Expat Diamond 1000 Policy Terms and Conditions

WellAway
Keeping You Well, While You're Away.®

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Limit & Cost Sharing

	In-Network	Out-of-Network	Worldwide
Maximum Annual Coverage	$3,000,000	$3,000,000	$3,000,000
Deductible	$1,000 – Individual $2,000 – Family	$1,000 – Individual $2,000 – Family	$1,000 – Individual $2,000 – Family
In-Network Coinsurance you pay	No Coinsurance	N/A	No Coinsurance
Out-of-Network Fee Schedule	N/A	50%	N/A
Out-of-Pocket Maximum	$1,000 – Individual $2,000 – Family	Unlimited Individual and Family	$1,000 – Individual $2,000 – Family

Benefits are subject to the limitations and exclusions contained in the Policy.
All Treatments must be Medically Necessary.
Services with an asterisk must be Pre-Authorized by Plan Administrator.

Preventive Services

These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility only. If Services are not performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility, Services will not be covered.

	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2
	In-Network	Out-of-Network	
DEDUCTIBLE DOES NOT APPLY TO THIS BENEFIT	No Coinsurance	Not covered	No Coinsurance
Annual Physical Examination			
Adult Annual Physical Exam includes: • CBC, lipid profile, blood glucose, urinalysis, thyroid, blood pressure measure, heart rates, weight and BMI • Papanicolaou (PAP) screening • Mammogram (eligible age: 40 years and over) • PSA screening test (eligible age: 55 years and over)			
Immunizations: Flu shot and COVID-19 vaccine only			
Child Periodic Preventative visits			
Periodic preventive services are age specific for children and babies up to 16 years of age. After 3 years of age, children should have one preventive visit per year up to age 21. Pediatric visits should follow the intervals recommended by the age specific schedule of the Pediatric Guidelines.			

Services That Require Hospitalization

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. A search feature is available to help you find local Network Providers by using the link provided on the reverse side of your ID card or calling the telephone number also located on the reverse side of your ID card. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network	
Pre-Admission Testing (must be performed 3-5 days in advance in a Physician's office or at a participating lab under the order of the admitting Physician)	No coinsurance	50%	No coinsurance
Inpatient Hospitalization* (room & board, Inpatient general nursing care and special diets)	No coinsurance paid in full at average private room rate per day	50% paid in full at average private room rate per day	No coinsurance
Intensive Care Unit/Telemetry/Surgical Intensive Care/Medical Intensive Care/Trauma/Pediatric Intensive Care*	No coinsurance (Maximum 180 days per Policy Year)	50% (Maximum 180 days per Policy Year)	No coinsurance (Maximum 180 days per Policy Year)
Inpatient Mental Health* (Treatment must be provided in an accredited Psychiatric unit of a Hospital and must be under the direct control of a Psychiatric Physician)	No coinsurance Maximum 30 day limit per Policy Year	50% Maximum 15 day limit per Policy Year	No coinsurance Maximum 30 day limit per Policy Year
Emergency Medical Services in an Emergency Room (Treatment for a sudden onset of a medical condition with Acute symptoms of sufficient severity that in the absence of immediate medical attention (or as soon as care can be made available, but not any later than 24 hours after the onset) and in the absence of which, if left untreated, could reasonably result in a significant deterioration in health) If you use an Emergency room in the Hospital for a non-emergency Service, the Services will not be covered.	No coinsurance	50%	No coinsurance
Inpatient Physician and Specialist Services	No coinsurance (Maximum 1 specialty per day)	50% (Maximum 1 specialty per day)	No coinsurance (Maximum 1 specialty per day)
Inpatient Advanced Diagnostic Services (e.g., MRI, CT scans, nuclear imaging)	No coinsurance Maximum Benefit $3,000 per Service	50% Maximum Benefit $1,500 per Service	No coinsurance Maximum Benefit $3,000 per Service
Inpatient Routine X-rays and Lab Tests (tests commonly performed while Inpatient)	No coinsurance	50%	No coinsurance
Inpatient Renal Failure Dialysis* (for Acute Renal Failure which is not the result or complication of a Chronic Condition)	No coinsurance Maximum Benefit $30,000 per Policy Year	50% Maximum Benefit $30,000 per Policy Year	No coinsurance Maximum Benefit $30,000 per Policy Year

**Pre-Authorization Required*

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	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network	
Inpatient Oncology Treatment* (includes diagnostic tests, oncologist fees, radiation therapy and chemotherapy alone or in combination from the point of diagnosis and pharmaceutical treatments which have approved efficacy and market distribution) Benefits are only available when you utilize a Premium Care/Select Provider.	No coinsurance Maximum Benefit $350,000	Not covered	No coinsurance Maximum Benefit $350,000
Inpatient Reconstructive Surgery* (resulting from an Illness or Injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability) Benefits are only available when you utilize a Premium Care/Select Provider.	No coinsurance Maximum Benefit $75,000	Not covered	No coinsurance Maximum Benefit $75,000
Inpatient Rehabilitation * (physical, occupational and speech therapy for the purpose of restoring the previous state of health after an Illness or Injury) Benefits are only available when you utilize a Premium Care/Select Provider.	No coinsurance Maximum 36 day limit per Policy Year	Not covered	No coinsurance Maximum 36 day limit per Policy Year
Inpatient Surgical Procedures and Surgeon Fees * • Surgeon's fees for Medically Necessary Treatments related to an Injury or Illness which are charged by the main surgeon that performed the Surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. Claims in the United States will be paid based on AMA guidelines for assistant surgeons and surgery reimbursements. International Claims will be paid based on UCR. • Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered Surgical Procedure are also covered.	No coinsurance	50%	No Coinsurance

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Services That Require Hospitalization

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. A search feature is available to help you find local Network Providers by using the link provided on the reverse side of your ID card or calling the telephone number also located on the reverse side of your ID card. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network	
Inpatient Surgical Appliances and Prosthesis (covered for prosthetic, surgical, orthopedic and cardiac Procedures which are an integral part of the Surgical Procedure) Please refer to your Policy for a list of devices, appliances or prostheses that may be excluded.	No coinsurance	50%	No coinsurance
Organ Transplant* • Includes heart, heart and lung, kidney, kidney and pancreas, liver, cornea, bone and skin grafts, small intestines and allogenic and autologous, bone marrow (refer to your Policy for coverage of approved Diagnosis), blood and stem cell transplants. Benefits are only available when you utilize a Premium Care/Select Provider.	No coinsurance Maximum Benefit $60,000 Lifetime	Not covered	No coinsurance Maximum Benefit $60,000 Lifetime
Emergency Ground Ambulance (limited to one way trip when responding to a medical Emergency where other means of transportation will endanger the patient life or special medical equipment must be used en route to the closest medical Facility available to treat the emergency that results in an Inpatient Admission)	No coinsurance	No coinsurance	No coinsurance

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Outpatient Care

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online. All Ambulatory Services must be performed in a free-standing independent Ambulatory Facility. If Ambulatory Services are not performed in a free-standing independent Facility, a Site of Service Differential will apply.

	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network	
Urgent Care Clinic / Facility	No coinsurance	50%	No coinsurance
Outpatient Ambulatory Surgical Facility & Surgical Care* • Surgeon's fees for Medically Necessary Treatments related to an Injury or Illness which are charged by the main surgeon that performed the Surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. Claims in the United States will be paid based on AMA guidelines for assistant surgeons and surgery reimbursements. International Claims will be paid based on UCR. • Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered Surgical Procedure are also covered.	No coinsurance	50%	No coinsurance
Routine X-rays and Laboratory Tests Benefits are only available when performed in a Premium Care Physician/Select Provider's office or in a free-standing non-hospital Facility.	No coinsurance	Not covered	No coinsurance
Advanced Diagnostic and Interventional Radiology Services* Benefits are only available when performed in a Premium Care Physician/Select Provider's office or in a free-standing non-hospital Facility.	No coinsurance Maximum Benefit $4,000 per Policy Year	Not covered	No coinsurance Maximum Benefit $4,000 per Policy Year
Outpatient Therapeutic Services Combined (physical, occupational and speech therapy for the purpose of restoring the previous state of health after an Illness or Injury)	No coinsurance Maximum allowance $150 per session, Maximum 36 sessions per Policy Year	Not covered	No coinsurance Maximum allowance $150 per session, Maximum 36 sessions per Policy Year
Outpatient Renal Failure Dialysis* (for Acute Renal Failure which is not the result or complication of a Chronic Condition)	No coinsurance Maximum Benefit $100,000 limit per Policy Year	Not covered	No coinsurance Maximum Benefit $100,000 limit per Policy Year

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Outpatient Care

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online. All Ambulatory Services must be performed in a free-standing independent Ambulatory Facility. If Ambulatory Services are not performed in a free-standing independent Facility, a Site of Service Differential will apply.

	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network	
Outpatient Oncology Treatment* (includes diagnostic tests, oncologist fees, radiation therapy and chemotherapy alone or in combination from the point of diagnosis and pharmaceutical treatments which have approved efficacy and market distribution) Benefits are only available when you utilize a Premium Care/Select Provider.	No coinsurance Maximum Benefit $350,000 per Policy Year	50% Maximum Benefit $100,000 per Policy Year	No coinsurance Maximum Benefit $350,000 per Policy Year
Outpatient Reconstructive Surgery* (due to Illness or Injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability). Benefits are only available when you utilize a Premium Care/Select Provider.	No coinsurance Maximum Benefit $75,000 per Policy Year	Not covered	No coinsurance Maximum Benefit $75,000 per Policy Year
Outpatient Emergency Dental Treatment (due to Accident or Injury and resulting in damage to Sound Natural Tooth and treated within 24 hours of the Emergency event)	No coinsurance Maximum Benefit $300 per tooth up to $1,500 per Policy Year	Not covered	No coinsurance Maximum Benefit $300 per tooth up to $1,500 per Policy Year
Home Health Care* (care must begin immediately following your Hospital stay of no less than 3 days, ordered by a Physician and provided under the supervision of a registered nurse)	No coinsurance Maximum 90 days per Policy Year	Not covered	No coinsurance Maximum 90 days per Policy Year
Hospice or Palliative Care* (accommodation, nursing care and support for the Treatment of end-of-life stages)	No coinsurance Maximum Benefit $25,000 or 90 days per Policy Year, whichever occurs first	Not covered	No coinsurance Maximum Benefit $25,000 or 90 days per Policy Year, whichever occurs first
Durable Medical Equipment (helps to complete your daily activities e.g., walker, wheelchair, oxygen device or other equipment that can withstand repeated use which must be prescribed by a Physician)	No coinsurance Maximum Benefit $3,000 per Policy Year	Not covered	No coinsurance Maximum Benefit $3,000 per Policy Year

** Pre-Authorization required*

Physician Services

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network	
Telemedicine Consultations and Visits (for Illnesses including cold & flu Symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	No Co-payment Maximum 8 consults per Policy Year		only available in the USA
Physician E-Visits (E-visits are available for established patients and should not exceed 1 visit in a 7-day period. E-Visits are limited to 1 per day per Physician and must be legally authorized in your state of residence)	No coinsurance Maximum allowance $250 per visit	50% Maximum allowance $125 per visit	No coinsurance Maximum allowance $250 per visit
Primary Care Visit (includes Physicians, general or Family practitioner and gynecologist, when designated as the Primary Care Physician who provides the first contact for an individual with an undiagnosed health issue) Benefits are only available when you utilize a Premium Care/Select Provider.	No coinsurance Maximum allowance $250 per visit	Not covered	No coinsurance Maximum allowance $250 per visit
Specialist Visit • When medically indicated • When your medical condition or Diagnosis requires that you are treated by a Physician with specific training for your condition or Diagnosis Benefits are only available when you utilize a Premium Care/Select Provider.	No coinsurance Maximum allowance $400 per visit	Not covered	No coinsurance Maximum allowance $400 per visit
Outpatient Mental Health Visit (Treatment must be provided via e-visit or in a Physician's office under the direct control of a Psychiatric Physician)	No coinsurance Maximum 25 visits per Policy Year	50% Maximum 15 visits per Policy Year	No coinsurance Maximum 25 visits per Policy Year
Alternative Medicine (acupuncture, chiropractic, homeopathy only)	No coinsurance Maximum allowance $200 per session Combined Maximum 5 visits per Policy Year	Not Covered	No coinsurance Maximum allowance $200 per session Combined Maximum 5 visits per Policy Year
Podiatry (Treatment for bursitis, heel spur, plantar fasciitis, ingrown toenail, infections, warts (including plantar warts), and fungal infections) Routine foot care and any Surgery of the foot are not covered under this benefit.	No coinsurance Maximum allowance $300 per session Maximum 12 visits per Policy Year	Not covered	No coinsurance Maximum allowance $300 per session Maximum 12 visits per Policy Year
Allergy Testing & Treatment* (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum) Benefits are only available when you utilize a Premium Care/Select Provider.	No coinsurance	50% Maximum Benefit $500 per Policy Year	No coinsurance

** Pre-Authorization required*

Outpatient Prescription Drugs and Supplies	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2
	EHIM In-Network Pharmacy	Out-of-Network	
• Generic Medications only • Not subject to Deductible or Out-of-Pocket Maximum	No coinsurance	Not covered	No coinsurance

Evacuation & Repatriation

Emergency Medical Evacuation* (transportation to the nearest Facility if the Treatment needed is not available locally)	Paid in full up to $75,000 per Insured Person, per Policy Year	Paid in full up to $75,000 per Insured Person, per Policy Year
Repatriation of Mortal Remains* (transportation cost and cost for burial or cremation)	No coinsurance Maximum Benefit $25,000	No coinsurance Maximum Benefit $25,000

** Pre-Authorization required*

Health Care Coverage and Benefits

Scope of Coverage

This Policy is designed to provide expatriates worldwide coverage***** for the benefits and amounts stated in the Summary of Benefits. All benefit amounts will be in the same currency as the Premium currency for the Policy you purchased. Your Policy includes the Summary of Benefits table (in effect at the time Services are rendered). This Policy and the Summary of Benefits describe each party's rights and obligations, what the plan covers and how benefits are paid for that coverage. Please note that benefits are subject to Deductible, Coinsurance, Maximum Benefit amounts and any excess charges between the Provider's billed charges and the allowed amount (as applicable). Certain Procedures and medical Services covered by your Policy require Pre-Authorization. If we have not provided Pre-Authorization, a 50% penalty will apply.

We agree to provide coverage, up to the limits stated in the Summary of Benefits, for Covered Expenses of Covered Services in accordance with the conditions, limitations and exclusions stated in this Policy. The Policyholder's receipt of the most current Summary of Benefits shall constitute delivery to each Insured Person. All Covered Services must be Medically Necessary and in accordance with Evidence-Based Medicine guidelines. You may also purchase a dental and vision package When reading through this Policy, capitalized words are defined terms whose definition appears in the Definitions section of this Policy.

**Please refer to the Coverage Outside Your Zone of Coverage section for certain limitations and exclusions.*

We provide a 10-day free look period from the effective date of your Policy. It is important that you read and understand the terms and conditions of your benefits and coverage to make sure you are aware of your Deductible, Coinsurance amount, Out-of-Pocket limit, if any, Maximum Benefit limits and any Waiting Periods, Exclusions and limitations Please take the time to familiarize yourself with this Policy. If you are not satisfied, you may cancel this Policy within ten (10) days after the Policy Effective Date. The Premium will be refunded as long as there is no claim in process, or a claim has not been paid. If you have any questions, or would like to cancel the Policy during the free look period, contact WellAway or email enrollment@wellaway.com. After the free look period, the Policy will be deemed 100% non-refundable.

Important Information:

- You are eligible for two geographical zones of coverage based on your destination at the time of purchase.
    - Zone 1 is worldwide excluding your Country of Origin, the European Union if you permanently reside there and the Restricted Areas (as defined in the Definitions Section of this Policy).
    - Zone 2 is worldwide excluding the USA, Bahamas, Bermuda, Brazil, Canada, China, Hong Kong, Japan, Panama, Singapore, Switzerland, United Kingdom, your Country of Origin, the European Union if you permanently reside there and the Restricted Areas.
    - Please check your Certificate of Coverage for the geographical zone you purchased.
- Pre-Existing conditions are not covered, whether they are declared or not declared on your Application Form.

Providers – United States
(only applicable to Insured Persons with Zone 1 coverage)

This Policy is designed to help make your health care more affordable in the United States by offering you access to a robust Network of medical Providers. ***It is important that you understand how the Providers you choose to use for medical care and the type of Services you receive in the United States affect how much you have to pay for medical Services***. This section explains payment rules when receiving Covered Services from different types of Providers in the United States under this Policy. This section does not include the specific Cost Share amounts under your plan. As you read this section, please keep in mind that you will have to check your Summary of Benefits for those details. WellAway provides access to a PPO Network in the United States which allows a maximum cost-effective use of your Policy benefits and permits you to comply with the terms and conditions for utilizing In-Network Premium Care/Select Providers.

In-Network Providers
In-Network Providers are available to you for your healthcare needs. Not all Providers in the Network are Premium Care or Select Providers. However, Premium Care or Select Providers and independent free-standing Facilities will provide you with the least Out-of-Pocket costs. Non-Premium Care or Select Providers and hospital affiliated Facilities, while In-Network,

may be subject to excess or differentials in addition to your Cost Share amounts. Using an In-Network Premium Care/Select Provider and independent free-standing Facilities will reduce your costs and allow you to obtain significant savings but are still subject to certain requirements such as Pre-Authorization and other requirements under this Policy. Pre-Authorization may include the required use of designated Premium Care or Select Providers and independent free-standing Facilities who have demonstrated high quality and cost-efficient care.

Your ID Card is your key to accessing all of the Premium Care/Select Providers and free-standing independent Facilities available to you as an Insured Person. Your ID Card will indicate the necessary details of the Provider Network and your ConciergeCare Counselor will advise you of how to use the Network, find In-Network Providers, In-Network Premium Care/Select Providers and independent free-standing Facilities, and assist you with your medical needs while residing in the United States. Contact our ConciergeCare team via the telephone number on your ID Card. They are experienced in guiding you to the most appropriate Providers for you. Please present your ID Card to your Provider at the time of receiving Services to avoid being charged for Services rendered by your Provider.

What is a Premium Care/Select Provider? Premium Care/Select Providers are those Primary Care Physicians and certain Specialists who meet certain quality and cost-efficient care criteria. Using a Premium Care/Select Provider will reduce your costs and allow you to obtain significant savings. You may find that certain specialties do not have any Premium Care/Select Providers i.e., dermatology. For those specialists, an excess or differential is not applicable if you visit the Specialist in his/her office and not in a hospital setting. The Premium Care/Select Specialties are:

- Allergy
- Cardiology
- Ear, Nose and Throat
- Endocrinology
- Family Medicine
- Gastroenterology
- General Surgery
- Internal Medicine
- Nephrology
- Neurology
- Neurosurgery, Orthopedics and Spine
- Obstetrics and Gynecology
- Oncology
- Pediatrics
- Pulmonology
- Rheumatology
- Urology

In the event you decide not to utilize a Premium Care/Select Provider (Primary Care or one of the designated Specialists above), you will be responsible for any excess or differentials in addition to your Cost Share amounts.

