+ countries of residence. It can be used as a top-up coverage (e.g., dental, vision) in countries with local insurance requirements and tax considerations. We cannot provide advice on tax implications or visa requirements for every country we operate in.

Remote Health would be treated as a benefit like any other from a company taxation standpoint.

Notable exceptions: In the following countries, local regulations may restrict members from using Remote Health as their primary health insurance. Fortunately, it can still be used as a top-up plan for extra benefits like dental, vision, and maternity care.

- Germany
- Switzerland
- Netherlands
- Australia

▲ **What is the company application time frame? How long before a company is signed up?**

Once everything is filled out, turned in, and verified, the approval process takes up to a week. During that time, we will introduce you to your account manager, who will create the custom dashboards and set up meetings with your team to show how the system works, confirm that all members are added, and be ready to start using your

FAQ Case studies**► What if I have another insurance?**

You can enroll in Remote Health as a top-up plan.

The advantages of also using Remote Health with another insurance include:

- Faster treatment: reduced wait times to get the treatment you need by not joining public waiting lists.
- Freedom to choose the hospital you want: using a public health service can often restrict the hospitals you can visit. Remote Health gives you access to any public or private hospital.
- Eligible for cash payout: get paid up to \$150/night when staying in a free public hospital or when your treatment is covered by different insurance.
- Global coverage: use this coverage wherever you live, move, or work, so if you are a nomad or traveling, you don't need another insurance to cover your medical care.
- A referral from your general practitioner is not required before seeking care with a specialist.

► What are the extra benefits if an employee already has public healthcare in their country of residence?

In countries with public systems (for example, the UK and Norway), SafetyWing has an added advantage: it can be used in addition to a country-specific plan.

SafetyWing's added benefits include visiting any private hospital for the best and quickest service.

If your public healthcare system covers your hospital treatment, you receive a \$150 cash bonus per night in a public hospital in your home country (up to 30 nights).

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FAQ Case studies**▲ Will the insurance also cover other short-term trips? Should I notify you if I want to use the insurance in a country different from my residence?**

Remote Health will cover short trips! You don't need to notify us if you're traveling to a country different from your residence.

Please note that some countries like the United States, Hong Kong, and Singapore have restricted coverage. This means that you will be covered for up to 30 days for accidental and emergency coverage. The maximum benefit for illness is \$50,000 and \$500 for outpatient.

▲ What are the perks of purchasing a group plan such as Remote Health?

Team members' medical history is disregarded. There will not be any questions about pre-existing conditions, and the team members will be covered for pre-existing conditions, provided they are not part of the general policy exclusions. There are no waiting periods.

Note: Our Affinity Plan application includes three simple health questions that form the medical evaluation part of the application process. While we strive to be inclusive, we reserve the right to deny coverage based on the applicant's responses.

▲ How is Remote Health different from other insurance plans?

We offer a complete global health plan that allows our members to spend as much time abroad as they please. Our members can have peace of mind while traveling, knowing that their health needs are covered.

Our plan also offers full coverage in the member's home country and no exclusions for pandemics! Regardless of where our members are, we are here to help in any time zone. We offer a fast and easy claims process, and our team is at their service to assist with coverage and claims questions anytime they need help.

FAQ Case studies**▲ Where can I see a general overview of the Community Plan?**

You can read an overview [here](#).

▲ Are individuals subject to any taxation on their benefits?

With both admitted and non-admitted policies, individuals are potentially subject to tax laws of the resident country on their benefits. The member would deal with this individually, depending on their country.

▲ How you can assist with benefit in-kind, or employee tax reporting requirements?

Currently, we are unable to assist with many major tax questions. We encourage you to seek advice from your accountant or legal counsel.

▲ Do you have a list of countries where employer-funded medical insurance is classed as a taxable benefit, such as benefit in-kind?

Currently, we do not, unfortunately.

▲ Who decides if something is “medically necessary”?

Treatment, medical services, or medical supply is deemed medically necessary by Remote Health in mutual agreement with the member's provider to diagnose and/or treat an injury or illness.

The following is not considered to be medically necessary: provided as a matter of convenience to the insured or the hospital/physician; not appropriate for the diagnosis or treatment of the condition; exceeds the level of care required for the diagnosis or

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- ▲ **You mentioned this covers us when we travel abroad. Does that include any accidents that may happen during vacations? Or would coverage be limited to work-related events only?**

Yes, you are also covered while you travel! Travel can be for any reason, business or pleasure. The only exception is in Hong Kong, Singapore, and the United States. In those three countries, coverage is limited to 30 days per trip, not to exceed 183 days or half of the year.

The coverage is limited to emergency or non-elective coverage only.

There are a few countries where we cannot arrange direct billing for hospital stays. They are listed [here](#).

- ▲ **Are we able to use this as travel health insurance?**

This plan is a global medical insurance: you can carry it with you where you travel, and you'll be covered. We have a separate travel plan called Nomad insurance for things like lost luggage and travel delays.

- ▲ **Are there any countries where coverage is limited or restricted?**

You can view a list of countries with restricted coverage [here](#).

- ▲ **What about travel insurance?**

We also offer a travel medical plan, Nomad Insurance, that can protect your members in emergencies outside of their home country. Nomad Insurance also includes some travel benefits for lost luggage and delays. It can be purchased on a subscription or using fixed dates. Feel free to read more about Nomad Insurance [here](#).

- ▲ **Can I use Remote Health to apply for a Schengen visa?**

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will require a Certificate of Insurance and Insurability letter which we can provide by request to any member with an active Remote Health contract.

▲ How do I sign up?

Once your company adds you to the group plan, you will receive a welcome email from SafetyWing, and the email will contain a link to activate your insurance.

You must activate your coverage **within the first 30 days** of receiving the welcome email. *Delays in creating your member profile could impact your start date of coverage.*

▲ When can I add my family members (dependents)?

We will ask you about your dependents when you activate your insurance after receiving the welcome email. You have 30 days from your start date to add a spouse, partner, or child (biological, step-child, or minor in your home that you have legal guardianship over).

▲ Does the maximum policy benefit of \$1.5M include dependents?

The maximum benefits are not shared amongst the family. Each member will have their own benefits! That means that each member on the plan will have a \$1,500,000 maximum benefit per policy year.