Out-of-Network Providers
Out-of-Network Providers are not contracted Providers with WellAway or the Network supporting your Policy. If you were to receive Services from Out-of-Network Providers, the payment will be sent or reimbursed directly to you. These amounts are based on 50% of the Out-of-Network Fee Schedule and the Insured Person will be responsible for settling the claim with the Out-of-Network Provider. We are not contracted with Out-of-Network Providers and will not pay them directly. Out-of-Network Providers may bill the Insured Person for any amounts above 50% of the Out-of-Network Fee Schedule and are under no obligation to discount their services in any way and will bill you their full charges directly. We urge you to use In-Network Premium Care/Select Providers and independent free-standing Facilities to minimize your Out-of-Pocket Costs. WellAway does not accept an assignment of benefits from an Insured Person to pay an Out-of-Network Provider directly. Coverage, if applicable, for Out-of-Network is subject to the Cost Share amounts indicated in the Summary of Benefits. Insured Persons will be responsible for the cost of all Services which are not covered Out-of-Network.

Out-of-Area Providers
If there is no Premium Care/Select Provider or In-Network Provider located within a 50-mile radius of your local residence, the claim will be paid as In-Network subject to Allowable Charges or at the Rate of a similarly situated In-Network Provider, after applicable Cost Share amounts have been applied. In the event the Insured Person travels outside the state of local residence, the claim will be paid based on the Provider's status in the Network in such location (i.e., Premium Care/Select Provider, In-Network or Out-of-Network), subject to Allowable Charges and after applicable Cost Share amounts have been applied.

Allowable Charges

In order to assist you in understanding how we determine the Allowable Charges under this Policy, please review the information provided below.

1. In the case of an In-Network Provider and Facility (including an In-Network Premium Care/Select Provider and independent free-standing Facility), this amount will be established in accordance with the applicable contracted agreement between that Network Provider and WellAway (via its third-party administrator and/or its Network). The Allowable Charges is the maximum amount the Company will pay for specific healthcare Services. You may also hear it referred to as "Eligible Expenses," "Payment Allowance" or "Negotiated Rate". When the Provider is an In-Network Premium Care/Select Provider or independent free-standing Facility, you may not have to pay the difference between the billed amount and the Allowable Charges, however, you will be responsible for Cost Share amounts as outlined in your Summary of Benefits.

2. In the case of an Out-of-Network Provider that has not entered into a contracted agreement with WellAway (via its third-party administrator and/or its Network) to provide access to its usual reduced fee from the billed amount of that Provider for the specific Covered Services provided to you:

(i) When processing Out-of-Network claims the prevailing Allowable Charges will be 50% of the Out-of-Network Fee Schedule.

(ii) WellAway will pay the Out-of-Network Covered Services to the Policyholder as outlined in the Summary of Benefits under the Out-of-Network column, if applicable. These amounts are based on the Out-of-Network Fee Schedule and the Insured Person will be responsible for settling the claim with the Out-of-Network Provider for any balances above this amount.

(iii) If you are unable to negotiate a price with the Out-of-Network Provider, the maximum amount paid by your Policy will be 50% of the Out-of-Network Fee Schedule. The Provider may bill you for any amounts above this amount at its discretion. Because WellAway and its third-party administrator are not contracted with Out-of-Network Providers, we recommend you negotiate any balances above the allowed Out-of-Network payment as soon as possible with the Out-of-Network Provider that treated you. Negotiating directly with your Out-of-Network Provider may reduce the amount they may bill you above the payment made by WellAway.

3. In no event will the Allowable Charges be greater than the amount the Provider actually charges.

4. You may obtain an estimate of the Allowable Charges for a particular Service by calling the ConciergeCare telephone number on your ID Card. Cost estimates may only be provided once we have determined that the service enquiry pertains to a Covered Service and that all Pre-Authorizations have been granted for the Procedure. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in this Policy apply. You should refer to the What Your Plan Covers section of this Policy and your Summary of Benefits to determine what is covered and how much we will pay.

All Other Countries

(applicable to Insured Persons with Zone 1 coverage outside the USA and Insured Persons with Zone 2 coverage)

The Insured Person may utilize any licensed Provider. However, we suggest that you contact our ConciergeCare team via the telephone number on your ID Card. Our team can assist you in finding an appropriate Provider that accepts direct billing to us. We retain the right to limit or prohibit the use of Providers as solely determined by us or which significantly exceed Allowable Charges.

Guarantee of Payment – ***Within 48 hours of an Emergency which requires an Inpatient Procedure, or if an Inpatient Procedure is planned or you require Outpatient Surgery, you must contact a ConciergeCare Counselor before Services are rendered.*** This is essential so that we may provide the necessary information to guarantee the costs or to pay the Provider and/or Hospital. This includes conducting a medical review of the invoices to make sure that they are Usual, Customary and Reasonable Charges in the country where Services are being rendered. We require the following information prior to placing a guarantee of payment to the Provider and/or Hospitals outside the United States:

- Medical reports from your Physician stating the Diagnosis, date of occurrence, beginning of the Symptoms, Treatments previously received for the same condition, evolution, complications, and current medical/Surgical Procedures recommended.
- Results of lab tests, x-rays, and all medical tests performed in relation to the specific condition.
- Copy of past medical history.
- Cost Estimate for Services Incurred outside the United States, including Hospital fees, surgeon's fees, anesthesiologist fees and/or assistant fees if one is required.

Upon receipt of this information, our medical advisors will evaluate all pertinent information and make a determination based on Medical Necessity. We will review the cost Estimate and advise if the same is within the Usual, Customary and Reasonable Charges. Upon final determination by our medical advisors, the ConciergeCare Counselor will inform the Insured Person of the cost as determined to be Usual, Customary and Reasonable Charges in the country where Services are being rendered. We will proceed to send verification of benefits to the Hospital and Providers if they agree to accept direct settlement. If the Insured Person does not provide the required information as outlined above, provide advance notice, request a guarantee of payment, or receive a Pre-Authorization from the Plan Administrator in writing, the Insured Person will be required to pay and then submit eligible invoices for Reimbursement. ***Failure to request a Pre-Authorization for Services in advance may result in the application of a penalty as indicated in the Pre-Authorization section of this Policy.***

Note: We will attempt at all times to settle the costs directly with the Hospital and/or Provider; however, it is in the Hospital's and/or Provider's discretion to accept payment from us. In the event a direct settlement is not accepted, the Insured Person will be required to settle the invoices in full directly with the Hospital and/or Provider. Thereafter, the Insured Person may submit the invoices for Reimbursement; provided, however, Reimbursement will be in the amount of the Usual, Customary and Reasonable Charges for such Services.

For information on the Providers, Physicians and Hospitals in our network, you may log into your member portal at www.wellaway.com or contact your ConciergeCare Counselor by calling collect +1-786-453-4008.

Coverage Outside Your Selected Zone

The Expat Diamond product offers two (2) Zones of Coverage options: Zones 1 and 2. If the Policyholder purchased Expat Diamond Zone 1, coverage is available worldwide including the United States. Insured Persons with Zone 1 coverage will be covered for a maximum of thirty (30) days if the Insured Person travels to his/her Country of Origin or the European Union.

If the Policyholder purchased Expat Diamond Zone 2, coverage is available worldwide excluding the United States, Bahamas, Bermuda, Brazil, Canada, China, Hong Kong, Japan, Panama, Singapore, Switzerland, and the United Kingdom. Insured Persons are free to travel within, and coverage will be provided, in all countries in the purchased Zone of Coverage. In addition, Insured Persons with Zone 2 coverage will be covered for a maximum of thirty (30) days if the Insured Person travels to his/her Country of Origin or the European Union. Except as previously stated, no coverage will be provided for any medical Services outside your purchased Zone of Coverage. Any and all claims or medical expenses will be the responsibility of the Insured Person. We reserve the right to request a copy of the Insured Person's passport.

Whether you purchased Zone 1 or Zone 2 coverage, an Insured Person will never be covered in a Restricted Area. Please refer to your Certificate of Coverage for the Zone you purchased.

Portability of Your Coverage

If an Insured Person is travelling, or intends to be located, outside the purchased Zone of Coverage for more than thirty (30) days during a Policy Year, the Insured Person must request to change to a new Zone of Coverage. To make any changes to the Zone of Coverage, the Insured Person must submit a new Application Form to the Insurer. Subject to any Eligibility requirements, the change of the Zone of Coverage will be effective after the new Application Form has been submitted to us, the corresponding Premium is received by the Insurer and the Insurer has approved the request. If we discover that the Insured Person has travelled outside the purchased Zone of Coverage for more than thirty (30) days, WellAway will automatically change your Zone of Coverage to the correct Zone.

When and How Your Coverage Begins

Who May Be Covered

All applicants are subject to underwriting review and approval. Acceptance of your Application Form is not guaranteed.

Eligibility Requirements for Policyholder

- Policyholder must be between the ages of 18 and the attained age of 60 at the time of application and intending to reside outside of his/her Country of Origin, the European Union or the Restricted Areas.
- This Policy will terminate at the attained age of 65 years old. If your attained age occurs after your new Policy Year begins, the Policy will terminate at the end of the coverage period.
- Policyholder must be in good health and not confined to a Hospital, nursing home, not be pregnant, hospitalized or disabled as of the Policy Effective Date; and
- The complete Application Form with all questions answered accurately and Premium must have been received by us.

WellAway has the right to investigate eligibility status to verify eligibility requirements are met. If it is discovered the eligibility requirements are not met, the insurance coverage will be terminated.

Eligibility Requirements for Dependents

- Provided Dependent coverage has been elected, coverage under this Policy can be extended to the following Family Members as Dependents): (i) Policyholder's spouse or Domestic Partner; and (ii) Policyholder's unmarried natural children, legally adopted children, and stepchildren up to age 19, or up to age 26 if single and a full-time student at an accredited college or university and/or who receive financial support from the Policyholder. Confirmation of full-time student status is required.
- When a Dependent child marries or attains age nineteen (19) or twenty–six (26) if a full-time student, coverage under the current Policy will end. Insurer will automatically issue a separate Policy with the same plan option(s) and conditions as the previous Policy.
- All Dependents must be in good health and not confined to a Hospital, nursing home, not be pregnant, hospitalized or disabled as of the Policy Effective Date; and
- The complete Application Form with all questions answered accurately for each Dependent and Premium must have been received by us.

WellAway has the right to investigate eligibility status to verify eligibility requirements are met. If it is discovered the eligibility requirements are not met, the insurance coverage will be terminated.

When Your Coverage Begins

Your coverage begins as of the date the Policyholder's Application Form is received, reviewed, approved and the Premium has been paid (which is stated in your Certificate of Coverage). Dependent's coverage takes effect on the same day that the Policyholder's coverage becomes effective, if you have enrolled a Dependent in the plan by then and the corresponding Premiums have been paid. Dependents can only be covered if the Policyholder is covered by the Policy and has elected Dependent coverage. The period of coverage for an Insured Person is referred to as the Policy Year in this Policy and such coverage will end at midnight at the end of twelve (12) months from the effective date of the Policy Year. Your new Policy Year will begin the following day so as long as you have received an invitation to continue coverage and you have paid your Premium.

How and When to Enroll

Addition of a New Dependent

To enroll a new Dependent after the Policyholder's enrollment, the Policyholder must submit a completed Application Form. The Dependent will be subject to medical underwriting and approval, the Eligibility requirements set forth above, and may be subject to the additional eligibility requirements set forth below for a newborn, legally adopted child or surrogacy child. We may also require the completion of a medical health questionnaire. The effective date of coverage for the new Dependent will be the date that the Insurer accepts the Application Form and the required Premiums are received by the Insurer. The new Dependent will be enrolled under the same coverage and Policy Year as the Policyholder and coverage will be based upon the terms and conditions of this Policy.

Addition of a Newborn Baby

Newborn babies may be covered, without qualifying periods, upon the Insurer's receipt of a Certificate of Birth, if at least one parent is covered by this Policy prior to the newborn's birth; provided, however, the newborn will be subject to medical underwriting, at our discretion. We will require the completion of an Application Form, the medical health questionnaire, a Certificate of Wellness and other additional information requested by Insurer. If the newborn is approved for coverage by the Insurer, the effective date of the newborn's coverage:

(i) will be subject to a 30-day Waiting Period if all required information is received by us within thirty (30) days of the newborn's date of birth; or

(ii) will be subject to a Waiting Period greater than thirty (30) days if we receive all required information more than 30 days after the newborn's date of birth.

Note: The newborn will be enrolled under the same coverage and Policy Year as the Policyholder and coverage will be based upon the terms and conditions of this Policy. This Coverage is subject to the payment of the additional Premium for the newborn Dependent.

Addition of a Legally Adopted Child or Surrogacy Child

Adopted and surrogacy children may be covered, subject to the following conditions:

- The child must be less than 19 years old;
- The Policyholder must provide written Notification to the Insurer at the time that the surrogacy or adoption agreement has been entered into (an official copy of the legal adoption document is required);
- We will require the completion of an Application Form, the medical health questionnaire, a Certificate of Wellness and other additional information requested by Insurer; and
- Child(ren) will be subject to underwriting review and approval.

The Dependent(s) effective date will be subject to a 30-day Waiting Period and will be covered from the date that the Insurer accepts the Application Form and the required Premiums are received by the Insurer. The new Dependent will be enrolled under the same coverage and Policy Year as the Policyholder and coverage will be based upon the terms and conditions of this Policy.
Policy.

Divorce

If marital status changes due to divorce, the Policyholder must notify Insurer within thirty (30) days of the date of the divorce. Coverage for the Dependent spouse, under this Policy will cease at the end of the current Policy Year. Policyholder must provide the divorce decree.

How Your Coverage Works

Pre-Authorization

Certain Services require Pre-Authorization and we always recommend, in the United States, you use a **Premium Care Physician/Select Provider and an In-Network Facility** in order to minimize your costs. Pre-Authorization is a process by which an Insured Person obtains approval for certain non-Emergency medical Services prior to the commencement of the proposed Service. Please contact our ConciergeCare team to request a Pre-Authorization at least five (5) business days prior to the scheduled Service, unless a greater time period is required as stated in this Policy. When you contact us for Pre-Authorization, we will recommend that you use a Premium Care Physician/Select Provider and an In-Network Facility within the Network if we anticipate that the contracted amount with the Provider will exceed the Usual, Customary and Reasonable Charges. Complete medical records must be submitted to our Plan Administrator for review of Medical Necessity in accordance with the terms of this Policy. A cost Estimate of the Services will also be required at the time of the request for Pre-Authorization for any Services.

The following Procedures require Pre-Authorization:

- Inpatient Hospitalization
- Inpatient Treatment for Behavioral Health
- Inpatient Surgical Procedures and Surgeon Fees
- Inpatient Rehabilitation
- Organ Transplants
- Outpatient Ambulatory Surgical Facility & Surgical Care
- Reconstructive Surgery
- Oncology Treatment (chemotherapy and radiation)
- Renal Failure Dialysis
- Advanced imaging/diagnostic Services (MRI, CT Scans, PET Scans)
- Endoscopy and Colonoscopy Services
- Allergy Testing & Treatment
- Durable Medical Equipment
- Home Health Care
- Emergency Medical Evacuation and Repatriation
- Repatriation of Mortal Remains

If we have not provided Pre-Authorization, a 50% penalty will apply to all Services including, but not limited to, Hospitalization, Procedures, Treatments, and Physician fees. Pre-Authorization approval does not guarantee payment of the claim in full.

Notification of Medical Emergency Services must be received by the Insured Person, or someone acting on behalf of the Insured Person, within 48 hours of an Admission or Procedure. In the event of an Emergency, the Insured Person should go to the nearest Hospital or Provider for assistance even if that Hospital or Provider is not part of the Network.

Site of Service Differential Costs and Premium Care/Select Providers

In order to minimize your costs, (i) certain Services must be rendered by an In-Network Premium Care/Select Provider ***(except when such Services are Medical Emergency Services)***; and/or (iii) be performed in a Physician's office or in a free-standing independent (non-hospital) Facility (e.g., Outpatient diagnostic center, endoscopy center, Ambulatory Surgical Facility). Our In-Network free-standing Facilities are conveniently located and provide Basic Diagnostic Services, Advanced Imaging/Diagnostic Testing and other Outpatient Services. For laboratory tests, visit Quest Diagnostics. You will be responsible for the Site of Service Differential cost if you choose to have Services performed at a Facility or Provider not indicated in this Policy. ***Contact our ConciergeCare team via the telephone number on your ID Card. ConciergeCare are experienced in guiding you to the most appropriate Providers for you.***

Services which are subject to an In-Network Premium Care/Select Provider or independent free-standing Facility provision means those Services are only covered when provided by the Provider designated, solely by us, as the In-Network Premium Care/Select Provider, independent free-standing Facility or Participating Pharmacy for such Services. Please refer to your Summary of Benefits and the What Your Plan Covers section of your Policy to determine which benefits are subject to this requirement.

Annual Maximum Amounts

Covered Expenses are subject to an Annual Maximum per individual Insured Person as indicated in your Summary of Benefits, as long as the Policy remains in force. The Annual Maximum includes all Maximum Benefits specified your Summary of Benefits and in any Policy Endorsements or Riders.

Choice of Deductible

You have chosen a plan with a Deductible to help you reduce the cost of your coverage. The higher the Deductible you choose, the lower your Premium. The Deductible applies to all Services except for Preventive Services. You may choose one of the following Deductible amounts: $1,000, $2,000 or $5,000.

If you have elected coverage for your Dependents, the family Deductible applies and may be met by any one (1) Insured Person or any combination of Insured Persons under the Policy. Once the family Deductible is met, no further Deductible is required for any Insured Person under the Policy.

You must pay the amount of the Deductible during each Policy Year before we provide coverage. After the individual or family Deductible is met (as applicable), your plan covers your Covered Expenses, subject to your Coinsurance and any Maximum Benefit and Annual Maximum amounts.

The following charges will not apply towards your Deductible and when you have reached your Deductible, you will still have to pay these charges:

- Premium amounts you must pay for this Policy;
- charges for Services that are not covered;
- charges that are in excess of our Allowable Charges/Covered Expenses and Maximum Benefit amounts;
- Prescription Drugs; and
- any penalties.

Coinsurance

Coinsurance is a percentage of our Allowable Charges that you must pay before we will pay our portion of the Allowable Charges for Covered Services. The Coinsurance percentage is calculated after all other Cost Share amounts for a given Service, such as your Deductible. Your Coinsurance amount is stated in your Summary of Benefits and your Certificate of Coverage. Your Coinsurance applies to all benefits with the exception of those Benefits which are listed as not covered. If you purchased the Optional Dental and Vision Benefits, these benefits are subject to a different Coinsurance amount which is stated in your Summary of Benefits.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum (if applicable to your Policy), is the Policy Year limit on all Cost Share amounts that you have to pay for Services that are covered under this Policy. If you are the only person on your Policy, only the individual Out-of-Pocket Maximum applies to you. If you have elected Dependent coverage, the family Out-of-Pocket Maximum applies to your Policy and may be met by any one (1) Insured Person or any combination of Insured Persons under the Policy. Your Out-of-Pocket Maximum amount for an individual and family, if applicable, is stated in the Summary of Benefits. After you have reached the individual or family (if applicable) Out-of-Pocket Maximum, you will have no additional Cost Share for the rest of the Policy Year, and we will pay 100% of our Allowable Charges for Covered Services rendered during the rest of the Policy Year.

The following costs will not apply towards your Out-of-Pocket Maximum and when you have reached your Out-of-Pocket Maximum, you will still have to pay these costs:

- Premium amounts you must pay for this Policy;
- costs for Services that are not covered;
- costs that are in excess of our Allowable Charges/Covered Expenses and Maximum Benefit amounts; and
- any penalties.

What Your Plan Covers

PREVENTIVE SERVICES

Preventive care includes a Physical Examination that is used to prevent Illnesses, disease, and other health problems, or to detect Illness at an early stage when Treatment is likely to work best. Getting recommended preventive services and making healthy lifestyle choices are key steps to good health and well-being.

Adult Annual Physical Examination

The adult annual Physical Examination includes the following: CBC (complete blood count), lipid profile, glucose test, urinalysis test, thyroid test, cholesterol screening for adults of certain ages or at higher risk, colorectal cancer screening for adults 50 to 75 (fecal occult blood test only), measures your blood pressure, heart rate, weight and BMI, updates your list of Providers and prescriptions; and sets up a screening schedule for appropriate Preventive Services. The annual Physical Examination also includes a Papanicolaou (PAP) test, Mammogram (eligible age: 40 years and over), PSA test for males (eligible age: 55 years and over) and immunizations for Influenza (Flu Shot) and Covid-19 are also covered. These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility only and are subject to the Maximum Benefit amount stated in your Summary of Benefits.

Note: It is important to note that while you receive Preventive Services, if you are experiencing Symptoms which were evident, have received any Diagnosis, medical Advice or Treatment; have taken Prescription Medication or Drug; experienced medical certainty of an Illness, Injury, physical or mental condition which existed prior to the Policy Effective Date is not considered a Preventive Service but rather a diagnostic service which is not covered under Preventive Services benefit.

Child Pediatric Preventive Visits

Periodic Preventive Services are age specific for children, babies up to the 16 years of age. After 3 years of age, children should have one (1) preventive visit per year up to age 21. Pediatric visits should follow the intervals recommended by the age specific schedule of the Pediatric Guidelines. These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility only and are subject to the Maximum Benefit amount stated in your Summary of Benefits.

Note: It is important to note that while you receive Preventive Services, if you are experiencing symptoms which were evident, have received any Diagnosis, medical Advice or Treatment; have taken Prescription Medication or Drug; experienced medical certainty of an Illness, Injury, physical or mental condition which existed prior to the Policy Effective Date is not considered a Preventive Service but rather a diagnostic service which is not covered under Preventive Services benefit.

SERVICES THAT REQUIRE HOSPITALIZATION

Pre-Admission Testing

Benefits are payable for Pre-Admission testing only when performed 3-5 days in advance of an Inpatient hospitalization or Surgery *(preferably in a Physician's office or at a participating lab under the order of the admitting Physician)*. If Services are not performed in a free-standing independent Facility a Site of Service Differential cost will apply.

Hospital Room and Board

This Policy provides coverage pursuant to your Summary of Benefits for Medically Necessary Inpatient Hospital Services up to the Maximum Benefit amount. The Facility must be an accredited Hospital in the country where the Insured Person is being treated. The Hospital must be operated under constant medical management, have suitable diagnostic and therapeutic facilities and keep complete medical records. Coverage is provided for Hospital Room and Board, special diets and general nursing care. The use of a private room will be paid at the allowable semi-private maximum daily rate. All charges in excess of the allowable semi-private maximum daily rate will be the responsibility of the Insured Person. All Treatment must be Pre-Authorized by the Plan Administrator.

Inpatient Ancillary Hospital Services

If Medically Necessary for the Diagnosis and Treatment of the Illness or Injury for which an Insured Person is Hospitalized, the following Services are covered:

- Use of the operating room and recovery room;
- All medicines administered while you are an Inpatient;
- Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and Services;
- Medical and Surgical Supplies and Dressings;
- Laboratory testing;
- Diagnostic x-ray examinations, MRI, CT Scans and PET Scans (subject to Maximum Benefit amounts); and
- Respiratory therapy rendered by a Physician or registered respiratory therapist.

Intensive Care Unit/Telemetry/Surgical Intensive Care/Medical Intensive Care/Trauma/Pediatric Intensive Care

An intensive care unit will be utilized, if it is the most appropriate place for the Insured Person to be treated, the care provided is an essential part of the Insured Person's Treatment, and the care provided is routinely required by patients suffering from the same type of Illness or Injury or receiving the same type of Treatment. The Hospital is responsible for providing updated medical records with the progress of the Insured Person and any further Treatment plans in order to confirm the Eligibility of coverage based on Medical Necessity and limited to one hundred eighty (180) days per Policy Year.

Inpatient Physician/Specialist Visits

Inpatient Physician visits are limited to one (1) specialty per day and must be Medically Necessary. Visits in excess of this amount will become the Insured Person's responsibility. Visits that are part of normal preoperative and postoperative care are covered under the Inpatient Surgeon Fees category set forth below and the Insured Person will not pay separate charges for such care.

Inpatient Mental Health

Treatment must be provided in an accredited Psychiatric unit of a Hospital and must be under the direct control of a Psychiatric Physician. We will only cover the costs of Inpatient psychotherapy if the Treatment is provided by a Psychiatric Physician, psychotherapist or other specialist with appropriate qualifications in the field of psychiatry, psychotherapy or psychoanalysis. This benefit is subject to the Maximum Benefit amount stated in your Summary of Benefits. All Treatment must be Pre-Authorized by the Plan Administrator.

Emergency Medical Services/Emergency Room

We will cover Treatment for a sudden onset of a medical condition with Acute symptoms of sufficient severity that in the absence of immediate medical attention (or as soon as care can be made available, but not any later than 24 hours after the onset) and in the absence of which, if left untreated, could reasonably result in a significant deterioration in health. ***If you use an emergency room in the Hospital for a non-emergency Service, it will not be covered.*** Upon the Services being rendered, our medical advisors will evaluate the medical records and make a determination based on Medical Necessity as to whether the Insured Person should have sought care at a Convenience Care/Urgent Care Clinic in lieu of an emergency room in the Hospital.

Limitation: Insured Persons with Zone 2 coverage will not be covered for Medical Emergency Services due to an Emergency or Accident outside Zone 2 unless the Insured Person is traveling to his/her Country of Origin or the European Union for a period not to exceed thirty (30) days. Services provided due to an Emergency or Accident must be Medically Necessary and are subject to Usual, Customary and Reasonable Charges. Except as previously stated, no coverage will be provided for Medical Emergency Services outside your purchased Zone of Coverage and any and all claims or medical expenses will be the responsibility of the Insured Person.

Renal Failure Inpatient

Benefits will be paid for the Acute onset of Renal Failure including renal Dialysis (Acute only), on an Inpatient basis up to the Maximum Benefit specified under your option plan when first diagnosed under this Policy and after the Policy's Effective Date.

Please refer to your Summary of Benefits for the Maximum Benefit for this Service. All Treatment must be Pre-Authorized by the Plan Administrator.

Inpatient Oncology/Cancer Treatment (chemotherapy/radiation)

Benefits will be covered for Treatment provided as an Inpatient. This benefit includes diagnostic tests, oncologist fees, Surgery, radiation therapy and chemotherapy alone or in combination from the point of Diagnosis. Radiation therapy must be rendered by a radiologist for proven malignancy or neoplastic diseases. Chemotherapy must be rendered by a Physician or Nurse under the direction of a Physician. Prescription Medication for Cancer Treatments which have approved efficacy and market distribution will be covered, subject to the Maximum Benefit set forth under the Oncology/Cancer benefit stated in your Summary of Benefits. All Treatment must be Pre-Authorized by the Plan Administrator and is only available when you utilize an In-Network Premium Care/Select Provider and Facility.

Inpatient Reconstructive Surgery

Benefits are payable under this Policy for any Reconstructive Surgery as a result of a medical condition, Illness, Injury or Accident which first occurred while the Insured Person is covered under this Policy e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability. Reconstructive Surgery must be Medically Necessary and performed within twelve (12) months from the date of the Illness, Injury or Accident. This benefit is subject to Pre- Authorization in writing by the Plan Administrator and is only available when you utilize an In-Network Premium Care/Select Provider and Facility.

When a mastectomy has been performed and covered under this Policy for an Insured Person, breast reconstruction Surgery as a consequence of breast Cancer and which is performed within twelve (12) months of the mastectomy will be covered for the following:

- Breast Prosthesis;
- Breast reconstruction;
- Surgery to the opposite breast to achieve a symmetrical appearance (after unilateral mastectomy); and
- Treatment for any complications of a mastectomy or reconstruction.

Note: Breast reconstruction Surgery must be authorized by us prior to the Surgery taking place and is only available when you utilize a Premium Care Provider/Select Provider. In addition, coverage for breast reconstruction Surgery is based on Medical Necessity, medical review by us, and the use of FDA and/or EMA approved devices.

Inpatient Rehabilitation

Benefits are available for Inpatient Rehabilitation provided in an approved and accredited Facility following an Admission to a Hospital as a result of an Illness or Injury for physical therapy, speech therapy and occupational therapy. Treatment must be under the direct supervision and control of a Specialist. Care must begin immediately following your Hospital stay of no less than three (3) days. Insurer has the right to review a Confinement, as it deems necessary, to determine if the stay is Medically Necessary. Insurer will reimburse one (1) Physician visit per day per specialty while the Insured Person is a patient in an approved Facility. Visits that are part of normal preoperative and postoperative care are covered under the Surgical fee and Insurer will not pay separate charges for such care. Coverage at a Rehabilitation Facility is subject to Pre-Authorization, the Maximum Benefit amount stated in your Summary of Benefits and is only available when you utilize an In-Network Premium Care/Select Provider and Facility.

Inpatient Surgical Procedures

Surgeries must be Medically Necessary. Certain expenses will not be covered due to the following:

1. When multiple Surgeries are performed in addition to the primary Surgery, on the same or different areas of the body, during the same operative session, our payment will be based on 50% of the Allowable Charges for any secondary Surgery performed and is subject to the Cost Share amounts (if any) indicated in your Summary of Benefits. This limitation applies to all bilateral Procedures and all Surgery Procedures performed on the same date of service.
2. Payment for incidental Surgery Procedures is limited to the Allowable Charges for the primary Procedure, and there is no additional payment for any incidental Surgical Procedure. An “incidental Surgical Procedure” includes Surgery where one,

or more than one, Surgery is performed through the same incision or operative approach as the primary Surgery, which, in our opinion, is not clearly identified and/or does not add significant time or complexity to the Surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental Surgical Procedure (there is no payment for the removal of the normal appendix in this example).

Note: All Surgeries *(except when such Services are Medical Emergency Services)* must be Pre-Authorized by the Plan Administrator.

Inpatient Surgeon Fees, Assistant Surgeon Fees and Anesthesiologist

Surgeon's fees for Medically Necessary Treatments related to an Injury or Illness which are charged by the main surgeon that performed the Surgical procedure. Some complex medical procedures may require an assistant surgeon or co-surgeon performing Services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. Claims in the United States will be paid based on AMA guidelines for assistant surgeons and surgery reimbursements. International Claims will be paid based on UCR. Benefits are also provided for the Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered Surgical Procedure.

Inpatient Surgical Appliances and Prosthesis

Surgical appliances required due to Illness or Injury during Inpatient Treatment are covered for prosthetic, surgical, orthopedic and cardiac procedures which are an integral part of the Surgical procedure or for Treatment immediately following Surgery when medically necessary, such as cardiac pacemakers, artificial limbs and prosthetic devices or tools. The Surgical appliance must be fitted during the Hospital stay and in or on your body. Benefits are subject to Maximum Benefit amounts stated in your Summary of Benefits.

Organ Transplant and Services

Coverage is provided for Transplant Services in accordance with your Summary of Benefits for and in relation to a human organ transplant of the kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the Insured Person as a recipient. The lifetime Maximum Benefit for Transplants is limited to the amount stated in your Summary of Benefits. An Organ Transplant required as a result of, or for the Treatment of a Congenital Condition(s), including a genetic disease or defect, will not be covered and is specifically excluded from this Organ Transplant benefit. Medical costs will only be covered for Transplants carried out in internationally accredited institutions by accredited surgeons and where the Organ procurement is in accordance with WHO guidelines.

Medical Costs include the following:

1. All pre-Transplant care which includes Services directly related to the evaluation that establishes the need for the Transplant, the evaluation of the Insured Person to undergo the Transplant and the medical stabilization of the Insured Person to undergo the Transplant.
2. All pre-Surgery tests including labs, x-rays, CT scans, MRIs, ultrasounds, biopsies, Prescription Medication and administration of the same.
3. The Surgery to Transplant the Organ.
4. All post-Transplant care directly related to the Transplant, including, but not limited to, follow-up care based on Medical Necessity of the Transplant and or any complications directly or indirectly or as a consequence of the Transplant.
5. Any medication or therapeutic Treatments required to secure and maintain the health of the transplanted Organ.

Benefits are only payable for Medically Necessary Transplants performed while an Insured Person is covered under this Policy and was first diagnosed under this Policy.

Limitations: Bone marrow Transplants are covered only for the following approved diagnoses: aplastic anemia; severe immune deficiency; Hodgkin's disease; Acute and chronic myelogenous; granulocytic leukemia; and multiple myeloma. Medically Necessary Transplants will only be covered for the Insured Person.

Note: This benefit is subject to Pre-Authorization in writing by the Plan Administrator and is only available when you utilize an In-Network Premium Care/Select Provider and Facility. As a result, the Insured Person must notify us as soon as the

Insured Person is a candidate for a Transplant. Coverage will begin once approved by the Insurer and (i) after the need for the Transplant has been determined by a Provider; and (ii) has been certified by a Second Surgical or Medical Opinion.

Emergency Ground Ambulance

Benefits are provided for Medically Necessary Emergency ground ambulance transportation (one-way only) to the nearest Hospital able to provide the required level of care and are payable in accordance with your current Summary of Benefits. The use of ambulance Services for the convenience of an Insured Person, which are not Medically Necessary, will not be considered a Covered Service.

Outpatient Care Benefits

Urgent Care Clinic/Facility Services

The Policy will provide coverage for Services Incurred in a Convenience Care Clinic for non-critical but urgent care needs. You may be able to reduce your expenses and, in many cases, your wait time for care by using Convenience Care Clinic. All Convenience Care Clinics maintain extended weekday and weekend hours and treat non-Emergency conditions such as:

- Animal bites;
- Cuts, scrapes and minor wounds;
- Minor burns;
- Minor eye irritations or infections;
- Rash, poison ivy, or allergies; and
- Sprains, strains, dislocations and minor fractures.

Outpatient Ambulatory Surgical Facility & Surgical Care

Surgeries mut be Medically Necessary. Charges necessary for the Treatment or Diagnosis of an Illness or Injury including, but not limited to, operating room, medical and Surgical Supplies will be covered. However, certain expenses will not be covered due to the following:

1. When multiple Surgeries are performed in addition to the primary Surgery, on the same or different areas of the body, during the same operative session, our payment will be based on 50% of the Allowable Charges for any secondary Surgery performed and is subject to the Cost Share amount (if any) indicated in your Summary of Benefits. This limitation applies to all bilateral Procedures and all Surgery Procedures performed on the same date of service.

2. Payment for incidental Surgery Procedures is limited to the Allowable Charges for the primary Procedure, and there is no additional payment for any incidental Surgical Procedure. An “incidental Surgical Procedure” includes Surgery where one, or more than one, Surgery is performed through the same incision or operative approach as the primary Surgery, which, in our opinion, is not clearly identified and/or does not add significant time or complexity to the Surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental Surgical Procedure (there is no payment for the removal of the normal appendix in the example).

Note: All Surgeries under this benefit are subject to Pre-Authorization.

Outpatient Reconstructive Surgery

Benefits are payable under this Policy for any Reconstructive Surgery as a result of a medical condition, Illness, Injury or Accident which first occurred while the Insured Person is covered under this Policy e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability. Reconstructive Surgery must be performed within twelve (12) months from the date of the Illness, Injury or Accident. This benefit is subject to Pre- Authorization in writing by the Plan Administrator. Benefits are only available when you utilize an In-Network Premium Care/Select Provider and Facility.

When a mastectomy has been performed and covered under this Policy for an Insured Person, breast reconstruction Surgery as a consequence of breast Cancer and which is performed within twelve (12) months of the mastectomy will be covered for the following:

- Breast Prosthesis;
- Breast reconstruction;
- Surgery to the opposite breast to achieve a symmetrical appearance (after unilateral mastectomy); and
- Treatment for any complications of a mastectomy or reconstruction.

Note: Breast reconstruction Surgery must be authorized by us prior to the Surgery taking place and is only available when you utilize a Premium Care/Select Provider. In addition, coverage for breast reconstruction Surgery is based on Medical Necessity, medical review by us, and the use of FDA and/or EMA approved devices.

Outpatient Surgeon Fees, Assistant Surgeon Fees and Anesthesiologist

Surgeon's fees for Medically Necessary Treatments related to an Injury or Illness which are charged by the main surgeon that performed the Surgical procedure. Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. Claims in the United States will be paid based on AMA guidelines for assistant surgeons and surgery reimbursements. International Claims will be paid based on UCR. Benefits are also provided for the Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered Surgical Procedure.

Outpatient Emergency Dental Treatment

Dental care Services are limited to an Accidental Injury of a Sound Natural Tooth sustained while covered under this Policy. The Treatment must be received within 24 hours of the Emergency event (Accidental Injury does not include damage to teeth Incurred while chewing food or foreign objects) and you must provide proof of the Accident through a medical or police report. Benefits are limited; please refer to your Summary of Benefits.

Routine X-rays and Laboratory Tests

These Services (other than laboratory tests) should be performed in an In-Network Physician's office or in an In-Network free-standing Facility and must be Medically Necessary for the Treatment or Diagnosis of an Injury or Illness. Our In-Network free-standing Facilities are conveniently located. For laboratory tests, use an independent free-standing laboratory. When Services are not provided by an In-Network Premium Care Physician/Select Provider′ office or in a free-standing non-hospital Facility, they will not be covered.

Advanced Diagnostic Imaging and Interventional Radiology Services

These Services should be performed in an In-Network free-standing Facility, e.g., MRI, CT scans, PET scans, MRA, endoscopies, biopsies. All Treatment must be Medically Necessary for the Treatment of an Injury or Illness. Our In-Network free-standing Facilities are conveniently located. When Services are not provided by an In-Network Premium Care Physician/Select Provider′s office in a free-standing non-hospital Facility, they will not be covered.

Outpatient Therapeutic Services (physical, speech, & occupational therapy)

All Services must be Medically Necessary and relate specifically to the Physician's written Treatment plan, containing long term and short term goals. Therapeutic Services must produce significant improvement in the Insured Person's condition in a reasonable and predictable period of time for the Services to be eligible for payment. Therapy must have a level of complexity and sophistication that the required therapy can safely and effectively be performed by the patient in order to obtain maximum results.

Physical Therapy

Physical Therapy Services require a Physician's Treatment plan which must include the frequencies and duration of such therapy. Services must be rendered by a Physician or registered physical therapist, be Medically Necessary and relate specifically to the Physician's written Treatment plan. Your Policy will cover interventions/modalities/therapeutic procedures

(therapeutic modalities) per visit as long as the therapeutic modalities are consistent with the Insured Person's plan of Treatment for the same Condition. More than one (1) therapeutic modality may be billed as long it is identifiable by the type of Treatment and consistent with the Treatment plan. The therapeutic modalities must be electrical, thermal or mechanical energy that causes physiological changes, and a therapist must provide direct, one-on-one therapy for at least eight minutes to receive reimbursement for one unit of a time-based Treatment code. Physical Therapy Services are limited to number of visits stated in your Summary of Benefits.

Physical Therapy Services require a Physician's Treatment plan which must include the frequencies and duration of such therapy. Services must be rendered by a Physician or registered physical therapist, be Medically Necessary and relate specifically to the Physician's written Treatment plan.