▲ Who can be considered a dependent that I can add to my plan? Are they on the same plan as I am?

Eligible dependents include your spouse, domestic partner (only requirement is you reside in the same home), biological children, legally adopted children, step-children.

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Each family member will have their own policy, so that the maximum benefit limit applies to each member, not the entire family.

- ▲ **I do not have a passport which is a required field to sign up for SafetyWing. Can I provide an alternative ID?**

You can use a government-issued ID number to enroll.

- ▲ **I used my expired passport to sign up, is it better to replace it with an actual and valid document from my country?**

It is best to provide a valid form (non-expired) form of ID. You can share a government issued ID number. Our customer service specialists can help you change your ID via the live chat on our website.

- ▲ **I'm married, and we have children. My spouse has their own insurance coverage, but I would like to include my kids. Is this possible?**

If you only wish to cover your children and not have your spouse on your Remote Health coverage, you can do this!

- ▲ **Are same-sex partners allowed?**

Legally married or domestic partnerships can be covered as dependents of the main policyholder, regardless of their gender.

- ▲ **Can I add a dependent at any time?**

New members (dependents) can be added within 30 days of the main member enrolment or at any time if there is a life event with no restrictions, such as birth.

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If you leave your team during the contract, your Remote Health coverage will be canceled.

▲ How can I get a visa letter confirming my coverage?

Get in touch with the SafetyWing customer service team through the live chat widget on our website, and we can send this to you!

▲ Can I change/customize the Standard and Premium Community Plans? Add-ons? Maternity?

When we built our Community Plans, we analyzed what our members want and need the most. As a result, we created the best plan we could imagine for an incredible cost.

The plans are fixed and do not allow custom add-ons. If you are looking for the most coverage possible, we suggest the Premium Plus Maternity Plan. The only add-on available for any plan is the add-on for coverage in Hong Kong or Singapore.

▲ Can I switch between the Standard Plan and Premium plan? Especially if I decide to add on dependents?

Switching plans mid-policy year (twelve months) is not currently an option. You must add dependents either at the sign-up time or within 30 days of the policy start date.

▲ Can I decide to add on dependents mid-way through my plan?

You must add dependents at the time of sign-up, within 30 days of the policy start date, or as a result of a new life event (i.e., marriage or birth).

▲ If I add a dependent to my plan, I will pay for the cost of coverage. Is this a

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- ▲ **If a member has Standard plan, but then gets married and wants his wife to have Premium+Maternity, would this be a qualifying event that would allow him to change plans mid-policy year?**

Plan upgrades or changes to your existing plan can only be made at renewal or within the first 15 days of your contract starting. A life-changing event like marriage or birth does qualify for your spouse or baby to be added to your plan throughout the policy year, but your plan will stay the same until your renewal.

- ▲ **What happens if I have to undergo surgery? Would those be covered within the \$5,000 outpatient limit or is it in a separate budget?**

Most surgeries are covered under the Core Plan as you are typically admitted to the hospital. Our plan includes up to 100% UCR for inpatient surgery and \$500,000 for outpatient surgery, sometimes called day surgery. This would not come out of your \$5,000 outpatient benefits.

If you need surgery, you must provide advanced notice by filling out [this form](#). Please provide at least two weeks' notice if you're requesting direct billing.

- ▲ **For the vision benefit, what if your glasses cost over \$500? Can members use the outpatient amount to cover the excess? What about Lasik?**

The vision benefit includes one set of frames every 24 months and one set of lenses or contact lenses every 12 months. You can submit vision claims for up to \$500 USD, and any extra cost would be a personal expense.

You cannot use outpatient benefits to cover claims related to vision. **Lasik** is not a covered benefit because it is an elective procedure.

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Over-the-counter medications are not eligible for reimbursement.

▲ What is the coverage for chemotherapy/cancer treatment?

Cancer tests, medication, and treatment (chemotherapy and/or radiotherapy) are covered under the base plan up to 100% of the UCR for either inpatient or outpatient care. It is subject to the policy maximum benefit of USD\$1,500,00 per policy year, including all your other claims.

▲ Is special equipment for a medical condition covered? For example, if I have to wear special boots due to a foot condition, are the boots covered by my Remote Health coverage?

Remote Health does provide coverage for medical equipment, but advance notice is required.

Please fill out [this form](#) to let us know when a medical device is needed.

▲ How would coverage work for specialists and surgical procedures?

Specialist: It isn't necessary to have a referral from your general practitioner to seek treatment with a specialist. Unless you are admitted to the hospital, specialist fees will be covered under the outpatient benefit (max \$5000 per policy year).

Surgical procedures: some treatments like surgery require you to provide advance notice. Fill out [this form](#) to notify us of your surgery. After receiving the information about your surgery, our team will get started right away to pre-authorize the treatment. Please give as much notice as possible as well as all medical notes. Most direct billing can be arranged within two weeks. As soon as we receive all documents required, direct billing can be arranged within 72 hours.

▲ How does the coverage handle pre-existing conditions? For example, if

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Generally, pre-existing conditions are covered as long as they are not excluded in the overall policy.

The application for the plan will ask if any new members have a major medical condition already in treatment, such as cancer or heart issues. If the answer is yes, please let our team know of the condition or treatment. It could result in the application being denied or a waiting period.

For new members added mid-policy term, the admin won't be asked if the member has pre-existing conditions, but if the admin has information about the major undergoing treatment, they should let us know.

▲ What conditions and treatments are covered?

[Here](#) is a complete list of coverage in our most comprehensive plan, Premium Plus Maternity. It includes add-ons that may not be part of your plan if you're an existing customer on a Standard or Premium plan.

▲ Does Remote Health cover extreme activities like scuba diving or bungee jumping?

There are no exclusions for specific sports, but if you're training or practicing a sport for which you receive compensation, it would be excluded.

▲ What does the outpatient benefit cover?

This benefit has a \$5,000 maximum limit per policy year. It covers doctor's visits for medically necessary treatment (nothing routine), specialist visits, physical therapy, prescription medications, and lab tests or diagnostic studies outside of hospital stays.

The Standard plan has a 10% co-insurance for outpatient benefits. This means that members are responsible for 10% of the total cost of each claim. There is no co-insurance for our Premium or Premium Plus plans.

FAQ Case studies

life-threatening and critical, and treatment cannot be available at their current location.

Evacuation must be arranged/pre-approved in advance.

Repatriation benefit covers a return ticket in economy class on a commercial airline flight for the insured and one (1) companion to the place from which the insured was evacuated, provided that the trip is made within ninety (90) days of discharge and is approved in advance.

▲ **What does the vision benefit cover?**

It covers eye exams, lenses, frames, and contacts up to a maximum of \$500 per policy year.

▲ **What does the dental benefit cover?**

It covers routine dental care such as cleanings, x-rays, fillings, and procedures such as crowns, dentures or inlays, up to a maximum of \$1,500 per policy year.

▲ **What does the screenings & vaccine benefit cover?**

It covers yearly physicals, routine check-ups, routine blood work, and vaccinations, up to a maximum of \$500 per policy year.

▲ **Does the plan cover medication?**

Prescription medications are covered under the \$5k outpatient benefit.

Over-the-counter medications are not covered.

▲ **What mental health benefits are available through Remote Health?**

FAQ Case studies

One benefit is coverage for inpatient psychiatric treatment. This covers 100% of the cost for up to 30 days.

The second benefit is covered through outpatient services. This allows you to be seen in-person by a psychologist, therapist, or licensed medical doctor for mental health concerns. You have 10 visits per policy year, covered at 100% of the UCR.

Telehealth/virtual doctors' visits are not covered for mental health, only for in-person outpatient.

▲ **If I need to use more than 10 physiotherapy sessions, can I have special authorization for more sessions?**

Remote Health comes with two different benefits for physiotherapy.

The rehabilitation and physio coverage under the outpatient benefit is covered at 100% of the UCR, up to the maximum of the overall benefit (\$5,000). This treatment must be approved in advance.

You'll need to fill out [this form](#) and submit a treatment plan, estimated costs, and medical notes from your provider.

The 10 sessions under complementary therapy can also be used for physiotherapy.

▲ **Can I see my doctor for routine care, like a yearly physical?**

Routine care, like a yearly physical, is covered under the Premium screenings and vaccines benefit. If you have this benefit included in your plan, you're covered!

▲ **Are tests like an MRI or CT scan covered?**

Medically necessary tests such as an MRI or CT scan are covered.

Please note that we need advance notice of any major procedures, such as MRIs, CT

FAQ Case studies**▲ What is covered in the complementary therapy benefit?**

You are covered for up to 10 visits per policy year up to \$60 per visit for physiotherapy, osteopaths, chiropodists, podiatrists, chiropractors, homeopaths, dieticians, and acupuncture.

▲ Is the COVID-19 vaccine covered?

We do not cover COVID-19 vaccines.

▲ My glasses broke. Are my new frames covered?

If you need new frames, you can purchase them and submit your claim for reimbursement. Please attach your proof of payment to your claim. New frames are covered once every 24 months, and new lenses every 12 months.

▲ Are blue light lenses for glasses covered?

Standard lens enhancements like blue light lenses (ultraviolet (UV) coating) are covered once every 12 months.

▲ Are contacts covered?

Contacts are covered in lieu of eyeglasses once every 12 months.

▲ Are frames covered?

Frames are covered once every 24 months, and lenses are covered one time every 12 months.

FAQ Case studies**▲ Are eyesight tests or vision correction covered?**

With the vision benefit (under Premium and Premium+ plans), you can be seen once every 12 months for an eye exam.

It also includes coverage for glasses and frames or contact lenses.

Eye surgery to correct vision, such as Lasik, is excluded. However, eye surgery to repair an eligible medical condition is covered with pre-authorization.

▲ Can I go to the dentist for routine care, like a cleaning?

Routine dental care, including cleanings, is covered under the dental benefit, which also includes fluoride, x-rays, and exams.

▲ If I have a cavity is a filling or crown covered?

Fillings and crowns are covered under the dental benefit.

▲ Does Remote Health cover braces?

Unfortunately, all orthodontic treatment is excluded, so braces are not covered.

▲ What if I need to have a tooth removed?

The dental benefit includes coverage for extractions.

▲ Does Remote Health cover chiropractic care?

Under the complementary therapy benefit, you're covered for up to 10 visits with a chiropractor, or similar, per policy year. Each visit is covered for up to \$60 USD.

FAQ Case studies

Yes! Remote Health provides coverage for high-altitude sports like hiking, motorcycling, driving, etc.

▲ **Does Remote Health cover volunteering/working with animals and any injuries sustained from that?**

Yes, there are no relevant exclusions that would apply to working with animals.

▲ **Is driving a motorized vehicle restricted in any way?**

To be covered for a medical condition incurred by driving a motorized vehicle (car, motorcycle, scooter, etc.), there are two relevant exclusions:

1. Self-inflicted injury ([Exclusion 7.25](#)). For example, reckless driving or driving under the influence of drugs and/or alcohol.
3. Professional sport ([Exclusion 7.23](#)). For example, if you are a professional race car driver or being paid for a race.

▲ **I plan to get a tattoo soon, and while the infection rate is very low, it would be nice to know that I am covered should something happen.**

Remote Health does not have an exclusion for pigments or body ink. Therefore, should a member get a tattoo and has the misfortune of getting an infection, we would cover the treatment of the infection and symptoms under the outpatient benefit.

▲ **I play soccer on a professional team. If I'm injured, will my treatment be covered?**

If you are participating in any sport professionally, claims resulting from injuries or illness are not covered by Remote Health. See [exclusion 7.23](#).

FAQ Case studies

With the outpatient benefit, there's coverage for complementary therapies, up to 30 per visit up to 10 visits per policy year, which includes physiotherapy, osteopathy, chiropractics, homeopathy, dietician and acupuncture, as well as therapies administered by a recognized traditional Chinese or an Ayurvedic medical practitioner.

▲ Is search and rescue covered?

Under the evacuation benefit, search and rescue is covered if you're at a recognized ski resort or similar winter sports resort. Search and rescue at sea or during off-site winter sports is not covered.

▲ Are things like an ACL tear, past sports injury, torn rotator cuff, etc. considered pre-existing conditions?

As long as your pre-existing condition is not a general policy exclusion, it will not affect your coverage under Remote Health.