Speech Therapy

Speech Therapy is covered for a condition resulting from Injury or Illness. Medical records must be provided to establish the Medical Necessity of the prescribed exercises and therapy for treating voice and speech disorders, and Treatment must be provided by a Physician or speech therapist. A Treatment plan including the frequencies and duration must be provided and approved by the Plan Administrator prior to the Treatment taking place.

Occupational Therapy

Occupational Therapy is covered for a condition resulting from Surgery, Illness or Accidental Injury in order to:

- Learn or re-learn Activities of Daily Living; or
- Provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of an Illness or Injury.

Medical records must be provided to establish the Medical Necessity, and Treatment must be provided by a Physician or occupational therapist. A Treatment plan including the frequencies and duration must be provided and approved by the Plan Administrator prior to the Treatment taking place.

Limitation: Outpatient Therapeutic Services are limited to the combined Maximum Benefit amount stated in your Summary of Benefits. Coverage will only be approved in accordance with the benefit amounts stated in your Summary of Benefits until such time that the Insured Person reaches his/her maximum potential, improvement or function.

Outpatient Renal Failure

Outpatient Treatment of Acute onset of Renal Failure, including renal Dialysis (Acute only) on a day patient or Outpatient basis, is subject to a Policy Year Maximum Benefit when first diagnosed under this Policy and after the Policy's Effective Date as specified in your Summary of Benefits. All Treatment must be Pre-Authorized by the Plan Administrator.

Outpatient Oncology/Cancer Treatment (chemotherapy/radiation)

Benefits will be covered for Treatment provided as an Outpatient. This benefit includes diagnostic tests, oncologist fees, Surgery, radiation therapy and chemotherapy alone or in combination from the point of Diagnosis. Radiation therapy must be rendered by a radiologist for proven malignancy or neoplastic diseases. Chemotherapy must be rendered by a Physician or Nurse under the direction of a Physician. Prescription Medication for Cancer Treatments which have approved efficacy and market distribution will be covered will be covered, subject to the Maximum Benefit set forth under the Oncology/Cancer benefit stated in your Summary of Benefits. All Treatment must be Pre-Authorized by the Plan Administrator and is only available when you utilize an In-Network Premium Care/Select Provider and Facility.

PHYSICIAN SERVICES

Telemedicine Consultations and Visits

This Policy will cover access to a doctor anytime; receive quality care via phone, video or mobile app. By using telemedicine, your Cost Share amount is less than if you visit an Emergency Room or Urgent Care Facility. A telemedicine Physician will only provide consultations for the following Illnesses:

(i) cold & flu symptoms
(ii) allergies
(iii) pink eye
(iv) respiratory infection
(v) sinus problems
(vi) skin problems.

Note: Please refer to the Summary of Benefits for any limitations.

Physician and Specialist Visits

Primary Care -One (1) visit per day per specialty (either in person or via e-health, if medically appropriate) for Treatment of an Injury or Illness. Includes physicians, osteopaths, general or family practitioner and gynecologist when designated as the primary care physician (who provides the first contact for an individual with an undiagnosed health issue). All Services conducted at a Physician's or Osteopath's office and billed as an office setting or Outpatient visit setting.

Specialist -One (1) visit per day per specialty (either in person or via e-health, if medically appropriate) for Treatment of an Injury or Illness. All Services conducted at a Physician's or Osteopath's office and billed as an office setting or Outpatient visit setting. Services must be medically indicated when your medical condition or diagnosis requires that you are treated by a physician with specific training for your condition or diagnosis.

Note: All Services conducted at a Physician's office and billed as an office setting or Outpatient visit setting are limited to payment as specified in your Summary of Benefits. Benefits are only available when you utilize an In-Network Premium Care/Select Provider and Facility.

Outpatient Mental Health

Outpatient Mental Health Treatment is covered based on Medical Necessity only in accordance with your Summary of Benefits. The initial consultation (either in person or via e-health) must be performed by a licensed Psychiatrist only. Visits and Treatment under this benefit must be performed under the direct control of a Psychiatric Physician, psychologist, psychotherapist or other Specialist with appropriate qualifications in the field of psychiatry, psychotherapy or psychoanalysis and with the referral from a Psychiatric Physician. The referral from the Psychiatric Physician must be forwarded to the Plan Administrator prior to Treatment taking place. Medications prescribed to be administered on an Outpatient basis are not covered by this Policy, unless approved by us.

Alternative Medicine

Services provided by Alternative Medical Providers are covered if prescribed by a Physician in order to confirm Medical Necessity. Please refer to the Summary of Benefits for combined Maximum Benefit amounts and/or visits specified. The following alternative medical services are covered:

- Chiropractic;
- Acupuncture; and
- Homeopath.

Podiatric Services

Benefits are payable for Services performed by a certified podiatrist for Treatment of bursitis, heel spurs, plantar fasciitis, ingrown toenails, infections, warts (including plantar warts) and fungal infections up to the Maximum Benefit stated in your Summary of Benefits.

Allergy Testing and Treatments (includes injections for allergies)

Testing and desensitization therapy (e.g., injections) and the cost of hypo-sensitization serum are covered under this Policy. The Allowable Charges are based on the following conditions:

1. This Policy will only cover office-based skin tests (in vivo testing) and Treatment for a medical condition that first manifests itself during the Policy Year and for a medical condition that has not been previously diagnosed, treated or have suffered distinct signs or symptoms prior to the Policy Effective Date.
2. Allergy testing or Treatment and the frequency of allergy testing and/or Treatment must be Medically Necessary and ordered by a Physician specializing in allergies.

Note: All Treatment must be Pre-Authorized by the Plan Administrator and not be Experimental in nature. This benefit is only available when you utilize an In-Network Premium Care/Select Provider and Facility.

OTHER SERVICES

Home Health Care

Home Health Care Services may be covered when all the following criteria are met:

1. You are unable to leave your home without considerable effort and assistance because you are bedridden or chair-bound or because you are restricted in ambulation, whether or not you use assistive devices; or you are significantly limited in physical activities due to an Illness or Injury;

2. The Home Health Care Services rendered have been prescribed by a Physician by way of a formal written Home Health Care Plan to us;

3. The Home Health Care Plan has been reviewed and renewed by the prescribing Physician at least every thirty (30) days until benefits are exhausted. (We reserve the right to request a copy of any written Treatment plan in order to determine whether such Services are covered under this Policy);

4. The Home Health Care Services are provided by or through a Home Health Care Agency; and

5. You are meeting or achieving the desired Treatment goals set forth in the Home Health Care Plan as documented in the clinical progress notes.

To obtain benefits, an Insured Person must meet all of the following conditions:

1. The Insured Person would have to be admitted to a Hospital or Skilled Nursing Facility if he or she did not receive Home Health Care Services;
2. The Home Health Care Services program must be directly related to the Condition for which Hospitalization was required; and
3. The Insured Person has been admitted as an Inpatient in the Hospital for at least three (3) consecutive days and the Home Health Care Services program must begin within three (3) days of discharge from the Hospital or Skilled Nursing Facility.

Note: All Treatment must be Pre-Authorized by the Plan Administrator.

Home Health Care Services are limited to:

1. Part-time or intermittent nursing care by a Registered Nurse or Licensed Practical Nurse or a vocational Nurse under the supervision of a Registered Nurse, and/or home health aide Services (part-time is defined as less than 8 hours per day and less than 40 hours per week and an intermittent visit will not exceed 2 hours per day);

2. Home health aide Services must be consistent with the Home Health Care Plan, ordered by a Physician, and provided under the supervision of a Registered Nurse;

3. Medical social Services;

4. Nutritional guidance;

5. Respiratory or inhalation therapy, such as oxygen; and

6. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist.

Hospice

We will cover the eligible expenses for Hospice care provided in an Inpatient Facility or at an Insured Person's home. Hospice care must be certified by a physician. Hospice must work together with nursing staff and doctors with experience in palliative medical care. Hospice must be operated under the professional supervision of a Nurse, or other suitably qualified person, with several years of experience in palliative medical care or with relevant qualifications and licensure, as well as a supervisory nursing care or management qualification. We only cover benefits if the Insured Person is suffering from an Illness which:

- is progressive (in other words, it continues to get worse) and has already reached an advanced stage;
- is incurable, so that Inpatient Palliative Care has become necessary; and
- only gives a life expectancy of two (2) months or less.

Note: All Treatment must be Pre-Authorized by the Plan Administrator.

Durable Medical Equipment (therapeutic aids and appliances)

Benefits for Durable Medical Equipment will be provided when all of the following criteria below are met:

1. Prescribed by a Physician;
2. Customarily and generally useful to a person only during an Illness or Injury; and
3. Determined by us to be Medically Necessary.

The therapeutic aids and appliances that are covered without Pre-Authorization by the Plan Administrator are: orthopedic braces for the arm, neck, leg and back; bandages; trusses; compression stockings; corrective splints; plaster shells for lying and sitting. The covered amount is based on the Usual, Customary and Reasonable Charges for the DME, which meets the Insured Person's basic medical needs. The Allowable Purchase Price of the DME must not exceed the rental fees and Insurer will determine, in its sole discretion, if the DME is purchased or rented. Benefits are subject to the Maximum Benefit amount set forth in the Summary of Benefits.

The therapeutic aids and appliances that require Pre-Authorization by the Plan Administrator are: walkers, wheelchairs, canes. commode chair, bath chair, crutches, cardiac and respiratory monitors, infusion pumps, inhalation devices, oxygen devices, and speaking aids (electronic larynx) which is appropriate for home use and that can withstand repeated use. All other devices not listed above do not qualify as therapeutic aids and appliances and will not be covered. The covered amount is based on the Usual, Customary and Reasonable Charges for the DME, which meets the Insured Person's basic medical needs. The Allowable Purchase Price of the DME must not exceed the rental fees and Insurer will determine, in its sole discretion, if the DME is purchased or rented. Benefits are subject to the Maximum Benefit amount set forth in the Summary of Benefits.

Optional Dental and Vision Package

Dental and Vision coverage is available as an add on to your Policy as a combined package. As an optional benefit, we offer dental coverage with a maximum annual limit of $3,500 per person per Benefit Period. The benefits include Preventive, Basic, Major and Orthodontic treatment. The Orthodontic treatment is available to Dependent children under the age of 18, with a lifetime limit of $/€1,200 USD/EUROS. Our Vision benefits cover routine vision exams, eye glass frames and contact lenses.

Evacuation and Repatriation Benefits

Emergency Medical Evacuation

Emergency Medical Evacuation applies when the Insured Person is: (i) traveling outside his/her Country of Residence but still within the purchased Zone of Coverage; or (ii) travels to his/her Country of Origin or the European Union for a maximum of thirty (30) days. In the event of a life-threatening Emergency, where the necessary Treatment for which the Insured Person is covered and the treatment is not available in the destination where the Insured Person is traveling, we will evacuate the Insured Person to the nearest appropriate medical Facility capable of providing the required care. The Emergency Medical Transportation, which should be requested by the treating physician, will be carried out in the most efficient way with regard to the medical condition. In the event of such Emergency, the Plan Administrator reserves the right to determine the medical Facility to which the Insured Person shall be transported and the means of transportation. If the Insured Person chooses not to be treated at the Facility and location arranged by the Plan Administrator, the transportation expenses shall be the responsibility of the Policyholder or Insured Person. Should Treatment be available locally, but the Insured Person chooses to be treated elsewhere, transportation expenses shall be the responsibility of the Insured Person.

Following an Emergency Medical Evacuation, this Policy will cover the costs of transportation (economy class flight), to the Insured Person's Country of Origin or Country of Residence. The return journey must be made within fourteen (14) days after the Emergency Medical Evacuation and the treating Physician must provide a fit to fly certificate. The Plan Administrator will coordinate the transportation to return the Insured Person to the Country of Origin or Country of Residence.

Note:

1. Where an Insured Person has been evacuated to the nearest appropriate medical Facility and requires ongoing treatment, we will not cover the cost for the hotel accommodation or transportation to/from the nearest appropriate medical Facility.
2. This benefit is subject to Pre-Authorization by Plan Administrator in conjunction with our medical advisors. Failure to obtain Pre-Authorization will result in denial of the claim.
3. The Insured Person, or if unable, an individual acting on his/her behalf, must contact the Plan Administrator at the first indication that Emergency Medical Transportation is required. From this point onward, the Plan Administrator will organize and coordinate all stages of the transportation until the Insured Person is safely received into care at his/her destination. In the event that transportation Services are not organized by the Plan Administrator, all costs Incurred will not be covered and will be the sole responsibility of the Insured Person.
4. Insurer and its agents accept no liability in the event that such endeavors were unsuccessful or that contaminated blood or equipment is used by the treating Facility.
5. No coverage will be provided under this benefit if the Insured Person has travelled: (i) to his/her Country of Origin or the European Union for more than thirty (30) days; (ii) outside the purchased Zone of Coverage; or (iii) to a Restricted Area.
6. The Insured Person must not have had symptoms, treatment or received medical advice for the medical condition prior to initiating travel which resulted in the Emergency Medical Evacuation.

Repatriation of Mortal Remains

In the event the Insured Person dies outside his/her Country of Origin, this Policy will provide coverage for:

- The cost of transportation of the body or ashes of an Insured Person to his/her Country of Origin or Country of Residence, including all necessary documentation; or
- The cost of sending the urn to the Country of Origin or the Country of Residence.

The Plan Administrator will arrange for the mortal remains to be returned to the Country of Origin as soon as reasonably possible, subject to airline requirements and restrictions. This benefit must be Pre-Authorized by the Plan Administrator.

Limitations: This benefit is subject to the following limitations:

1. Coverage is limited to expenses for embalming, a container legally appropriate for transportation, shipping costs and necessary government authorizations.
2. Funeral costs are not covered.

3. This benefit is subject to Pre-Authorization by the Plan Administrator.
4. The original death certificate must be provided along with copies of any payment of cremation Services of the Insured Person when a request for Reimbursement is made.
5. No coverage will be provided under this benefit if the Insured Person, at the time of death, is located: (i) in his/her Country of Origin; (ii) in the European Union for more than thirty (30) days; (ii) outside the purchased Zone of Coverage; or (iii) in a Restricted Area.

Outpatient Prescription Drugs and Supplies

Prescription Drug Benefits

Prescription Drugs are medications which are prescribed by a Physician, and which would not be available without a prescription, approved by the Federal Drug Administration in the United States or other applicable regulatory body in the Country of Residence, and cannot be obtained over the counter ("OTC") at a pharmacy. This Policy only covers Generic Prescription Drugs up to the maximum amount of $150 USD, subject to the applicable Cost Share amounts indicated in the Summary of Benefits.

Zone 1 - (United States Only)

In the United States, benefits are available for Outpatient Prescription Drugs listed in our Medication Guide when dispensed by a participating pharmacy in the Network of our Pharmacy Benefit Manager (PBM).

Covered Prescription Drugs & Supplies

A Generic Prescription Drug is covered under this section only if it is:

1. Prescribed by a Physician or other health care professional (except a pharmacist) acting within the scope of his or her license, except for vaccines, which are covered when prescribed and administered by a pharmacist who is certified in immunization administration;
2. Dispensed by a pharmacist acting within the scope of his or her license;
3. Medically Necessary;
4. A Prescription Drug contained in an anaphylactic kit, such as Epinephrine
5. Authorized for coverage by us, if prior coverage authorization is required as indicated with a unique identifier in the Medication Guide, then in effect;
6. Not specifically or generally limited or excluded as stated in this Policy; and
7. Approved by the applicable regulatory body in the Country of Residence, the EMA, or, in the United States, the FDA and assigned a National Drug Code.

A Supply is covered under this section only if it is:

1. A covered Prescription Supply;
2. Prescribed by a Physician or other health care professional (except a pharmacist) acting within the scope of his or her license;
3. Medically Necessary; and
4. Not specifically or generally limited or excluded as stated in this Policy.

In certain circumstances, Pre-Authorization may be required. Any medical or prescription information submitted to us is highly confidential and only used to help determine whether the Pre-Authorization request may be approved.

Please present your ID card to the pharmacy when the prescription is filled. If you do not use an approved pharmacy, you will be responsible for paying the full cost for the Prescription Drug. If you do not present your ID card, you may need to pay for the Prescription Drug and then submit a Reimbursement form for the Prescription Drug along with the paid receipt and Prescription Drug receipt in order to be considered for Reimbursement.

For enquiries regarding your Medication Program, Prescription Drug Benefits or to obtain information regarding participating pharmacies, please contact your ConciergeCare Counselor.

Note: This policy covers Generic Prescription Drugs only, all other Prescription Drug categories are excluded from coverage.

Changes to the Formulary

The Prescription Drug Formulary listed in the Member Guide is subject to change at any time. The Prescription Drug Formulary is reviewed and updated quarterly to examine new medications and new information about medications that are already on the market concerning safety, effectiveness, and current use in therapy. The most up-to-date information about modifications to the medications listed in the Member Guide can be found by contacting your ConciergeCare Counselor.

Zone 1 (Outside the United States) and Zone 2

When Prescription Drugs are filled at pharmacies outside the United States for Zone 1 or in the geographic areas of coverage for Zone 2, the Insured Person must pay for the Prescription Drug and seek Reimbursement from us. You will be required to provide the following:

- Completed claim form;
- Copy of Physician's prescription;
- Prescription Drug invoice; and
- Proof of payment.

Please send the requested information to:

Attention: PayerFusion Holdings, LLC
1825 Ponce de Leon Blvd.
#207
Coral Gables, FL 33134

You may download claim form via your member portal at:
www.wellaway.com or
Email: conciergecare@wellaway.com

Note: We will reimburse the Usual, Customary and Reasonable Charges for the Prescription Drug(s). In the event the cost of the Prescription Drug is more than the cost of the Generic medication in the United States up to the maximum amount of $150 USD, we will only pay for such Prescription Drug up to the equivalent cost of the Generic medication in the United States. Outside the United States, this Policy will pay the cost of the Brand medication if less than the cost of the Generic medication in the United States up to the maximum amount of $150 USD.

Prescription Drug Exclusions

In addition to the Exclusions and Limitations set forth in this Policy, the following Exclusions apply to Prescription Drugs:

1. Any Prescription Drug filled in excess of the quantity limit or day supply limit covered by this Policy.

2. Any Prescription Drug refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.

3. Experimental or Investigational medications. The Plan Administrator's decision, whether a Prescription Drug or its use is "investigational" or "experimental" shall be binding.

4. Compounded Prescription Drugs that do not contain at least one (1) ingredient that has been approved by the FDA or the EMA and requires a prescription for refill.

5. Compounded Prescription Drugs that are available as a similar commercially available Prescription Drug.

6. Prescription Drugs available over the counter that do not require a prescription order or refill by the applicable regulatory body in the Country of Residence before being dispensed.

7. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the Treatment of an Illness or Injury, except as approved by the Plan Administrator.

8. Vitamins, herbs, aspirin, cold remedies, and any other over the counter medicine or medical Supply even when recommended by a Physician.

9. Medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals.

10. Prescription Drugs refilled before 85% of the previous filling has been used.

11. Prescription Drug scripts or orders that are forged or otherwise wrongfully obtained.

12. Fertility medications.

13. Growth hormones.

14. Contraceptive intrauterine device, diaphragm, ring and injectable *(only generic oral contraceptives for a 28 or 30-day supply (up to $100) and one implantable per year (up to $250) are covered under this Policy)*.

15. Medical devices and appliances.

16. Impotency agents.

17. Cosmetic drugs.

18. Smoking cessation medications.

19. Medications for Attention Deficit Disorder or Attention Deficit Hyperactivity Disorders.

20. Medications for Psychiatric conditions treated on an Outpatient basis, unless previously approved by us.

21. Retinoids such as Retin-A and their generic or therapeutic equivalents.

22. Certain Prescription Drugs and Supplies that require prior authorization in order to be covered.

23. Brand Medications, Preferred Medications, Non-Preferred Medications and Specialty Drugs.

How Do I Make Changes to My Plan?

When can I make changes to my plan? Your Policy is designed for a minimum twelve (12) month commitment each Policy Year. If you would like to make changes in plan options or coverage, contact WellAway Enrollment so we may assist you with finding the right solution to your situation. Changes to your coverage will take effect on the Anniversary Date unless we agree otherwise. If you decide to upgrade your benefits, you may be subject to underwriting review.

Can I cancel my Policy at any time? You may only cancel your Policy as of your Anniversary Date. You must provide us with written notice thirty (30) days prior to your Anniversary Date. However, if you have a change of circumstances, contact us as soon as possible. If you choose to stop paying your Premium, your claims may not be paid, and we will have the right to take certain actions against you. WellAway has the right to:

(i) Rescind coverage back to the Policy Effective Date (or Anniversary Date, as applicable) and recover all claims or member Reimbursements paid by WellAway to the Insured Person or Providers.
(ii) retain all Premiums paid by the Policyholder to be applied to any claims paid by WellAway.
(iii) collect the full Premium amount due for the entire Policy Year and you authorize WellAway to charge your credit/debit card for the full Premium due.

If the Policyholder does not make a request to cancel or change his/her plan options in the time frame stated in this Policy, the Policy will continue for the same plan option and in accordance with the terms and conditions consistent with your current benefits and coverage as long as Premiums are paid within the stipulated time frame and the product is still in existence.

If you are relocating to a country outside of your purchased Zone, back to your Country of Origin, or a Restricted Area (as defined by the Policy), please contact WellAway Enrollment. Supporting documentation will be required to support early termination of the Policy (i.e., utility bill, lease, return ticket to Country of Origin, copy of new Certificate of Coverage, letter of resignation, termination from employer or any other relevant documentation).

How Does My Premium Work?

When is my Premium due? Your Premium due for coverage under this Policy is for a one (1) year term commitment and must be paid in USD or EUROS currency ($/€). Any other forms of currency shall not be accepted. Your Premium is due on or before coverage is provided. The effective date of coverage is stated on your Certificate of Coverage. All coverage under this Policy is subject to the timely payment of Premium, which must be made payable to the Insurer. This Policy and Rates shall be guaranteed for one (1) year unless the product's Risk Class characteristics change and premiums need to be adjusted. Rates are continually subject to the terms enforced at the time of each Anniversary Date.

Will I receive a Premium notice? Premium notices are provided as a courtesy. We do not guarantee delivery of Premium notices. If you have not received a Premium notice thirty (30) days prior to the Premium Payment Due Date and you do not know the correct Premium amount, please contact WellAway Enrollment.

What happens if my Premium is not received? Your Policy has a grace period which begins on the Premium Payment Due Date. If any required Premium payment is not received by us on or before the Premium Payment Due Date, it may be paid during this grace period. The grace period is 31 days from the Premium Payment Due Date. Coverage will stay in force during the grace period; however, claims will not be paid for Services for which Premiums are not received. If your Premium payment is not received by the end of the grace period, your coverage will terminate effective as of the Premium Payment Due Date and the Premium due for the entire Policy Year is immediately payable. Failure to pay the Premium and our termination of your Policy does not cancel the debt. We will take legal action to obtain payment of any unpaid Premium. Policyholder will be liable for any legal and administrative charges resulting from any action taken by us or our legal service providers. The Policy allows for a maximum of two (2) grace periods during the Policy Year. The Policy will automatically be terminated, and any pending claims will not be covered if more than two (2) grace period events occur during the Policy Year.

Will the amount of my Premium change? We have the right to change the amount of your Premium, or Rate basis, on:

(i) your Anniversary Date, however, we must notify you of the change at least forty-five (45) days before we make the change; or
(ii) at any time the demographics or Country of Residence of Insured Person changes.

Certain Premium changes will occur automatically and will be charged from the date the change occurs:

(i) An increase or decrease in benefits provided under this Policy; or
(ii) Additions, deletions, increases or decreases of Policyholder's Dependent's insurance; or
(iii) Addition of a new Dependent; or
(iv) Termination of an existing Dependent;
(v) Changes in the Rates.

Any such change will be prorated to the applicable Policy Year and reflected in your next payment.

Can I reinstate my Policy? If your Policy has been terminated for non-payment of Premium, we will consider its reinstatement only after receipt of payment of the Premium and the reinstatement Application Form. No reinstatements will be accepted sixty (60) days after expiration of the last Premium Payment Due Date. The reinstatement will occur when the Insurer:

(i) accepts the overdue Premiums; and
(ii) approves the reinstatement Application Form.

The reinstated Policy will only cover Accidents that occur after the Policy reinstatement date or an Illness, the Symptoms of which first manifest themselves not less than ten (10) days after the reinstatement date. Illness or Injuries or anything that manifests during the lapsed period and ten (10) days immediately after the reinstatement date will not be eligible for coverage under the Policy.

Note: Reinstatement is not guaranteed, and Insurer is under no obligation to accept the reinstatement.

Is my Premium eligible for Reimbursement? Your Premium will only be reimbursed if you decide to cancel the Policy within ten (10) days from issuance of the Policy.

Can My Policy Be Terminated?

Insurer reserves the right to terminate your Policy effective as of 12:01 a.m. Eastern Standard Time (EST) on such date that an Insured Person:

1. Not eligible or no longer eligible as defined by this Policy. We reserve the right to review Eligibility requirements at each Anniversary Date.
2. Failed to observe the terms and conditions of this Policy or failed to act with utmost good faith.
3. Failed to pay the required Premium at the end of the grace period. Insurer may, at its sole discretion, reinstate the Policy if the Premium is subsequently paid (in such event, Insurer will defer or cancel payment of all or any claims for expenditures Incurred during the period the Premium remains unpaid).
4. Failed to comply with the Country of Residence requirements of the Policy.
5. Acts in a manner that results in added costs to the Insurer.
6. Acts in a manner that is disruptive, unruly, abusive, unlawful, intentionally fraudulent or uncooperative to the extent that your continued coverage with us impairs our ability to provide coverage and/or benefits or to arrange for the delivery of Services to you or any other Insured Person under this Policy. Prior to terminating your coverage for any of these reasons, we will:
    a. make a reasonable effort to resolve the problem presented by you, including the use or attempted use of our Appeal Process;
    b. ascertain, to the extent possible, that your behavior is not related to the use of medical Services or mental Illness; and
    c. document the problems encountered, efforts made to resolve the problems, and any of your medical conditions involved.

7. Committed an act of Fraud with respect to this Policy. Fraud means deception by a person with the intent to wrongly benefit him/her. It includes any act that is defined as fraud under applicable laws or regulations, and includes, but is not limited to:
    a. Using another person's name as your own;
    b. Using an ID Card that does not belong to you;
    c. Giving your ID card to someone else;
    d. Misuse of Services;
    e. Billing for Services that were not provided;
    f. Giving false information on your records which may be regarded as being of importance to us. This includes records that relate to your Eligibility;
    g. Making statements on the Application Form or in the course of applying for the Policy which we determine, on reasonable grounds, that you have knowingly or recklessly provided information which you know or believe to be untrue or inaccurate or failed to provide information which we have asked for;
    h. When making any claim under the Policy, knowingly or recklessly providing information which you know or believe to be untrue or inaccurate, failing to provide information which we have asked for, or knowingly claiming benefits for any purpose other than as provided for under this Policy;
    i. Agreeing to any attempt by a third party action or omission to obtain an unreasonable pecuniary advantage to our detriment; or
    j. Purchasing or extending this Policy for the purpose of receiving a medical Service.

In addition, Insurer reserves the right to extend, or not extend an invitation for coverage to an Insured Person at the end of the current Policy Year. Insurer further reserves the right to cancel your Policy in the event the plan ceases to operate. Insurer will inform the Policyholder at least forty-five (45) days in advance and will inform the Policyholder of similar plans and benefit options available. If we are no longer in the market to sell your current plan or a suitable alternative in your geographical area, any termination will be effective as of the end date of your Policy. Insurer will inform the Policyholder at least forty-five (45) days in advance.

Note: In the event an Insured Person's coverage terminates for any reason other than fraud or Eligibility, we would only be liable for the Treatment covered under the terms of the Policy that took place before the effective date of termination of the Insured Person's coverage. However, we reserve the right to Rescind this Policy due to fraud or Eligibility.

The Information You Provide

In deciding whether to accept you under this Policy and in setting the terms and Premium, we have relied on the information that you have given to us. You must take care when answering any questions that we ask by ensuring that all information is accurate and complete. If we establish that you deliberately or recklessly provided us with false or misleading information, it could adversely affect this Policy and any claim. For example, we may:

1. treat this Policy as if it had never existed, refuse to pay all claims and return the Premium paid. We will only do this if we provided you with insurance cover which we would not otherwise have offered;
2. amend the terms of your insurance. We may apply these amended terms as if they were already in place if a claim has been adversely impacted by your carelessness; or
3. cancel your Policy.

We will write to you if we intend to treat this Policy as if it never existed or need to amend the terms of your Policy. If you become aware that information you have given us is inaccurate, you must inform us as soon as possible using the contact details that we have provided in this Policy.

General Terms and Conditions

1. The headings of sections contained in this Policy are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
2. References to “you” or “your” throughout refer to you as the Policyholder and to your Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Policyholder or solely to your Dependents will be noted as such.
3. References to “we”, “us”, “our”, “Insurer” and “Company” throughout this Policy refer to Davies Insurance Limited on behalf of the WellAway Segregated Account.
4. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the Definitions section of this Policy or within the particular section where it is used.
5. The official language governing this Policy is United States English and shall remain the ruling language on coverage, benefits and definitions. If any dispute arises as to the interpretation of this document, the English version of this document shall be deemed to be conclusive and take precedence over any other language version of this Policy.
6. The Plan Administrator, PayerFusion Holdings, LLC, is an entity designated by the Insurer for purpose of providing administrative services related to this Policy on behalf of the Company.
7. The declarations of the Policyholder and the Dependents serve as the basis for this Policy. Any references in this Policy to the Insured Persons that are expressed in the masculine gender shall be interpreted as including the feminine gender whenever appropriate.
8. We reserve the right to make any changes to this Policy at the time of the Anniversary Date. The changes will be valid only if made by a new Policy wording, a Policy amendment or endorsement, or by a Policy rider duly approved and signed by an officer of the Insurer. No agent or other person may change this Policy or waive any of its provisions. Any changes to the provisions of this Policy, including any increase or decrease of Premium, shall become effective forty-five (45) days after formal written Notification of such change(s) from the Company to the Policyholder or to the Policyholder’s broker or agent.
9. Any notice required under this Policy must be in writing. Any notice given by us will be communicated to either the Policyholder or the Policyholder’s agent or broker. Such notices are limited to e-mail, postal mail or via the member portal. Any notice from the Policyholder related to claims should be sent to the Plan Administrator’s office. For all other matters, notices should be sent by e-mailing: enrollment@wellaway.com.
10. In the event any clerical error or delays in keeping records by the Insurer, the Insurer:
    a. will not deny insurance which should otherwise have been granted;
    b. will not extend insurance which should otherwise have been terminated; and
    c. will be subject to proper adjustment of Premium when an adjustment is needed.
11. Benefits are paid to the extent that an Insured Person receives any of the Treatments covered under the Summary of Benefits following the Policy Effective Date, including any additional Waiting Periods and up to the date such individual no longer meets the definition of Insured Person.
12. Insurer may alter any of the terms of this Policy at any Anniversary Date. A copy of the current Policy will be sent to the Policyholder at such time.
13. This Policy is governed by and shall be construed in accordance with the laws of Bermuda and shall be subject to its exclusive jurisdiction.
14. All disputes arising out of or relating to this Policy, or any matter that is related directly or indirectly to this insurance, which cannot first be resolved by the parties through settlement negotiations for a period of sixty (60) days, shall be resolved exclusively through binding, non-appealable and confidential private arbitration. The arbitration and such proceedings shall be administered based on the arbitration laws of Bermuda. Notice requesting arbitration must be in writing and sent certified or registered mail, return receipt requested. Each party shall choose one arbitrator and the two arbitrators shall choose an impartial third arbitrator who shall preside over the arbitration proceeding. If either party fails to appoint its arbitrator within thirty (30) days after being requested to do so by the other party, the latter, after ten (10) days’ notice by certified mail or registered mail of its intentions to do so, may appoint a second arbitrator. Within thirty (30) days after notice of appointment of all arbitrators, the panel shall meet and determine the timely period for briefs, discovery Procedures and schedule for hearings. The panel shall be relieved of all judicial formality and shall not be bound by the strict rules of Procedure and evidence. The decision of any two arbitrators when rendered in writing shall be final and binding. The panel is empowered to grant interim relief as it may deem appropriate. The place of any arbitration hearing

shall be Bermuda. The panel shall interpret this Policy as an honorable engagement rather than as merely a legal obligation and shall make its decision considering the custom and practice of the applicable insurance business as promptly as possible following the termination of the hearings.

15. All legal actions arising from this Policy shall be barred one (1) year from the event that gave rise thereto.
16. The Insurer's liability under this Policy will be conditioned upon each Insured Person complying with its terms and conditions.
17. The Policyholder must inform the Insurer within thirty (30) days of any changes related to Insured Persons (such as change of address, occupation or marital status) or of any other material changes that affect information given in connection with the Application Form under this Policy. Insurer reserves the right to alter the Policy terms or, including, but not limited to, a change in the Premium, cancel coverage for an Insured Person following a change of risk.
18. The confidentiality of your information is of paramount concern to Insurer. Insurer complies with data protection legislation and medical confidentiality guidelines. Information submitted to Insurer over our website is normally unprotected until it reaches us. We do share information, but only as it pertains to the administration of your health care benefits.
19. All paid claims will be settled in the same currency as the Premium currency for the purpose of this Policy. If the Insured Person paid for Treatment or receives a bill for Covered Services in a currency other than Premium currency, including bills sent directly to the Insurer or its Plan Administrator, such payments and bills shall be converted to Premium currency at the exchange rate in effect at the time such Service was rendered unless otherwise arranged by mutual agreement between us and the Insured Person.
20. Waiver by the Insurer of any term or condition of this Policy will not prevent us from relying on such term or condition thereafter. If we choose to waive our rights under this Policy regarding a specific term or provision, it shall not be interpreted as a waiver of our right to administer or enforce this Policy in strict accordance with its terms and conditions. In the event the Policyholder terminates this Policy prior to the expiration of the current Policy Year for any reason whatsoever, Policyholder waives all rights to enforce any specific term or provision of the Policy.
21. If the Policyholder dies, this Policy will automatically be transferred to the oldest Dependent over the age of 18 years who shall, upon the death of the primary Policyholder, become the Policyholder for all the purposes of this Policy and be responsible for paying the Premium. Insurer will issue the same plan option and conditions of the previous Policy. A Dependent that is no longer eligible for coverage under this Policy (as a Dependent) has no transfer or continuation rights or privileges with Insurer. Upon death of the Policyholder, the Insurer must be notified within thirty (30) days. A death certificate must be provided to Insurer.
22. The Insurer is not responsible for the quality of care received from any institution or individual. This Policy does not give the Insured Person any claim, right or cause of action against Insurer based on an act of omission or commission of a Hospital, Provider, Physician or other Provider of care or Service.
23. This Policy does not meet the United States requirements to qualify as "minimum essential coverage" for health insurance under the Affordable Care Act. As such, this Policy does not include all essential health benefits as required by the Affordable Care Act and is not subject to, and is not administered as, a PPACA (Patient Protection and Affordable Care Act).
24. This Policy is not subject to guaranteed issuance or continuation of coverage.

Definitions

Accident – means an unforeseen, unexpected, and unintentional event due exclusively to an external cause of a violent nature beyond the control of the Insured Person, resulting, directly and independently of all other causes, in bodily trauma to the Insured Person and which occurs after the Policy Effective Date.

Activities of Daily Living (ADL) – means those activities normally associated with the day-to-day fundamentals of personal self-care, including but not limited to: walking, personal hygiene, sleeping, toilet/continence, Dressing, cooking/feeding, medication and transferring (getting in and out of bed).

Acute– means Medically Necessary medical condition, which is brief, has a definite end point and which we, on medical Advice, determine responds to and can be cured by Treatment.

Admission – means the period from the time that an Insured Person enters a Hospital, or other approved health care Facility as an Inpatient until discharge.

Advice – means any consultation by a Physician or Specialist including the issue of drugs and Dressings or repeat Prescription Medications or Drugs.

AIDS - means medical Services and costs provided to the Insured Person as a consequence of Acquired Immune Deficiency Syndrome (AIDS) and all diseases caused by and or related to the virus HIV positive.

Air Ambulance – means an aircraft specially equipped with the necessary medical personnel, Supplies and Hospital equipment to treat life-threatening Illnesses and/or Injuries for persons whose conditions cannot be treated locally and must be transported by air to the nearest Facility that can adequately treat their conditions.

Allowable Charges– means the maximum dollar amount that we will pay a Provider (In-Network) or reimburse an Insured Person (Out-of-Network) for a specific Service.

Ambulatory Surgical Center – means a Facility which: (a) has as its primary purpose to provide Elective Surgical care; and (b) admits and discharges a patient within the same working day; and (c) is not part of a Hospital. Ambulatory Surgical Center does not include: (1) any Facility whose primary purpose is the termination of pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained by a Dentist for the practice of dentistry.

Anniversary Date – means the date your new Policy Year begins, 12 months following your initial Policy Effective Date.

Application Form – means the form, either written or electronic, that was completed and signed by the Insured Person to request insurance coverage under this Policy. It includes any medical history, questionnaires, and other documents requested by us prior to the issue of insurance coverage.

Attention Deficit Disorder (ADD) – means a biologically based condition causing a persistent pattern of difficulties resulting in one or more of the following behaviors: inattention; hyperactivity; impulsivity.

Attention Deficit Hyperactivity Disorder (ADHD) – means a problem with inattentiveness, over-activity, impulsivity, or some combination of these. For these problems to be diagnosed as ADHD, they must be out of the normal range for the child's age and development.

Bodily Injury – means an Injury, which is caused solely by an Accident, which results in the Insured Person's dismemberment, disablement or other physical external Injury.

Cesarean Section – means the delivery of the fetus through an abdominal incision in conditions where the vaginal route is contraindicated.

Cancer – means the general term used for all malignant disorders caused by the uncontrolled multiplication of mutated cells (new growths or tumors). These cells can destroy the surrounding tissue and produce metastases (secondary growths).

Chiropractic Services – means a system of Diagnosis and Treatment based on the idea that the nervous system co-ordinates all of the body's functions, and that disease results from a lack of normal nerve function. Chiropractic Services does not include Prescription Medication, Drugs or Surgery.

Chiropractor – means any person who is legally licensed to practice Chiropractic Services in the country where Treatment is provided. A Chiropractor uses manipulation to change body structures, such as the spinal column, to relieve pressure on nerves coming from the spinal cord caused by a vertebrae being displaced.

Chronic Condition – means an Illness, Injury, impairment or physical or mental condition that involves Inpatient care or continuing Treatment by a health care Provider, such as Cancer, etc.