▲ Can I be covered in my home country?

Remote Health can cover you in your home country or anywhere in the world that you travel.

▲ What does “passive war and terrorism” mean?

This refers to injuries sustained as a bystander during a war on terrorism. As long as you aren't engaged in the war on terrorism and are a spectator, injuries sustained are covered 100%.

▲ Is fitness included in any plans?

At this time, no. We'd love to roll out this benefit in the future.

FAQ Case studies

Dental coverage unfortunately is not covered on these plans, however, we're looking into offering it in the future.

▲ Does this plan cover orthodontics?

No, orthodontics is not covered in this plan.

▲ What exclusions are there?

[Here is the full list of exclusions](#), whether they are pre-existing or occur after the plan's start date.

▲ Does my Remote Health plan include coverage for maternity benefits?

The Premium Plus Maternity plan includes a \$7,500 maximum benefit for maternity coverage. This includes coverage for maternity checkups, pre and post-natal care, and the baby's birth.

This benefit does include a 20% co-insurance. That means that for maternity claims, you'll cover 20% of each claim. For example, if your claim is \$100, Remote Health will reimburse \$80, and you'll pay \$20.

The Standard and Premium plans do not include coverage for maternity benefits.

▲ What if you're on the Premium plan but happen to fall pregnant (unplanned)?

You cannot upgrade or downgrade your plan midway through the policy year. Once you are enrolled in a plan, you must have the same coverage until the policy renews the following year.

▲ Does this cover chronic meds?

FAQ Case studies**▲ Can I see a physical therapist?**

Yes! Medically necessary treatment with a physical therapist is a covered benefit of the policy, provided it's not a result of anything in the exclusions. We do require pre-approval in advance, and you can submit a notification [here](#).

▲ Will I be reimbursed for therapy sessions I do online?

To be eligible for our therapy benefit, the services must take place in the provider's office or the outpatient department of a hospital. The provider should be a psychologist (therapist) or psychiatrist.

▲ What are the benefit amounts?

The base plan comes with \$1.5 million USD in total coverage. Outpatient benefits have a maximum of \$5,000 (10% co-insurance with Standard plan, no co-insurance with other plans).

The following benefits are included only in Premium and Premium Plus Maternity:

- Dental max \$1,500,
- Vision max \$500,
- Screening & vaccines max \$500,
- Maternity max \$7,500.

These amounts are in USD per policy year.

▲ Is dental treatment covered under the 1.5M benefit if it's due to an emergency (e.g. damaged tooth in a car crash)?

FAQ Case studies

benefit limit (so that, for instance, you can continue to eat, drink, walk and talk properly following a serious accident). See [this page](#) of the policy document for more info.

▲ Is COVID-19 Testing covered?

COVID tests are covered if there is documentation of exposure or symptoms. If you do not have symptoms and get a negative result, the test would not be covered.

▲ Are hearing tests or hearing aids covered?

Hearing aids are covered under Durable Medical Equipment (pre-approval required), as long as they don't require surgical implantation.

Routine exams for hearing or cochlear implants are excluded from coverage. [View exclusion 7.24.](#)

▲ What happens if I have to undergo surgery? Would those be covered within the \$5,000 outpatient limit or is it in a separate budget?

Most surgeries are covered under the Core Plan as you are typically admitted to the hospital. Our plan includes up to 100% UCR for inpatient surgery and \$500,000 for outpatient surgery, sometimes called day surgery. This would not come out of your \$5,000 outpatient benefits.

If you need surgery, you must provide advanced notice by filling out [this form](#). Please provide at least two weeks' notice if you're requesting direct billing.

▲ What if I need to be seen in the emergency room? Will this be covered?

Emergency room care is eligible for full reimbursement. If you are transported to the

FAQ Case studies**▲ Is emergency assistance available in different languages?**

Currently, we can provide support in Spanish, English, French and Portuguese.

▲ If I go to the hospital for an emergency and I stay all day, will this be considered an inpatient stay, or do I have to be admitted and stay overnight?

An inpatient hospitalization means that you have been admitted to the hospital for a period of 24 hours or longer to receive medical or surgical care. Medical care limited to the emergency room or urgent care is not considered a hospitalization.

▲ If I'm going to the hospital for an emergency or for inpatient care, how should I present my insurance info to them?

We recommend printing your insurance card and keeping it on you. Your card will be loaded into your online member dashboard. Otherwise, you can pay for treatment, collect the medical notes and invoice and submit a claim on your online member dashboard.

If you need to go to the hospital for a pre-planned treatment, you can notify us in advance. You can learn more about notifications [here](#). You will use [this form](#) to submit a notification.

▲ How quick is the direct billing process? If a hospital sends over a bill, how quickly will the hospital get a response from SafetyWing? How long do payouts take?

Direct billing is available for claims greater than \$250 USD.

For routine or pre-planned treatment, please provide at least two weeks advance

FAQ Case studies

right away to process the reimbursement. Claims reimbursements are typically issued within 21 days or less from receiving the claim.

To request direct billing, please fill out [this form](#).

▲ Where can I go for treatment?

You can use Remote Health at any doctor, hospital, or clinic as long as they are legally licensed in the region.

▲ How do I use my SafetyWing insurance when I go to the doctor or hospital for treatment?

Pay upfront for most of your claims and file your claim in your SafetyWing member dashboard. You will need the following documents: a receipt that shows how much you paid and any medical notes that explain what the treatment was for, including diagnosis, treatment plan and/or prescriptions.

Direct billing can be arranged for claims over \$250 USD. However, if are struggling with payment for any amount, please reach out to the Remote Health team at rhnnotify@safetywing.com.

For emergency hospitalization or surgery, you can call our 24/7 emergency service at +1 855 276 8864, which will work with the hospital to handle billing directly.

▲ Which treatments require me to provide advance notice?

Here is the list:

- All hospital admissions,
- Inpatient and outpatient surgeries

FAQ Case studies

- ▲
- Physical and rehabilitative therapy,
 - Home health care,
 - Private nurse or therapist,
 - Nasal or reconstructive surgery,
 - Durable medical equipment or any special medical device,
 - Repatriation or cremation of mortal remains.

You can learn more about notifications [here](#). Please use [this form](#) to submit a notification.