Coinsurance – means the percentage of our Allowable Charges that you must pay before we will pay our portion of the Allowable Charges for Covered Services. The Coinsurance percentage is calculated after all other Cost Share amounts for a given Service, such as your Deductible. Your Coinsurance amount is stated in your Summary of Benefits and Certificate of Coverage.

Complications of Pregnancy – means: (a) when pregnancy is not terminated, conditions that require Hospital Confinement, whose diagnoses are distinct from pregnancy but are adversely affected by or are caused by pregnancy, including but not limited to: (1) Acute nephritis; (2) nephrosis; (3) cardiac decompensation; (4) missed abortion; and (b) when pregnancy is terminated; (1) non-Elective Cesarean Section; (2) ectopic pregnancy that is terminated; or (3) spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy will not include false labor; occasional spotting; Physician prescribed rest during the period of pregnancy; morning sickness; mild hyperemesis gravidarum; and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct Complication of Pregnancy.

Confinement – means an Inpatient stay at an approved Extended Care Facility for necessary skilled Treatment or Rehabilitation in accordance with this Policy.

Congenital Condition – means any Heredity condition, birth defect, physical anomaly and/or any other deviation from normal development present at birth, which may or may not be apparent at that time. These deviations, either physical or mental, include, but are not limited to, genetic and non-genetic factors or inborn errors of metabolism.

Cost Share - means your share (Deductible, Coinsurance) of the cost for specific Covered Services under the plan selected.

Country of Origin - means the country in which a person or thing is deemed to have originated for the purposes of laws and regulations.

Country of Residence - means (1) the country where the Insured Person resides the majority of any calendar or Policy Year; or (2) the country where the Insured Person has resided more than one hundred and eighty (180) continuous days during any three hundred and sixty-five (365) day period while the Policy is in force.

Covered Expenses – means the Allowable Charges Incurred by an Insured Person, while covered under this Policy for Medically Necessary Services, Treatments or Supplies described under the section titled *What Your Plan Covers*.

Covered Services - means those Services which meet the criteria listed in the *What Your Plan Covers* section of this Policy.

Custodial Care – means (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is

provided to an individual for whom it cannot reasonably be expected that medical or Surgical Treatment will enable him to live outside an institution; and (3) rest cures, Respite Care and home care provided by Family Members. Upon receipt and review of a claim, the Insurer or an independent medical review will determine if a Service or Treatment is Custodial Care.

Deductible – means the first part of the Allowable Charges you pay for Covered Services per Policy Year before your plan starts to pay as listed in the Summary of Benefits table. *Note*: Your cost of Prescription Medication/Drugs will not count towards the individual or Family Deductible.

Dependent – means a member of the Policyholder's Family (Family Member) who is enrolled under this Policy after meeting all of the Eligibility requirements and for whom Premiums have been received by the Insurer.

Diagnosis – means the determination by a Physician or Specialist of the nature of a disease or condition made from a study of the signs and Symptoms of a disease or condition.

Domestic Partner means a person of the same or opposite gender with whom the Policyholder has established a Domestic or Registered Partnership.

Domestic or Registered Partnership means a relationship between the Policyholder and one other person of the same or opposite gender who meet at a minimum, the following Eligibility requirements:

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the venue in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. the Policyholder has submitted to us acceptable proof of evidence of common residence and joint financial responsibility, and certificate of registered partnership (if applicable); and
5. the Policyholder has completed and submitted any required forms to us and we have determined the Domestic Partnership Eligibility requirements have been met.

Dressings - means materials used for Dressing wounds.

Durable Medical Equipment (DME) – means equipment prescribed by Physician designated for repeat and prolonged use and which is Medically Necessary to improve the functioning of a malformation of the body, Treatment of an Illness, or to prevent further deterioration of the Insured Person's medical conditions. Please refer to DME category under the *What Your Plan Covers* section of this Policy for more details.

Dentist or Dental Surgeon – means is a health care Provider who specializes in the Diagnosis, prevention and Treatment of diseases and conditions of the oral cavity.

Dialysis – means the provision of an artificial replacement for lost kidney function (renal replacement therapy) due to Acute kidney failure. Dialysis may be used for sudden but temporary loss of kidney function (Acute renal failure). Dialysis is done in Dialysis units which are part of Hospitals and clinics or at home.

Elective – means any care, Service, Procedure, or Surgery performed at the choice of the patient, for which there is no Medical Necessity, and/or which does not treat an Accident, Illness, or Injury (such as care provided primarily as a convenience or to improve or preserve appearance, self-esteem or future possible effects on health, posture or body function).

Eligibility – means the requirements that an Insured Person, including the Policyholder and/or his/her Dependents must meet at all times in order to be covered under this Policy.

Emergency - means a sudden onset of a medical condition with Acute Symptoms of sufficient severity that in the absence of immediate medical attention (or as soon thereafter as care can be made available, but in any case not any later than forty-eight (48) hours after the onset) and in the absence of which care an Insured Person could reasonably result in:

- permanently placing the Insured Person's health in jeopardy;
- causing other serious medical consequences;
- causing serious impairment to bodily functions;
- causing serious and permanent dysfunction of any bodily Organ or part;
- causing loss of life or limb; or
- causing death.

Emergency Dental Treatment – means Acute Emergency Dental Treatment due to a serious Accident requiring hospitalization. The Treatment must be received within 24 hours of the Emergency event.

Emergency Medical Transportation – means that in the event of a life-threatening Emergency, when appropriate Treatment is not available locally, this Policy provides Emergency Medical Transportation to the closest medical Facility capable of providing the required care.

Estimate – means the assumed cost for the Services or Procedures to be conducted either by a Physician or laboratory for the patient for a given Diagnosis or as part of an investigation in order to obtain a Diagnosis.

Evacuation – means costs Incurred in moving an Insured Person from the place of incident to the nearest appropriate medical Facility, as determined by the attending Physician in conjunction with our medical advisors.

Exclusion – means specific provision excluding coverage for conditions or Illnesses for this Policy. Exclusions are imposed when the Policy is issued as a condition for the issuance of coverage. Exclusion or Exclusions, if issued as a condition for the issue of coverage, form a part of this Policy through an endorsement or rider or as listed in the Exclusions and Limitations section of the Policy.

Experimental and/or Investigational – means any Treatment, Procedure, technology, Facility, equipment, Drug, Drug usage, device, or Supplies not recognized as accepted medical practice in the United States or by Insurer that fails to meet the following criteria:

1. Controlled studies published in peer review medical literature demonstrate that such Service or Supply has a net beneficial effect on health outcomes for a specific Diagnosis; or under study, investigation, trial period or is limited to research; or
2. Such Service or Supply is in accordance with generally accepted standards of medical practice in the United States; or
3. At the time such Service or Supply is received by an Insured Person, it has been approved for the particular indication or application in question by the United States Food and Drug Administration (FDA) or other federal or state governmental agency whose approval is required in the United States, regardless of where the medical expenses are Incurred.

Extended Care Facility – means a nursing and/or Rehabilitation center approved by Insurer that provides skilled and Rehabilitation Services to patients who are discharged from a Hospital or who are admitted in lieu of a Hospital stay. The term Extended Care Facility does not include nursing homes, rest homes, health resorts, homes for the aged, infirmaries or establishments for domiciliary care, Custodial Care, care of drug addicts or alcoholics, or similar institutions.

Facility – means any location where Services Supplies or Drugs are provided, including, but not limited to, an Ambulatory Surgical Center or Hospital.

Family - means the Policyholder and a Family Member.

Family Member – means a spouse, domestic partner, father, mother, brother, sister, or child of the Policyholder.

Food and Drug Administration (FDA) – means an agency of the United States Health and Human Services, one of the United States federal executive departments. The FDA is responsible for protecting and promoting public health through the regulation and supervision of food safety, tobacco products, dietary supplements, prescription and over- the-counter pharmaceutical

drugs (medications), vaccines, biopharmaceuticals, blood transfusions, medical devices, electromagnetic radiation emitting devices (ERED), cosmetics and veterinary products.

Hereditary - means transmitted from parents to offspring; inherited.

Hospital – means and includes only Acute Care Facilities licensed or approved by the appropriate regulatory agency as a hospital, and whose Services are under the supervision of, or rendered by a staff of Physicians who are duly licensed to practice medicine, and which continuously provides twenty-four (24) hour a day nursing service under the direction or supervision of registered professional Nurses. The term Hospital does not include convalescent and nursing homes, rest homes, health resorts, and homes for the aged, infirmaries or establishments for domiciliary care, Custodial Care, care of drug addicts or alcoholics, or similar institutions.

Home Health Care Agency – means an agency or organization, or subdivision thereof, that; a) is primarily engaged in providing skilled Nursing Services and other Therapeutic Services in the Insured Person's home; b) is duly licensed, if required, by the appropriate licensing Facility; c) has policies established by a professional group associated with the agency or organization, including at least one Physician and one registered graduate Nurse (R.N.), to govern the Services provided; d) provides for full-time supervision of such Services by a Physician or by a Registered Nurse (R.N.), maintains a complete medical record on each patient; and f) has a full-time administrator.

Home Health Care Plan – means a program: a) for the care and Treatment of an Insured Person in his home; b) established and approved in writing by his attending Physician; and c) Certified, by the attending Physician, as required for the proper Treatment of the Injury or Illness, in place of Inpatient Treatment in a Hospital or in an Extended Care Facility.

Hospice or Terminal Care - means an agency which provides a coordinated plan of home and Inpatient care to a terminally ill person for whom curative Treatment is no longer available and which meets all of the following tests: a) has obtained any required state or governmental license or certificate of need; b) provides services 24-hours-a- day, 7 days a week; c) is under the direct supervision of a Physician; d) has a Nurse coordinator who is a registered Nurse or a licensed practical Nurse; e) has a duly licensed social service coordinator; f) has as its primary purpose the provision of Hospice Services; g) has a full-time administrator; and h) maintains written records of Services provided to the patient.

Hospital Intensive Care Unit – means a section, ward or wing within the Hospital which is separated from other facilities and is operated exclusively for the purpose of providing twenty four (24) hour professional medical Treatment for critically ill patients and is equipped with Supplies and equipment for such medical Treatment.

Hospital Room and Board – means a private or semi-private Hospital room as specifically approved by our Plan Administrator.

Human Immunodeficiency Virus (HIV) – means all diseases caused by and/or related to the HIV Virus. (Refer to AIDS definition)

Identification Card (ID card) – means the cards we issue to Policyholders. The cards are our property, and are not transferable to another person. Possession of such card in no way verifies that an individual is eligible for, or covered under, this Policy.

Illness – means a physical sickness, disease, Complications of Pregnancy of an Insured Person. This does not include mental illness.

Incurred – means the date an Infectious Disease, Illness or Injury occurred and the Insured Person receives the Service or Supply for which the charge is made.

Infectious Disease – means a common communicable disease caused by viruses, bacterial fungi or parasites and presence of a microbial agent.

Injury – means a Bodily Injury that is: 1) sustained by an Insured Person while covered under this Policy; and 2) caused by an Accident externally, directly and independently of all other causes. An Insured Person must begin receiving Services, Supplies

or Treatment within 72 hours from the time of Accident in order for it to be considered an Injury. All Injuries sustained by one person in any one Accident including all related conditions and recurrent Symptoms of these Injuries, are considered a single Injury.

In-Network Provider – means any health care Provider, including a Premium Care Physician/Select Provider, who, at the time Covered Services are rendered to you, has agreed to accept a negotiated discount for Services.

Inpatient – means a person admitted to an approved Hospital or other health care Facility for a Medically Necessary overnight stay in excess of 24 hours.

Insured Person – means the Policyholder or his/her Dependents enrolled for and entitled to coverage under this Policy and for whom the required Premium has been paid.

Maintenance – means continuation of care and management of the patient when the therapeutic goals of a Treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, and the provision of Covered Services for a condition ceases to be of therapeutic value.

Maternity Care – means the cost of prenatal care, delivery charges for mother and baby, Medically Necessary Cesarean Sections, and postnatal Treatment subject to the specific limit.

Maximum Benefit – means the payment specified in your Summary of Benefits, for specific Services, which is the maximum amount payable by Insurer per person, per Policy Year (unless otherwise noted) regardless of the actual or Allowable Charges. This is after the Insured Person has met his/her Cost Share amounts.

Medical Emergency Services – means the initial Treatment for an Emergency.

Medically Necessary/Medical Necessity – means those Services or Supplies that which are provided by a Hospital, Physician or other approved medical Providers and are defined from a medical point of view as appropriate and necessary. They must:

1. Be necessary to define or treat the condition, the Illness or the Injury of the patient;
2. Be appropriate to the Symptoms, Diagnosis or Treatment of the patient;
3. Comply with the medical practices generally accepted and with the professional medical standards applied by the medical community at the same time the patient receives the relevant care;
4. Be required for other reasons than comfort or pleasure of the patient or his/her Physician;
5. Not solely for the Insured Person's convenience, the Physician's convenience or any other Provider's convenience;
6. Have medical proven and demonstrated effects;
7. Be considered as from the most appropriate type and level;
8. Be provided with an equipment, in quantity and quality appropriate to the level of care required by the patient condition;
9. Be only provided during the period appropriate to the patient condition;
10. When applied to an Inpatient, it further means that the medical Symptoms or condition require that the Services or Supplies cannot be safely provided as an Outpatient;
11. Is not a part of or associated with the scholastic education or vocational training of the patient; and
12. Is not Experimental or Investigative.

The Insurer retains the right to determine the Medical Necessity of a planned Treatment. Individuals with intellectual disabilities and vulnerable healthcare environments may require a special consideration of their health care needs. The appropriateness of care and the Treatment plan will be reviewed in consultation with the attending Physician and alternative care options may be recommended.

Medication Guide - means the guide then in effect issued by us where you may find information about Prescription Drugs that require prior coverage authorization and Self- Administered Prescription Drugs that may be covered under your plan. Note: The Medication Guide is subject to change at any time. Please visit www.wellaway.com for the most current guide or you may call the ConciergeCare Counselor phone number on your Identification Card.

Network – means the UnitedHealthcare Global Options PPO Network.

Non-Network Provider – means a Provider who does not take any insurance plans and has chosen to “opt-out” of billing an insurance company.

Notification – means an act of notifying, making known or giving notice of upcoming or planned Treatment by means of written notice or verbal request. Notification does not constitute approval by the Insurer.

Nurse – means a person licensed as a registered Nurse or licensed practical Nurse by the appropriate licensing authority in the areas which he or she practices nursing.

Nursing Services – means home nursing care (only payable if prescribed by attending Physician and approved by us). The service must immediately start after the patient is discharged from the Hospital. Nursing Services related to aid in the Activities of Daily Living are not covered by this Policy.

Oncology – means Specialist fees, diagnostic tests, and radiotherapy, chemotherapy and Hospital charges Incurred in relation to the planning and carrying out Treatment for Cancer, from the point of Diagnosis.

Organ – means a part of the human body that performs a specific vital function (heart, lung, kidney, pancreas, liver, bone marrow).

Organ Transplant/Transplant – means the Surgical Procedure of one or more Organs moved from a donor (living or deceased), to an Insured Person as the recipient or; tissue Surgically moved to an Insured Person from a donor (living or deceased) or the same Insured Person.

Other Insurance Plan – means a plan (other than this Policy) that provides insurance, Reimbursement or service benefits for Hospital, Surgical or other medical expenses, including the Caisse des Français de l’Etranger (“CFE”).

Out-of-Network Provider – means a Provider who, at the time Services are rendered to you, does not contract with your health insurance plan or your Provider Network and has not agreed to accept a negotiated discount for Services.

Out-of-Pocket - means your expenses for Services that are not reimbursed by us. Out-of-Pocket expenses include your applicable Deductible and Coinsurance for Covered Services.

Outpatient – means Services, Supplies or equipment received while not an Inpatient in a Hospital, or other health care Facility, or overnight stay.

Outpatient Services – means Medically Necessary Services provided to an Insured Person, who is not a registered Inpatient in a Hospital, to prevent and treat Injuries or Illnesses. Outpatient Services shall include, but are not limited to:

1. Comprehensive diagnostic and evaluation Services;
2. Outpatient care and Treatment, pre-care, aftercare, Emergency care, Rehabilitation and supportive transitional Services; and
3. Professional consultation.

Palliative Care – means Inpatient, day-care or Outpatient Treatment following the Diagnosis that the condition is terminal and Treatment can no longer be expected to cure the condition.

Pharmacy Benefit Manager (PBM) – means, in the United States, an entity that is primarily responsible for processing and paying prescription drug claims. It is also responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

Physician – means any person who is duly licensed and meets all of the laws, regulations, and requirements of the jurisdiction in which he/she practices medicine, who is acting within the scope of that license or certification; Physician (M.D. or D.O.), a Dentist (D.D.S. or D.M.D.), a Nurse Midwife or ARNP any other non-physician and non-dentist practitioner for whose Services benefits are

provided under this Policy. This term does not include; (1) an intern/resident; or (2) a person in training including medical fellowship programs.

Plan Administrator - means the third party administrator administering this Policy's terms and conditions on behalf of the Insurer.

Podiatric Care – means a medical specialty concerned with the care and Treatment of the feet.

Policy – means the agreement between Insurer and the Policyholder. The Policy includes this document, the Policy Declarations, the applicable Summary of Benefits, any Application Forms, any medical questionnaires, the last issued Identification Card, and any amendments or endorsement modifications made in accordance with the Policy. This also includes any riders or endorsements purchased by the Policyholder.

Policy Effective Date – means the date that this Policy first takes effect, without regard to renewals thereafter.

Policyholder – means a person that has applied for coverage and is named as the Policyholder in this Policy.

Policy Year – means the period that begins on the effective date of this Policy and ends twelve (12) months after the effective date of this Policy.

Policy Year Maximum – means the maximum which will be paid for all benefits in total for each Insured Person, each Policy Year.

Pre-Authorization – means a process by which an Insured Person obtains written approval for certain medical Procedures or Treatments, prior to the commencement of the proposed medical Treatment or Procedure. Certain medical Procedures will require the Pre-Authorization process to be followed in order for the Service to be covered and to maximize the benefits of the Insured Person.

Pre-Existing Condition – means any health issue or Illness that existed prior to the effective date of coverage. This includes chronic illnesses like diabetes, asthma, heart disease and any related conditions, or any medical condition not mentioned, which you have received medical advice, diagnosis, had symptoms or received treatment prior to purchasing this Policy. This Policy is designed to cover the necessary treatment of new medical conditions that arises after the effective date of coverage. In addition, if you:

(i) received any Diagnosis, medical Advice or Treatment prior to the Policy Effective Date; or
(ii) had taken any Prescription Medication or Drug prior to the Policy Effective Date; or
(iii) where distinct signs or Symptoms were evident prior to the Policy Effective Date

it will be considered a Pre-existing condition under this definition.

Premium(s) – means the consideration owed by the Policyholder to the Insurer in order to secure benefits for its Insured Persons under this Policy.

Premium Payment Due Date – means the recurring date specified in the Policy upon which the Premium for this Policy is due.

Prescription Drugs/Medication – means medications which are prescribed by a Physician and which would not be available without such prescription and approved by the FDA in the United States or other applicable administrative organizations in the Country of Residence and cannot be obtained Over-the-Counter at a pharmacy. Certain Treatments and medications, such as vitamins, herbs, aspirin, cold remedies, medicines, Experimental or Investigative drugs, or medical Supplies even when recommended by a Physician, do not qualify as Prescription Drugs.

Prescription Drug Formulary – means a schedule of Prescription Drugs approved for use which will be covered, if not otherwise excluded by this Policy and dispensed through participating pharmacies.