▲ **Does Remote Health have a network?**

Remote Health does not have a network! You can choose any hospital or specialist you like, as long as they are a licensed medical provider.

▲ **Which hospitals or doctors have a partnership with SafetyWing?**

SafetyWing allows you to choose any hospital, doctor, or clinic as long as they are legally licensed. Since Remote Health is an international product, you are not confined to a network.

▲ **What is “UCR”?**

UCR stands for “Usual, Customary, and Reasonable Cost.” Based on published industry standards, the UCR is determined based on the expected cost of a procedure in that country.

For example, if the UCR is \$100 for an arm splint and the hospital charges \$120, the

FAQ Case studies Search FAQ**Member Company****Making a claim** 

If your claim is greater than \$250, direct billing can be arranged, but we need to have advance notice to complete this process.

▲ What documents are necessary to submit a claim?

Please provide a receipt, an invoice, and a diagnosis report. A diagnosis report won't always be necessary. For example, if you buy new glasses (frames), you don't need to submit a note from your provider.

▲ How long does the claims process take?

Claims are usually processed in 21 days or less. If you want an update or have any questions, feel free to get in touch through the live chat widget on our website.

▲ If I go over the maximum benefit, will I need to cover the rest?

Remote Health will cover up to the maximum limit of the benefit, and the member pays for any coverage costs above this limit. For example, if you claim \$600 for vision services, you would receive a reimbursement for \$500 if the claim is approved.

FAQ Case studies

Reimbursements sent in a different currency than the one you paid in will be made based on the exchange rate between the two currencies on the date of your treatment.

▲ Does the claim reimbursement include the cost of the wire transfer?

Yes, we cover the cost of the wire transfer.

▲ How does the reimbursement process work, and how long does it take?

Log into your SafetyWing dashboard and click "Make a claim." There is a short form you will fill out and upload your documents, receipts, and medical notes stating the treatment you had and why. Typically claims are reimbursed in 21 days or less.

▲ In Colombia we don't usually get receipts for what we paid for consultations. Do I have to have a receipt to receive my claim reimbursement? Also, is it ok if my doctor provides me with a handwritten receipt?

A receipt of some sort is required for reimbursement. It can be handwritten, as long as they provide the receipt on doctor, clinic, or hospital letterhead, and there is a signature.

▲ If I go to a private doctor, should I pay the invoice myself and then make a claim?

You will pay for your treatment upfront and file your claim in your member profile. You will be responsible for the difference if your claim exceeds the usual and customary amount (UCR).

▲ Can I submit multiple claims at once?

FAQ Case studies**► When requesting a refund for medical expenses, do you need to provide a note from a doctor?**

When you submit a claim, we ask for a diagnosis report (doctor's note) and the receipt of payment. The claim form will ask for a brief description of your treatment, which you can provide in your own words.

► Do I need to translate documents from my local language to English?

There is no need to translate documents from any language. The same is also true for claims. You can submit your claim in your local currency or in whatever currency you paid in, and if a conversion is necessary for reimbursement, we will use the exchange rate between the currencies on the date of your treatment.

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Global health insurance

POLICY DOCUMENT



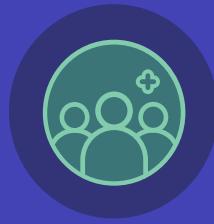
Premium

COMMUNITY PLAN 2.0

SafetyWing

Access healthcare wherever you are

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Live, travel and work from anywhere

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Simple and comprehensive

We back our great coverage up with updates around every claim.



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,
pre-authorizations:
rhnotify@safetywing.com

For reimbursement of claims:
rhclaims@safetywing.com

General Telephone: +1 214 276 6376
US Toll Free (from Skype): +1 855 276 8864



Summary of benefits

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

Plan summary

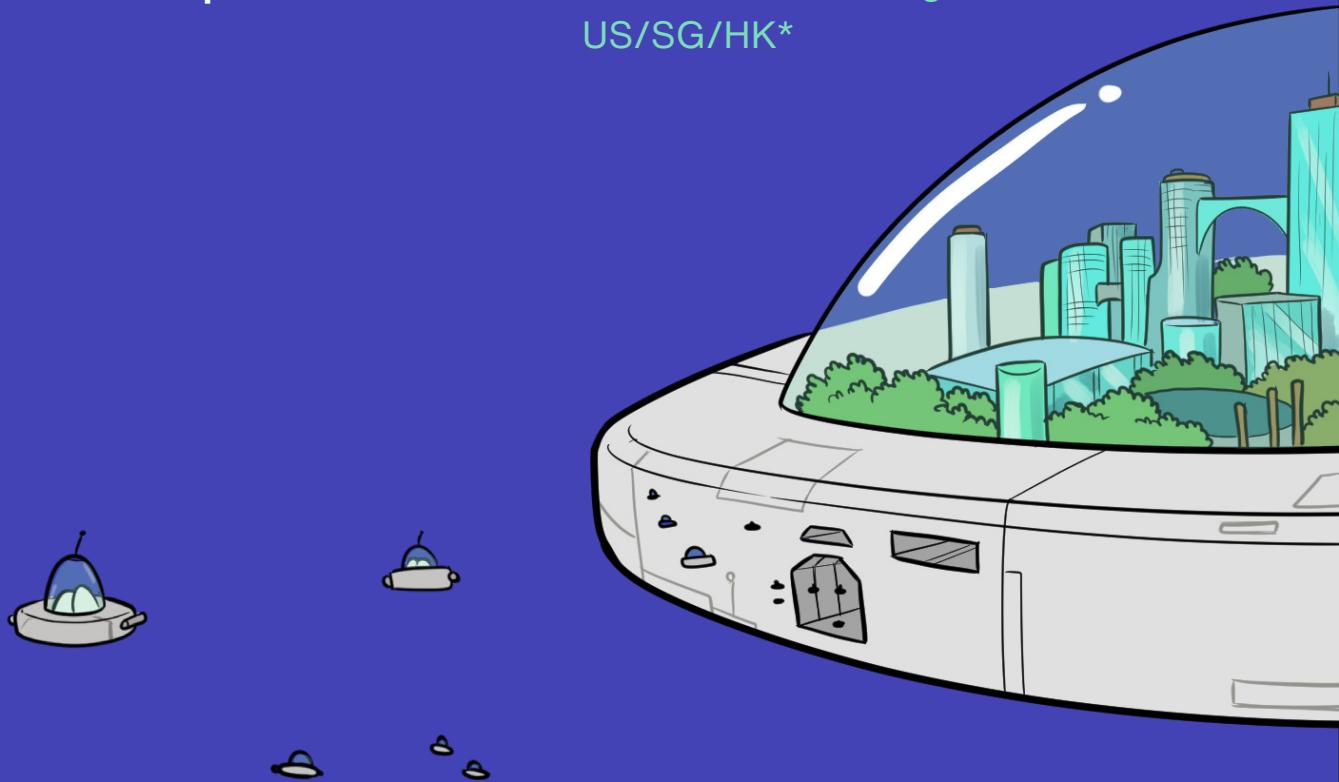
Premium benefits

General plan information

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

Age limit to apply Up to 74 years

Geographical cover options Worldwide excluding
 US/SG/HK*



Plan summary**Premium benefits***Base plan coverage*

Unless otherwise stated, the following benefits are for inpatient treatments

Standard private room (room & board)	100% UCR
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)
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)

Plan summary**Premium benefits**

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
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
Emergency dental coverage	100% UCR for treatment within the first 180 days of the covered Accident
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)

Plan summary

Premium benefits

Emergency Ground Ambulance transportation	100% UCR
--	----------

Evacuation and repatriation including repatriation or cremation of mortal remains	Up to US\$100,000
--	-------------------

Accident and Emergency non-elective treatment outside the geographical area of coverage	Injuries: 100% UCR Illnesses: Up to US\$50,000 Outpatient: Up to US\$500
--	--

United States, Hong Kong and Singapore
for up to thirty (30) days

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

Premium benefits



Dental

Dental coverage for routine care such as check-ups, fillings, etc.; or more complex care like repairing or receiving new crowns, dentures or inlays.

US\$1,500



Vision

Eyes exams, standard lens enhancement and contact lenses (instead of eye glasses) once every twelve (12) months; frames once every twenty-four (24) months.

US\$500



Screenings & vaccines

Routine health checks including cancer screening, cardiovascular and basic vital signs exams, as well as all basic immunization and booster injections. COVID-19 vaccines are not included.

US\$500



Plan summary
Premium 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
Outpatient psychiatric treatment
100% UCR
 up to a max. of 10 visits
 per Policy Year

Diagnostic study services
100% UCR

(Laboratory tests, pathology, X-rays, MRI/CT/ PET scans)

Complementary therapies
Up to US\$60

(Physiotherapy, osteopaths, chiropodists and podiatrists, chiropractors, homeopaths, dietitian and acupuncture)

per visit, up to a max.
 of 10 visits per Policy
 Year


\$0 deductible

The Deductible determines how much the Insured must pay out of pocket before receiving reimbursement for claims within one year.

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.

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 group 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 group Policy, including the applicable co-pays, 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)

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.

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, Riders 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.

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 Riders 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.

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.

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.

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.

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, among other factors, 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; or worldwide, excluding the United States of America, Hong Kong and Singapore, 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 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 be notified as soon as it is determined that an Insured is a candidate for a

Transplant in order to be coordinated and pre-authorized by the Company. To claim this benefit, the Insured must authorize the Company to submit all medical documentation related to the Transplant for a Second Medical Opinion VIP® to determine the Medical Necessity and relevance of the procedure.

6.6 Congenital Disorders

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

This benefit excludes Pre-existing Conditions, and conditions and/or consequences resulting from any type of fertility treatment or procedures for assisted fertility that manifest at any age.

6.7 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.

6.8 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.

6.9 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.

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

6.11 Inpatient Emergency dental treatment

The coverage for this benefit is one hundred percent (100%) UCR for Injuries resulting from a covered Accident. This benefit is limited to a necessary treatment to restore or replace sound natural teeth that have been damaged and/or lost in a covered Accident.

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 care includes services from certified professionals (Nurses or Therapists) and it does not include Custodial 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 up to thirty (30) days per trip.

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 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.

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). 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 it 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 Dental

The coverage for this benefit is up to a maximum of one thousand five hundred dollars (US\$1,500).

This benefit includes preventive oral examinations, such as cleanings, adult/child fluoride, sealants (permanent molars only), bitewing images and full mouth series images; basic treatment, such as stainless steel crowns, incision and drainage of abscess, uncomplicated

extractions, denture repairs, surgical removal of erupted tooth, surgical removal of impacted tooth (soft tissue), root canal therapy of anterior teeth/bicuspid teeth, scaling and root planing, gingivectomy, space maintainers, amalgam (silver) fillings, composite fillings (anterior teeth only), general anesthesia/intravenous sedation; and major treatment, such as root canal therapy of molar teeth, osseous surgery, surgical removal of impacted tooth (partial bony/full bony), crown build-ups, implants, inlays, onlays, crowns, crown lengthening, full and partial dentures, and pontics. This benefit excludes orthodontia.

6.24 Vision

The coverage for this benefit is five hundred dollars (US\$500).

This benefit includes:

- A.** One (1) eye exam once every twelve (12) months: eye health exam, dilation, prescription and refraction for glasses; retinal imaging.

- B.** One (1) frame once every twenty-four (24) months: standard corrective lenses once every twelve (12) months; single vision, lined bifocal, lined trifocal, lenticular.
- C.** Standard lens enhancements once every twelve (12) months: polycarbonate (child up to age 18) and ultraviolet (UV) coating; progressive, polycarbonate (adult), photochromic, anti-reflective and scratch-resistant coatings and tints.
- D.** Contact lenses (instead of eye glasses) once every twelve (12) months: contact fitting and evaluation.

6.25 Health screenings and vaccines

The coverage for this benefit is up to a maximum of five hundred dollars (US\$500). This benefit includes coverage for health screenings and vaccinations. This benefit excludes COVID-19 vaccinations.

Outpatient Benefits

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

6.26 Emergency room care

The coverage for this benefit is one hundred percent (100%) UCR.

6.27 Physician and specialist visits

The coverage for outpatient physician and specialist visits is one hundred percent (100%) UCR.

6.28 Prescription Medications

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).

6.29 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.