Prescription Supply – means certain Supplies approved for use which will be covered, if not otherwise excluded by this Policy, and dispensed through participating pharmacies, including, but not limited to, diabetic meters, test strips and lancets.

Primary Care - means the first contact by a Physician for an Insured Person with an undiagnosed health concern of varied medical conditions, not limited by cause, organ system, or Diagnosis not previously present.

Procedure – means a practice, a series of steps, or Treatment to follow after a given Diagnosis is obtained.

Professional Sports – means activities in which the participants receive payment for participation.

Provider – means any location where Services, Supplies or Drugs are provided, including, but not limited to, an Ambulatory Surgical Center or Hospital.

Psychiatric – means a health condition that changes a person's thinking, feelings, or behavior (or all three) and that causes the person distress and difficulty in functioning. As with many diseases, mental illness is severe in some cases and mild in others. Inpatient mental health, as indicated on the Summary of Benefits, may be approved by us for severe psychotic or neurotic episodes where Treatment cannot be given on an Outpatient basis for risk of injury to self or others.

Psychiatric Physician – means a Physician who specializes in psychiatry or has the training or experience to do the required evaluation and Treatment of mental conditions.

Rate - means the amount we charge for coverage. The Rate will vary depending on the Risk Class of each covered individual.

Reconstructive Surgery – means the use of Surgery that takes place due to a covered Surgical Procedure or Accident, and is Medically Necessary in order to maintain or restore normal bodily function.

Rehabilitation - means Therapeutic Services designed to improve a patient's medical condition within a predetermined time period through establishing a Maintenance program designed to maintain the patient's current condition, prevent it from deteriorating and assist in recovery. Inpatient Rehabilitation is only covered during the acute and sub-acute recovery phase of Treatment and only when authorized by the Insurer's Plans Administrator.

Reimbursement – means the amount of money refunded to the Policyholder for Covered Expenses, as indicated in the Summary of Benefits of this Policy.

Renal Failure - means the Acute, sudden and often temporary loss of kidney function.

Rescission or Rescind - means action to retroactively cancel or discontinue coverage under this Policy. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of Premium.

Respite Care – means is Inpatient care for a chronically or terminally ill patient, for the sole purpose of relieving the patient's primary caregiver.

Restricted Area – means any Country, Provider, Facility or individual, to the extent that the provision of coverage, payment of a claim or the provision of benefits would expose Insurer to any sanction, prohibition or restriction under United Nations resolutions or any trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or the United States.

Risk Class - means a grouping of Insured Persons who have similar characteristics. For example, Insured Persons who: are the same age, use tobacco products, live in the same geographical area, and who have elected the same benefit plan may be grouped into a Risk Class. The Risk Class of each Insured Person is determined by Insurer.

Self-Administered Prescription Drug – means an FDA approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Second Surgical or Medical Opinion – means the medical Advice given by a second independent Physician not involved in the Treatment, normally to get a second opinion if potentially fatal Illnesses or serious permanent disabilities are involved.

Service(s) means evaluations, Treatments, therapies, devices, Procedures, techniques, equipment, Supplies, products, remedies, vaccines, biological products, Drugs, pharmaceuticals, chemical compounds and other services rendered or supplied, by or at the direction of, a licensed Physician or Provider.

Site of Service Differential – means when Services are provided in a hospital-based Facility, the costs of the clinical personnel, equipment, and supplies are higher, and could result in multiple bills, than if such Services were provided in an independent free-standing Facility. For this reason, reimbursement for the Services provided in a hospital-based Facility may be lower than if the Services were performed in an independent free-standing Facility. This difference in reimbursement (based on where the Service is performed), is referred to as a "Site of Service Differential." This financial differential will be applicable to all bills generated as a result of the encounter at the hospital-based Facility and will be the Insured Person's responsibility.

Sound Natural Tooth – means a healthy unrepaired tooth or a tooth of which a major portion remains after restorative work. A Sound Natural Tooth is not carious, abscessed or defective. It does not include artificial items such as crowns or caps, braces or bands, jackets, inlays, bridges or dentures, which were installed before the date of the Injury. Repair or replacement of these items is not covered under this Policy.

Specialist – means a medical Physician whose practice is focused on a particular branch of medicine or Surgery (e.g., cardiologist).

Specialty Drug – means an FDA approved Prescription Drug that has been designated solely by us as a specialty drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty Drugs may be Provider administered or a Self-Administered Prescription Drug.

Subrogation – means the substitution of one person in the place of another relative to a lawful claim or right. In a health plan this type of provision allows the plan to be substituted for the Insured Person in a case where the Insured Person takes legal action. Theoretically, a Subrogation provision permits the Insurer to take direct legal action against a responsible third party and, therefore, the Insurer could force the Insured Person to pursue legal remedies, although he/she may not have intended to do so.

Summary of Benefits – means the summary description of the available benefits, Cost Share amounts and Maximum Benefits provided under this Policy. The Summary of Benefits is included with and is part of this Policy.

Supply – means items deemed necessary for the Treatment of an Illness or Injury.

Surgery/Surgical – means the performance of generally accepted operative and cutting Procedures including specialized instrumentations, and other invasive Procedures.

Symptoms – means a sensation or feeling that the Insured Person may experience and consider not to be normal. Such feeling or sensation may be in the form of pain or change of bodily fluids. This Symptom will not be considered an Illness or a medical condition until a licensed Physician or Specialist gives a Diagnosis.

Terrorist Acts – means an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist Acts can include, but not be limited to, the actual use of force or violence and/ or the threat of such use. Furthermore, the perpetrators of Terrorist Acts can either be acting alone, or on behalf of, or in connection with any organization(s) or government(s).

Therapeutic Services/Outpatient Rehabilitation – means physical therapy, occupational therapy, speech therapy or oculomotor therapy.

Treatment – means medical care given to a patient for an Illness or Injury.

Usual, Customary and Reasonable Charge – means the lower of: a) the Provider's usual charge for furnishing the Treatment, Procedure, Service or Supply; or b) the charge determined by the Insurer to be the general Rate charged by others who render or furnish such Treatments, Procedures, Services or Supplies to persons: (1) whose Injury or Illness is comparable in nature and severity. The Usual, Customary and Reasonable Charge for a Treatment, Procedure, Service or Supply that is unusual, or not often provided in the area, or that is provided by only a small number of Providers in the area, will be determined by the Insurer. The Insurer will consider such factors as: (1) complexity; (2) degree of skill needed; (3) type of Specialist required; (4) range of Services or Supplies provided by a Facility. When PPO Providers are not available within a 50-mile radius of the Insured Person's local residence, the Usual, Customary and Reasonable Charge may be the negotiated Provider fee for such Services.

Waiting Period – means the period of time beginning with the Policy Effective Date, during which limited or no benefits are available for particular Services. After satisfaction of the Waiting Period, benefits for those Services become available in accordance with this Policy.

Zone(s) of Coverage – means the geographic area of coverage. This Policy offers two (2) Zones of Coverage options: Zones 1 and 2.

Zone 1 – means the worldwide geographic area where coverage is available (*including the United States*), excluding your Country of Origin, the European Union if you permanently reside there and the Restricted Areas.

Zone 2 – means the worldwide geographic area where coverage is available excluding the United States, Bahamas, Bermuda, Brazil, Canada, China, Hong Kong, Japan, Panama, Singapore, Switzerland, United Kingdom, your Country of Origin, the European Union if you permanently reside there and the Restricted Areas.

What Your Plan Does Not Cover

Exclusions and Limitations

The Exclusions and limitations set forth in this section are in addition to any that are specified in the *What Your Plan Covers* and *Outpatient Prescription Drugs and Supplies* sections, including any Endorsement to this Policy. In addition, we will not pay for any of the Services, Treatments, or Supplies described in this section, even when recommended or prescribed by a Physician, or in the event it is the only available Treatment for your condition. We will not cover the following:

1. Any Services, Procedures or Prescription Medications/Drugs not specifically listed in this Policy as covered.

2. **Allowable Charges:** charges in excess of Allowable Charges for any Covered Service or Procedures, including, but not limited to, Maximum Benefit amounts, Maximum allowance amounts and Maximum number of days as stated in your Summary of Benefits.

3. **Services not Approved or Medically Necessary**: (i) not ordered, recommended, or approved by a Physician; (ii) not rendered under the scope of a Physician's license; (iii) charges for a Service or Procedure which is not Medically Necessary or in accordance with established Evidence Based Medicine; or (iv) not coordinated or approved by the Plan Administrator, if required under this Policy.

4. **Claims and costs for medical Services, Procedures or Prescription Medication/Drugs:** (i) occurring before the Policy Effective Date, during a Waiting Period(s), or after the expiration date of the Policy; (ii) for medical Services, Procedures or Prescription Medication/Drugs for any complications directly caused by an Illness, Injury or Procedure for which we exclude or limit coverage; (iii) for missed appointments, "after hours" expenses, or home visits; or (iv) for which you are not legally obligated to pay for or Services which no charge is made to you in the absence of insurance coverage.

5. **Reconstructive Surgery:** Any Reconstructive Surgery as a result of a medical condition, Illness, Injury or Accident which did not first occur while covered under this Policy or not performed within the timeframe as specified under the terms and conditions of this Policy. Reconstructive Surgery or any Treatment deriving from any Congenital Conditions.

6. **Pre-Existing Conditions:** Pre-Existing conditions are never covered (whether disclosed or not disclosed), including complications therefrom. We reserve the right to Rescind, cancel or not renew this Policy due to any omission to declare a Pre-Existing Condition(s). Please refer to the definition of a Pre-Existing condition.

7. **Maternity Care and Birth Benefits:** Any and all Services, Procedures, Treatments or Surgeries related to: (i) Maternity Care; (ii) Complications of Pregnancy arising directly or indirectly from Maternity Care; (iii) Well Baby Care; (iv) Breast Pumps; (v) non-healthy newborn infant care; (vi) Congenital Conditions or Habilitative Services for the Treatment of Congenital Conditions, Hereditary condition(s), genetic condition(s), birth defects or Reconstructive Surgery in a newborn; (vii) pregnancy of a Dependent daughter; (viii) post-natal classes following birth to deal with the physical effects on the body of being pregnant and giving birth; (ix) the cost or refund of Treatments directly relating to surrogacy, whether you are acting as a surrogate or are the intended parent; (x) elective abortions and complications thereof; or (xi) any voluntary induced termination of pregnancy.

8. **Fertility and Infertility Treatments:** (i) any and all fertility/infertility Services, Treatments, Procedures, tests, Prescription Drugs or Supplies that promote conception or any complications directly or indirectly related thereto; (ii) any Services, Procedures, Treatments or Prescription Drugs to prevent pregnancy except for generic oral contraceptives for a 28 or 30-day supply (up to $100) and one implantable per year (up to $250) are covered; (iii) any expenses for male or female reversal of sterilization; (iv) drugs to regulate the menstrual cycle/ovulation for family planning purposes, artificial inseminations, in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT); (v) procedures and Services for a surrogate mother; or (vi) Services, Treatments, Procedures, tests, Prescription Drugs or Supplies related to fertility and infertility or any complications directly or indirectly related to this Exclusion or which is

aimed at making a person unable to reproduce, including, but not limited to, hysterectomy, vasectomy, sterilization and male contraception.

9. **Sexual Dysfunction and Sex Change Services:** (i) any Service, Procedure, Treatment, Supply or Prescription Drug for sexual dysfunction, impotency or inadequacies, including sexual enhancement drugs; (ii) any Service, Surgery, Procedure, Treatment, Prescription Drugs, including hormone therapy, to change the biological sexual characteristics to those of the opposite sex, implantation or sexual transformation; or (iii) Psychiatric Treatment or a study related to sex changes, and psychological counseling.

10. **HIV/AIDS/STDS:** (i) any Services, Treatments, Procedures or Prescription Drug related to HIV (i.e., infected with the Human Immunodeficiency Virus, the cause of acquired immunodeficiency syndrome) or any and all sexually transmitted diseases, or complications directly or indirectly related to the same; (ii) any associated diagnostic tests or charges for HIV infection, seropositivity to the AIDS virus, AIDS related Illness(es), ARC Syndrome, AIDS, and all diseases caused by and/or related to HIV or arising as complications from these conditions including, but not limited to, the cost of testing for these conditions and/or charges for drug Treatment(s) or surgeries; or (iii) voluntary HIV screening.

11. **Dental and Vision Benefits (*adult and children*):** (i) any and all dental Treatment or orthodontic Treatment; unless the optional dental and vision rider was purchased (in which case Services will be limited to such Services covered under the rider); (ii) dental cosmetic Procedures, including, but not limited to, veneer restorations, tooth whitening, dental implants, or cosmetic contouring; (iii) any Treatment in relation to gum or gum disease including, but not limited to, flap Surgery, pocket reduction Surgery, bone grafts, soft tissue grafts, guided tissue regeneration or bone Surgery, Treatment for gingivitis, periodontitis, or any other similar Treatment; (iv) Treatment for temporomandibular malocclusion joint disorders; (v) dental reconstructive surgery, microsurgery, replantation and plastic surgery; or (vi) routine eye examinations, Services and Supplies related to visual therapy, radial keratotomy and photo refractive keratectomy Procedures, Lasik, or eye Surgery to correct refractive errors or deficiencies, including myopia or presbyopia, nearsightedness, farsightedness or astigmatism, orthoptics, eyeglasses, contact lenses, sunglasses, corneal abrasion from contact lens removal, and photorefractive keratectomy (unless the optional dental and vision rider was purchased in which case Services will be limited to such Services covered under the rider).

12. **Out-of-Network Outpatient Care:** Any and all Services, Procedures, Treatments, Surgeries or Prescription Drugs related to Out-of-Network Outpatient Care including, but not limited to, Physical Examinations, Routine X-rays and Laboratory tests, Advanced Diagnostic and Interventional radiology Services, Outpatient renal failure Dialysis, Outpatient Reconstructive Surgery and Alternative medicine.

13. **Hearing Services**: routine hearing examinations, hearing aids or devices, Surgical implantation of, or removal of bone anchored hearing devices and cochlear implants.

14. **Foot Treatment:** Podiatric Care including, but not limited to, Treatment of hammer, claw and mallet toes, structural and functional Treatment of the feet, the Treatment of weak arches, weak, strained or flat feet, bunions, symptomatic complaints of the feet, congenital foot disorders, shoe inserts of any kind or Supplies.

15. **Genetic Testing, Screening and Services:** (i) any genetic testing or screening including, but not limited to, BRCA1, BRCA2, cystic fibrosis, or genetic counseling, Treatment related to genetic medicine, and preventative prophylactic surgeries recommended by genetic testing or screening; or (ii) all associated services related to gene-based, cellular and other innovative therapies (GCIT) services (examples include, but are not limited to, infusion, laboratory, radiology, anesthesia, and nursing services).

16. **Growth/Height care:** any Treatment or Surgical Procedures and devices to stimulate growth, Treatment, device, Service or Supply to increase or decrease height or alter the rate of growth, or Services, Treatments, Procedures, tests, Prescription Drugs or Supplies relating to growth hormones.

17. **Circumcision:** unless Medically Necessary and Pre-Authorized by the Plan Administrator.

18. **Mental and Behavioral Health:** (i) Services for education, vocation or special education or job training whether or not given in a Facility that also provides medical or Psychiatric Treatment; (ii) Treatment for learning difficulties, hyperactivity, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, or any developmental and behavioral problems; (iii) any care for autistic disease of childhood, hyperkinetic syndromes, learning disabilities, mental retardation which extends beyond traditional medical management or for environmental or social change; (iv) Services for, or in connection with marriage, family, child, gender dysphoria, career, social adjustment or behavioral, pastoral, bereavement or financial counseling; or (v) mental health Services received in a health resort, spas or sanitariums or residential treatment facility.

19. **Durable Medical Equipment:** motor driven wheelchairs; beds; additional wheels; comfort items such as telephone arms and over bed tables; items used to alter 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 or similar items; or the cost of instructions for the use and care of any such durable medical devices. The customizing of any vehicle, bathroom facility, or residential facility is also excluded.

20. **Speech therapy:** for speech impediments or developmental delays.

21. **Elective and Cosmetic Surgeries, Treatments and Procedures:** (i) any elective and/or cosmetic Service, Surgery, Procedures, Treatments, technologies, Prescription Drugs, devices, items, products and Supplies that are not Medically Necessary, whether or not due to a covered Injury or Illness or for psychological purposes, and that may only be provided for the purpose of improving, altering, enhancing, or genetically manipulating the quality of an existing condition related to hair, skin, eyes, nose, vision, teeth, hearing, physical size, endurance, strength, physical condition, physical performance, aging, athletic or sexual capabilities or other mental or physical attributes not falling into these categories including, but not limited to, Treatment for Vitiligo; Treatment or Surgery for superficial varicose veins, spider veins, sclerotherapy for veins of the extremities or keloid or non-keloid scars; tattoo removal or other skin discolorations; Treatment for hair loss, male pattern baldness or age related thinning in women, hairplasty, alopecia, or hair transplants to correct permanent hair loss; the temporary removal of hair by laser, electrolysis, waxing or any other means; deviated septum, submucous resection, nasal and sinus surgery; Treatment of superficial, non-cystic or non-pustular acne or rosacea; Treatment or removal of benign skin lesions not demonstrating evidence of suspicious cellular activity, or recent changes in size, shape, and color; redundant skin Surgery; removal of skin tags; Treatment for moles, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hyperhidrosis (excessive sweating), hypertrophic and atrophic conditions of the skin or nevus; (ii) any complications arising directly or indirectly from any of the above; (iii) Services or Treatment for breast reductions or augmentation, regardless of a Physician's recommendation of Medical Necessity, or any Treatment or complication related to or arising from breast implants, even if due to an Accident (except in connection with covered breast Reconstructive Surgery after a mastectomy as stated in *What Your Plan Covers*); (iv) any medical complications arising directly or indirectly as a result of an elective or cosmetic Service or Procedure; or (v) full body CT scans.

22. **Medications/Drugs and Supplies:** products classified as vitamins or minerals (except clinically significant vitamin-deficiency syndromes), nutritional consultations and supplements, including, but not limited to, special infant formula and cosmetic products, even if medically recommended, prescribed or acknowledged as having therapeutic effects. We do not recognize nutriments, tonics, mineral water, cosmetics, hygiene and body-care products and bath additives as Medically Necessary. As a result, we will not refund the costs of these items. Over-the-counter drugs, Supplies or medical devices, which do not require a Physician prescription, even if recommended by a Physician, including, but not limited to, smoking cessation drugs, appetite suppressants, hair regenerative drugs or products, anti-photo aging drugs, cosmetic and beauty aids, acne and rosacea drugs, hormones, Retin A, megavitamins, sexual enhancement devices, supplements, or herbs. Any outpatient disposable supply or device such as, sheaths, bags, elastic garments, support hose, bandages, bedpans, splints, neck braces, compresses or other devices.

23. **Weight Related Services:** Surgical Procedures including, but not limited to, bariatric Surgery, gastric bypass combined with gastric band, biliopancreatic diversion without duodenal switch, fobi pouch, gastric loop gastric bypass, intra gastric ballons, gastric stapling, jejunal ileal bypass, stomaphyx and/o any complications arising directly or indirectly from the same. Treatments, Supplies, Services or Prescription Drug(s) for weight reduction, appetite suppression, weight

reduction programs, morbid or non-morbid obesity, medical fast diets, weight loss programs or complications arising directly or indirectly from the same.