6.30 Outpatient psychiatric treatment

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

This benefit only applies to outpatient psychiatric treatment. Services must be rendered in the Provider's office or in the outpatient department of a Hospital.

The Company must receive the physician's treatment plan, as well as evidence of Medical Need for said treatment plan. This coverage must be coordinated and approved in advance by the Company.

6.31 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. This benefit must be approved in advance by the Company.

6.32 Complementary therapies

The coverage for this benefit is up to sixty dollars (US\$60) per visit, for up to a maximum of ten (10) visits per Policy Year for physiotherapy, osteopathy, chiropodist, podiatrist, chiropractic, homeopathy, dietitian and acupuncture therapies.

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

Section 7. Exclusions

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

7.1 Active duty, war and disturbances

The treatment of Injuries that may result when an individual is an active member of the police force, the army or other military force of any country,

or is directly or indirectly participating in a war or military conflict, disturbance, civil or military coup d'état, hostility, civil war, riot, rebellion, martial law, act of terrorism or any illegal activity, including the possible arrest and incarceration resulting from said participation, except for cases in which the Insured is a simple spectator or civilian innocent of these actions.

7.2 Additional medical assistants

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

7.3 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.

7.4 Aesthetic treatments

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

This includes any treatment for nasal or septum deformities, except as specifically provided in Section 6.9 of this Policy.

7.5 Artificial kidney equipment

Any portable or home-use artificial kidney equipment.

7.6 Artificial or animal organs, cryopreservation and storage of tissues and Stem Cells

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

7.7 Dental or orthodontic treatment

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

7.8 Duplicate Durable Medical Equipment

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

7.9 Epidemics or Pandemics

Any medical treatment subject to the management of public authorities, including treatment and services related to infectious diseases declared as an Epidemic or public Emergency by the World Health Organization (WHO), the Centers for Disease Control and

Prevention (CDC), or any other government or governmental Agency or governing body of the country where the Epidemic occurred. In addition, such coverage is also excluded if there has been an official warning issued against travel to the area by the State Department or similar office, the embassies of the affected countries, the airline or another government Agency, before traveling to the affected country, except when the exposure occurs Accidentally or unknowingly while traveling to or from undeclared risk areas, or as a result of visiting the area prior to the declaration of an Epidemic or Pandemic.

7.10 Excessive expenses

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

7.11 Expenses covered by third parties

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

7.12 Expenses incurred in sanctioned countries

Any expense or claim incurred for the treatment, services or supplies rendered in countries, or 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 European Union, the United Kingdom, or any of its entities or asset control agencies.

7.13 Extended and Custodial Care; counseling services

Treatments in nursing homes for the elderly, assisted living facilities, hospices, long-term care facilities, hydro-Clinics, health spas and memberships to gyms.

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

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

7.14 Fetal surgery

Any surgery or treatment of a child while in the mother's womb.

7.15 Growth hormones

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

7.16 Hospital pre admission for more than twenty-three (23) hours

Any admission to a Hospital for more than twenty-three (23) hours the day before a programmed

surgery, or the admission to a Hospital to receive Outpatient medical Services, unless said admission was approved by the Company.

7.17 Injuries or Illnesses caused by radiation

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

7.18 Maternity or Newborn Complications

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

7.19 Medical care not prescribed and recommended by a physician, Non-Medically Necessary, Alternative, Investigative or Experimental procedures

Any service, treatment, Injury or Illness, or charges related to services or supplies that are not Medically Necessary, or provided to an Insured who is not under the care of a physician or medical professional who is legally qualified in the area or country in which he/she practices; or has not been prescribed by a physician or medical professional; or is considered homeopathic or alternative care; or is not scientifically recognized or is still in an Investigative phase or Clinical trial, as well as those that have not been approved by the U.S. Food and Drug Administration (FDA).

Any Medication that is not scientifically or

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

A prescribed Medication that is approved by the FDA for the specific condition of the Insured, but that is part of an Experimental treatment, it's also excluded from coverage.

7.20 Obesity and weight control treatments

Any treatment, expense or service to prevent obesity or for weight control, whether it is weight reduction or gain, and any alterations in the body size, including any type of food supplement.

7.21 Over the counter Medication

Any Medication that may be acquired without a physician's prescription including, but not limited to food supplements needed as a result of digestive intolerance, hunger suppressants, vitamins, anti-aging or hair growth Medications or products.

7.22 Podiatric care and orthopedic devices

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

7.23 Professional Sports

Treatments 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.

7.24 Routine exams

Any routine exam conducted as part of a preventive study not specified in the Table of Benefits; routine examinations of the ear and eyes, cochlear implants or any other surgical implant for hearing; eye glasses and contact lenses; prophylactic treatments, and the issuance of medical certificates and physical exams for work or travel, except as specifically provided in Sections 6.23, 6.24 and 6.25 of this Policy.

7.25 Self-inflicted Illness or Injury or criminal acts

Any care or treatment for self-inflicted Illnesses or Injuries, whether the individual is sane or insane; suicide; failed suicide; addictive conditions of any type; alcohol abuse; drug use or abuse; use of Illicit Substances or illicit use of controlled substances or Medication; being under the influence of alcohol or drugs; encounters with wild animals; and participating in fights or criminal acts in which the Insured or members of his/her family take part in a negligent manner, unless he/she/they are acting, legitimately, in self-defense; as well as any incident or Accident resulting from any of the criteria previously mentioned.

Care and treatment incurred in connection with Injuries which occurred during a crime committed by an Insured or which the Insured tries to commit including, without limitation, treatment and care for any Injuries sustained when the Insured's blood alcohol content is in excess of the legal limit in the place where the incident occurred, whether or not the Insured is charged with or convicted of any criminal offenses.

7.26 Sleep disorders, allergies, Alzheimer's and autism

The treatment or services related to any of the following conditions: sleep disorders, allergies, Alzheimer's and autism.

7.27 Sterilization, fertilization treatments; sexual reassignment

Any portion of a medical expense incurred in male or female sterilization; sterilization reversal; birth control; infertility treatments; artificial insemination; in vitro fertilization; conditions suffered by the mother or the Newborn as a result of any type of fertilization treatment; treatments or prostheses used to improve or restore potency, or other sexual deficiencies, even if the treatments or prostheses are secondary to a condition covered by this Policy. Sexual Reassignment, reproduction or modification services; including hormone therapy, intersex surgery, sexual deviations and disorders, psychosexual dysfunctions, genetic tests to determine paternity or sex of a child; disorders related to the Human Papilloma Virus (HPV) and genital herpes.

7.28 Treatment for mental health

Services for mental and nervous disorders and related Prescription Medication; neuro-developmental disorders, are not covered, except if they are required to treat a complication of a covered condition, as defined in the terms and limits of this Policy, and except as specifically provided in Sections 6.22 and 6.30 of this Policy.

7.29 Treatments provided by immediate relatives

Charges for physicians' services imposed by an immediate relative or member of the Insured's household; even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation, are excluded from coverage.

This exclusion also precludes an Insured who is also a physician from treating him/herself and submitting claims for such coverage. For the purpose of this exclusion, immediate relative means any of the following: husband or wife; natural or adoptive parent, child or sibling; stepparent, stepchild, stepbrother or

stepsister; father-in-law, mother-in-law, son in-law, daughter-in-law, brother-in-law or sister-in-law; grandparent or grandchild; Spouse of grandparent or grandchild. The Company reserves the right to authorize the treatment provided by the family member or the use of the Provider's facilities.

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, for example: washing, feeding or dressing 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.

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.

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.

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, and whose approval is required regardless of the location where the medical expenses are incurred.

Expiration Date

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

Grace Period

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

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.

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.

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.

Newborn

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

Nurse or Therapist

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

Outpatient Services

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

Palliative Care

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

Pandemic

An occurrence in which a disease spreads very quickly and affects a large number of people over a wide area or throughout the world, which

has been declared as such by the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC) or an equivalent organization.

Policy

Document where the general and particular conditions agreed by the Company and the 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.

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.

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.

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.

The Insured must notify the Company at least seventy-two (72) hours prior to receiving those medical services that require notification or pre-authorization. The Company must also be given notice of all medical Emergencies that require notification within seventy-two (72) hours after the event that caused the Emergency. If the Policyholder and/or the Insureds fail to notify the Company accordingly, they shall then be responsible for thirty percent (30%) of all covered costs.

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: rhnotify@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) 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.

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 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.

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.

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

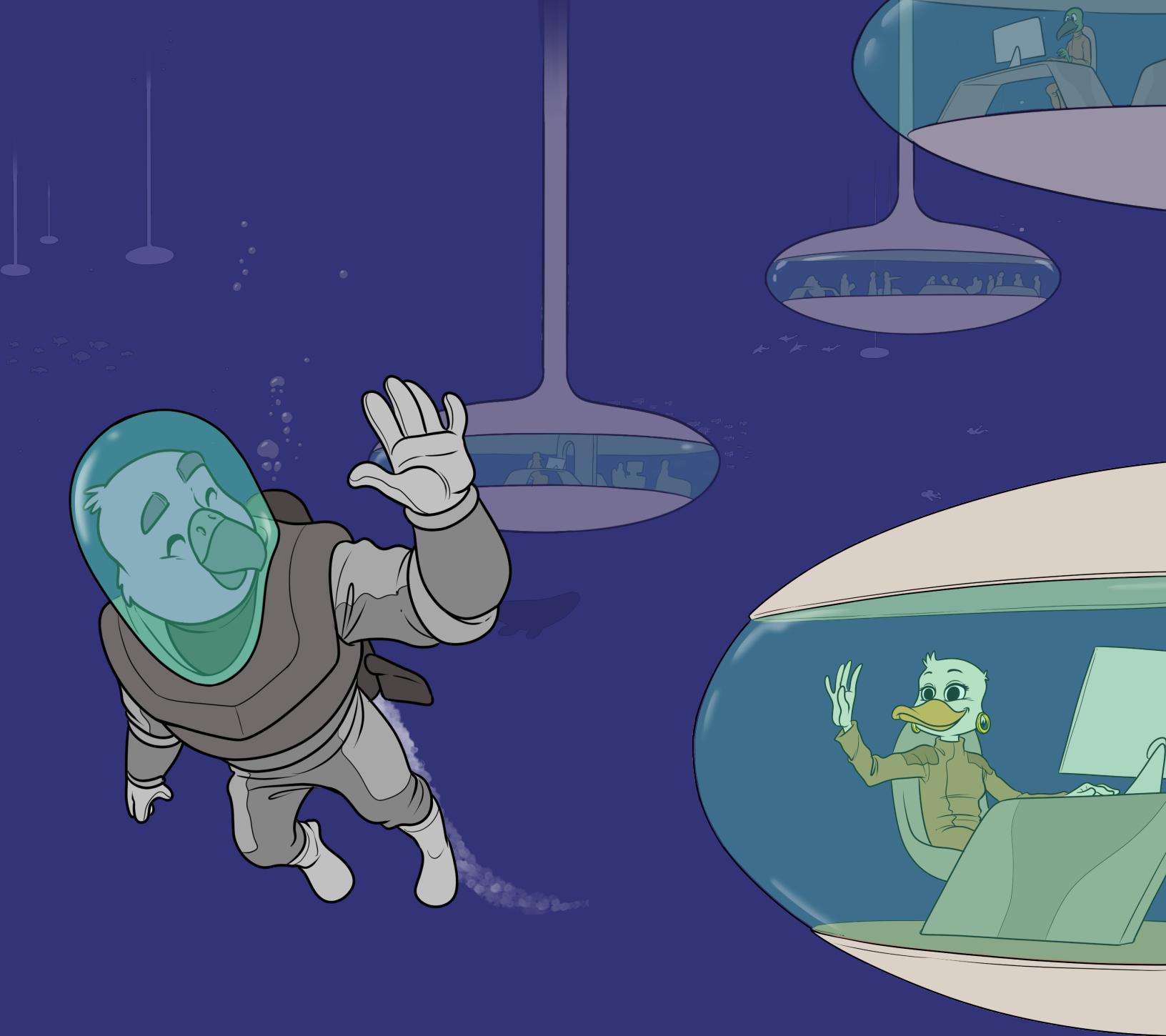
This contract constitutes and encompasses a complete agreement regarding matters or concerns regulated herein, and will prevail or

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.



Contact us

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