24. **Sleep Studies and Disorders:** Any Treatment, Procedures, Services for insomnia, sleeping disorders, sleep studies and other Treatments relating to sleep apnea, jet lag, fatigue, or stress or any related conditions. In addition, we do not cover investigations into such conditions by the use of a continuous positive airway pressure machine or a bi-level positive airway pressure machine.

25. **Therapies:** Stays in a cure center, a bath center, a spa, a health resort or a recovery center, even if they are medically prescribed. This also includes thermal baths, saunas and any kind of wellness massages. Services including, but not limited to the following types of Treatment: primal therapy; rolfing; psychodrama; bioenergetic therapy; carbon dioxide therapy; aromatherapy; bio-electromagnetic; magnetic therapy; massage therapy; yoga; vitamin and herbal therapy; naturopathic medicine; ayurvedic medicine; biofield therapies; energy medicines; color puncture; hair analysis; sensory or auditory integration therapy; light therapy; hypnosis and hypnotherapy; reflexology; spiritual healing; Ti-chi; faith-healing medicine, traditional oriental medicine; or chelation therapy.

26. **Alcohol and Substance Abuse:** (i) all Inpatient and Outpatient Services including diagnosis, counseling, and other medical Treatment related to alcohol or substance abuse, drug abuse or addictive conditions of any kind; (ii) Treatment for any Injuries or Illnesses caused by, contributed to or resulting from the Insured Person's use of alcohol, narcotics, illegal drugs, or any drugs or the use of non-prescribed medications or medicines that are not taken in the dosage or for the purpose prescribed by the Insured Person's Physician; (iii) any Injuries or Illnesses related to operating any type of vehicle or conveyance while under the influence of alcohol or any of the above listed substances including prescribed drugs for which the Insured Person was provided a written warning against operating a vehicle or conveyance while taking it; or (iv) marijuana, whether or not legalized in the Insured Person's domiciled state, or used for medicinal purposes.

27. **Self-Inflicted Illness or Injury:** (i) Illnesses and Accidents, as well as their consequences, with respect to any conditions as a result of self-inflicted Illnesses or Injuries, suicide or attempted suicide, while sane or insane, or Emergency air Services for the same which have been caused deliberately. We consider an Illness or Accident as being caused deliberately if the person concerned had at least some idea of the consequences of his/her actions and accepted the fact of the damage caused; (ii) where Treatment or Advice of a medical condition, whether related or not, was a result of self-treatment or auto therapy (self-administered); (iii) which we determine on medical Advice is either Experimental or unproven; or (iv) any Services, Procedures or Treatment that arise from, are related to or associated with specific medical Advice which has been disregarded (including travel where an Insured Person has traveled against medical Advice from any Provider), any changes in Prescription Drugs, therapies or diet that are a result of a previously known condition that can affect, degrade or alter the Insured Person's health, or any Services, Procedures or Treatment that is abandoned against medical advice.

28. **Services for Administrative Purposes:** routine health check-ups, preventive Services or visits, inoculations, vaccinations, immunizations or related tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.).

29. **Experimental and/or Investigational Services:** Services, Supplies or Prescription Medications, as determined by Insurer to be Experimental and/or Investigational. The Plan Administrator's decision, whether a Prescription Drug or its use is "investigational" or "experimental" shall be binding.

30. **Organ Transplants:** (i) expenses for the acquisition of an Organ including, but not limited to, donor searches, typing, harvesting, transportation and administration costs; (ii) supportive Services; (iii) all expenses of cryopreservation and the implantation of living cells on a deceased person or in conjunction with infertility or reproductive Treatments; (iv) Transplant that includes artificial mechanical equipment or artifacts designed to replace human organs; (v) any medication or therapeutic Treatments required to secure and maintain the health of the transplanted Organ; (vi) animal organs; or (vii) when alternative Treatment or Procedures are equally effective to treat the condition.

31. **Blood Services:** (i) any related services for donated blood including processing, storage or replacement expenses; (ii) the service of blood donors, including yourself, apheresis or plasmapheresis; or (iii) the blood you donate for your own use and any expenses related thereto.

32. **Long Term Care:** Any costs Incurred for accommodation in conjunction with the need for long-term care and custody including, but not limited to: rest cures, rest homes, Custodial Care, home-like care, assistance with Activities of Daily Living, milieu therapy for rest and/or observation, whether or not prescribed by a Physician, any Admission to a nursing home, home for the aged, long term care or Rehabilitation Facility, sanatorium, spa, hydro clinic or similar facilities that do not meet the Policy definition of a Hospital. Any Admission, arranged wholly or in-part for domestic reasons, where the Hospital effectively becomes or could be treated as the Insured Person's home or permanent abode.

33. **Convenience Items:** personal comfort and convenience items including, but not limited to, all non-medical consumables and catering, television, master suites, movies, or media related expenses, housekeeping services, guest meals and accommodations, special diets, telephone charges, take home Medications or Supplies, ambulance Services (other than those provided by this Policy), and all other Services and Supplies that are not Medically Necessary including expenses related to travel and accommodation costs unless specifically agreed to by us in writing prior to travel.

34. **Sports and Activities**: (i) Any Services, Treatments or Procedures for Injuries or Illnesses: (a) arising from participating in or providing instruction for recreational activities, semi or Professional Sports, recreational sports, or competitive sports; (b) traveling to or from any of the above sports, contests or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition; (ii) any deliberate exposure to exceptional danger including, but not limited to: to bungee jumping; sky diving; base jumping; parkour; winter sports, skiing, or snowboarding (stunts, jumps, pipes, trick parks, cliff jumping); mountaineering; rock-climbing (with or without the use of ropes); trekking or expeditions above 3,500 meters or 11,500 feet including, but not limited to, expeditions to Mount Everest, K2, Kilimanjaro, Antarctica, the Arctic, North Pole and Greenland; surfing; diving; scuba diving; flying within 24 hours of a diving activity; mountain biking; rappelling; whitewater rafting/ canoeing (level 3+); motorsport activities including racing or contests; hang-gliding; paragliding; parachuting; (iii) the use of any type of firearms (any device that discharges a projectile of any type); (iv) any activity relating to flying either as a Pilot in Command, student pilot, sport flying or the business or trade of flying (except while traveling as a passenger in a fully-licensed passenger carrying aircraft); or (v) any sport that requires a higher degree of knowledge or training and has an increased risk of injury or death. Determination and coverage for a sport not listed in this exclusion is at the Insurer's discretion and its decision is final.

35. **Emergency Medical Evacuation, Repatriation and Repatriation of Mortal Remains:** (i) any Repatriation arising out of any Condition while on a cruise ship; (ii) any expenses relating to search and rescue operations to find an Insured Person in mountains, at sea, in the desert, in the jungle and similar remote locations include air/sea rescue charges for evacuation to shore from a vessel or from the sea; or (iii) any accommodation fees, travel tickets, taxis or any other transportation costs not otherwise covered by this Policy, including, but not limited to, companion coverage and bedside visits.

36. **Claims Filing Period:** Charges not submitted within ninety (90) days from the date the Service was rendered, except in the event of legal incapacity.

37. **Claims Liability determination:** Charges for which we are unable to determine liability because the Insured Person failed, within ninety (90) days, or as soon as reasonably possible to: (i) authorize us to receive all the medical records and information we request; or (ii) provide us with information we requested regarding the circumstances of the claim or Other Insurance Plan.

38. **Court Ordered Treatment:** unless such Treatment is prescribed by a Physician and specifically covered by this Policy.

39. **Coverage Under Other Plans or Sources:** Services, Supplies or Procedures, including Prescription Drugs and/or Medical Emergency Services, that are provided by or payment is available from: (i) workers' compensation law, occupational disease law or similar law concerning job related conditions; (ii) an Other Insurance Plan or governmental

program; (iii) under the direction of public authorities related to epidemics and pandemics; or (iv) a state crime victims compensation program or similar type of governmental program which reimburses victims for crime-related expenses.

40. **Services from Relatives:** Professional Services received from a person who lives in the Insured Person's home or who is related to the Insured Person by blood, marriage or adoption including, but not limited to, a spouse, father, mother, brother, sister, child, grandchild, father-in-law, mother-in-law, grandparent, aunt or uncle of the Insured Person or Domestic Partner or non-marital partner.

41. **Military duties:** Illnesses and Injuries and their consequences: which are caused while the Insured Person is carrying out his/her military duties.

42. **War and Terrorism:** Illnesses and Injuries, and their consequences, as well as the consequences of Accidents and deaths caused by the following: (i) martial law or state of siege, or any event or causes which determine the proclamation or maintenance of martial law or state of siege; (ii) foreseeable acts of war or any act of war, declared or undeclared; (iii) civil unrest, or involvement in civil commotion or an illegal act, mutiny, riot, strike, military or popular uprising, insurrection, rebellion, military or usurped power; including resultant imprisonment; (iv) any act of any person acting on behalf of or in connection with any terrorist organization; (v) criminal acts unless the Insured Person suffers an Injury as a non-involved third party who has not put themselves in danger in a deliberate or negligent way and such Injury has not been paid or is not payable by a state crime victims compensation program or similar type of governmental program which reimburses victims for crime-related expenses. We will not provide coverage if the Insured Person moves to a territory where direct combat is taking place or provides services for any of the parties involved in that conflict; or (vi) Illnesses, Injuries and Accidents, directly or indirectly, as well as their consequences, which have been caused by nuclear energy (nuclear reactions, radiations, and contamination, asbestosis or any related condition), as well as Illnesses, Injuries and Accidents, as well as their consequences caused by chemical or biological weapons.

43. **Governmental Fees and Taxes**: charges for taxes, assessments, fees or surcharges imposed by any governmental agency or fees for required medical records where an Insured Person is required to substantiate his/her claim.

44. **Foreseeable Events/Restrictions on Travel:** (i) with the exception of COVID-19, any Services, Procedures or Treatments that arise from, are related to or associated with, an actual or likely contagious disease, epidemic or pandemic, the threat of a contagious disease, epidemic or pandemic or any foreseen event. This exclusion is designed to exclude losses caused by reasonably foreseeable events. The moment an event becomes a foreseen event, it will not be covered; (ii) any Services, Procedures or Treatments that arise from, or are associated with, travel to countries or parts of a country for which: (a) an advice or warning has been released by any governmental or official body, the Federation of European Risk Management Association, the US Government Department of Foreign Affairs and Trade, or the US Centers for Disease Control and Prevention, and the advice or warning risk rating is "reconsider your need to travel" or "do not travel" (or words to that effect) or the advice or warnings advise against all non-essential travel to or in that location or advise against specific transport arrangements or participation in specific events or activities; or (b) the mass media has indicated the existence or potential existence of circumstances (including circumstances referred to in clause (a) above that may affect your travel, and you did not take appropriate action to avoid or minimize any potential claim under your Policy (including delay of travel to the country or part of the country referred to in the relevant advice(s), warning(s) and/or mass media statement(s)).

45. **Illegal Activities:** Services, Treatments and Procedures related to Injuries and Illnesses resulting, arising from or occurring during the commission or perpetration of a violation of law by an Insured Person.

46. **Services not permitted by law:** some laws restrict the range of health care services a provider may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

47. **Motor Vehicles:** Any Services, Treatments or Procedures for Injuries or Illnesses related to: (i) the use of a motor vehicle by the Insured Person unless the Insured Person is carrying a legally issued driver's license in the jurisdiction where the motor vehicle accident occurred and motor vehicle insurance from the country in which he/she is an eligible Policyholder; (ii) operating of any type of vehicle or conveyance while under the influence of alcohol, an illegal substance, drug, gas, or fumes, including prescribed medications for which the Insured Person was provided a written

warning against operating a vehicle or conveyance while taking it; (iii) motorcycles; mopeds; scooters; ATVs; any two or three wheeled motorized vehicle; sport watercraft such as wave runners, jet skis; racing or speed testing any motorized vehicle or conveyance; or any other powered devices whether the vehicle is in motion or not; (iv) Incurred medical expenses resulting from a motor vehicle accident if such expenses are recoverable under Other Insurance, including any “No Fault” automobile insurance contract regardless of whether the Insured Person asserts his/her rights to obtain benefits from these sources will not be covered; or (iv) if the Insured Person does not exercise prudence and safety when: (a) a passenger in a motor vehicle; or (b) while operating a motor vehicle, driving safely and following traffic laws and restrictions. This includes, but is not limited to, the use of seat belts for the driver and front and back seat passengers, having the proper licensure, or operating or driving a motor vehicle at high speeds recklessly or inappropriately.

48. **International Sanction Laws**: Any Services, Procedures or Treatments, to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose Insurer to any sanction, prohibition or restriction under United Nations resolutions or any trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or the United States including, but not limited to, any Services, Procedures or Treatments provided in the Restricted Areas.

How Do I Make a Claim?

What We Pay

You will be reimbursed for the Allowable Charges in excess of any Other Insurance Plan you have for the Covered Services up to the Maximum Benefit amounts described in the Summary of Benefits table. If you have Other Insurance, please refer to the *Coordination of Benefits* clause below.

What to Do if You Have a Claim

In order to receive reimbursement under this Policy, you must submit to us a completed claim form and the supporting documents within **ninety (90) days** from the date of Service. The claim form is available on your member portal at www.wellaway.com or you may request the claim form by contacting a ConciergeCare Counselor at +1 855 773 7810 or e-mail: Conciergecare@payerfusion.com.

Please send us the following information with your completed claim form:

1. Claimant's name
2. Physician's specialty
3. Detailed description of Service rendered (office visits, Surgery, etc.)
4. Original itemized invoices with fees on Physician/Hospital letterhead. Invoice must include patient's full name, date of birth, Diagnosis (type of Illness), date of the visit, Treatment type, Physician's charges and acceptable proof of payment (credit card receipt)
5. Prescription medications must clearly provide the name of the patient, the price of the Drug, and prescription quantity. Copy of the Physician's script is required.
6. In the case of hospitalization, you must attach the Hospital medical notes or reports, and our Pre- Authorization provided to you. Please ensure that your invoice details the cost of private or semi-private room.
7. Type of Currency.

You may submit your claim via e-mail to conciergecare@payerfusion.com, courier, or by postal service. Mail your completed claim documents to:

PayerFusion Holdings, LLC
1825 Ponce de Leon Blvd.
#207
Coral Gables, FL 33134

Note: We will reimburse you in the currency in which the Premium was paid and in accordance with the terms and conditions of the Policy. We encourage you to keep copies of the invoices for your records. Copies of claims are accepted as long as the integrity of the document is not altered. However, we reserve the right to request original documents at our discretion. We will notify you, in writing, if the claim is denied or if additional information is necessary for the review and/or payment of the claim within the terms of this Policy. The claim will be paid at the exchange rate based on date of Service.

Services in the United States

If you receive Services in the United States, the Hospital or Provider may submit the claim directly to us and we will pay any Covered Expenses directly to the Provider or Hospital. You must present all health care Providers with a copy of your Identification Card. Your Provider will then contact us to verify Eligibility and the coverage provided under this Policy. You will only be responsible for: (i) expenses that are not covered by this Policy; (ii) any Cost Share amounts; (iii) any amounts in excess of the Allowable Charges; (iv) any amounts in excess of the Maximum Benefit; and (v) any excess or Site of Service Differential costs.

Note:

1. Your Providers must submit claims to us within ninety (90) days from the date of Service. No benefits will be paid for claims exceeding this time period.

2. Medical claims submitted by Providers within the United States must be in CMS 1500 formats, or UB04 CMS formats. If you have already paid the Provider, you must submit your Reimbursement pursuant to the guidelines set forth above. We will reimburse you in accordance with the terms of the Provider contract, if one exists.
3. In the event that you utilize a Non-Network Provider that has chosen to "opt-out" of billing an insurance company and did not provide you with a medical claim in CMS 1500 formats, or UB04 CMS formats, your claim will be deemed a non-reimbursable claim.

Claims Payment

Whenever possible, we will settle the expenses directly with the Providers for Services rendered. When not possible, we will reimburse the Policyholder in accordance with the terms and conditions of this Policy. In the event the Policyholder is deceased, the Plan Administrator will pay any unpaid benefits to the spouse as named in the Application Form. If no spouse is named, any unpaid benefits will be paid to the deceased primary Insured Person's estate. In the event of a divorce, all payments are payable to the Policyholder unless a divorce decree or court order indicates otherwise.

Fraudulent/Unfounded Claims

If any claims presented under this Policy are in any respect fraudulent or unfounded, or if any fraudulent means or devices are used by the Insured Person or anyone acting on the Insured Person's behalf, such as misrepresentation on the Application Form, omissions of information or any attempts, through deceit, to obtain benefits for any person that otherwise would not be provided or payable, we will deny all benefits paid and/or payable in relation to that claim and all Premiums previously paid shall be forfeited and, if appropriate, recoverable. We will terminate the Policy as of the Policy Effective Date. We reserve the right to take legal action in order to seek compensation for any damage caused to us. You will be required to pay back any benefits that were unduly paid to you under this Policy.

Refusal to Accept Assignment

Insurer reserves the right to make payment directly to the Insured Person and to refuse to honor an assignment of any claim to any person or party.

Release of Medical Records

By applying for coverage, the Insured Person agrees on behalf of him/herself and his Dependent(s), to let any Physician, Hospital, pharmacy or Provider give us all medical information determined by us to be necessary, including a complete medical history and/or Diagnosis in order to validate a claim. We will keep the information confidential. Furthermore, by applying for coverage, the Insured Person authorizes the Insurer to furnish any and all records pertaining to such Insured Person, including complete Diagnosis and medical information, to an appropriate medical review board, utilization review board or organization and/or to any administrator or other insurance carrier for purposes of administration of this Policy. There may also be additional health information requests from the Insurer.

The Plan Administrator will attempt to retrieve the medical records on behalf of the Insured Person; however, if these are not provided to us, it will be the responsibility of the Insured Person to provide the information in order to validate the claim. The claim will be closed with non-payment until the required information is provided to us. Expenses Incurred for such records will be at the sole expense of the Insured Person.

The Insured Person has ninety (90) days from date he/she received Notification in writing requesting additional information to authenticate and validate a claim. If the information is not provided to the Plan Administrator within the allotted timeframe, the claim will be denied.

Request for Reproduction of Records

Medical information such as claims, invoices, explanation of benefits, and Pre-Authorizations are available free of charge by logging into your member portal at www.wellaway.com. Reproductions of claims or records requested by the Insured Person or his/her representative to the Insurer will have a fee payable prior to such being provided.

Currency and Exchange Rate

For the purpose of this Policy, the exchange rate means the official exchange rate under www.oanda.com that the Insurer has accepted, between the currency in which the Premium was paid and the currency in which charges were Incurred, for the date on which the Insured Person received Services, Treatments or Supplies rendered. All claims will be reimbursed in the currency in which the Premium was paid.

Overpayments

We may recover benefit payments made erroneously and may supply subsequent benefits otherwise payable to offset any overpayment. We reserve the right to deduct overpayments made in error to a Provider on behalf of an Insured Person from a Reimbursement claim. Deduction of an overpayment to an Insured Person will be properly documented on the explanation of benefits.

Right of Examination and Autopsy

The Insurer and the Plan Administrator reserve the right, through our medical representatives, to examine any Insured Person whenever and as often as we may reasonably require within the duration of any claim. The Insured Person shall make available all medical reports and records, as well as requested health information questionnaires, and where required, shall sign all authorization forms necessary to give us a full and complete medical history. In the event of death, the Insurer and the Plan Administrator reserve the right to require an autopsy for the processing of a claim under this Policy. Failure to comply with this clause will result in the automatic denial of all related claims.

Coordination of Benefits

When an Insured Person has coverage under an Other Insurance Plan, including, but not limited to, government programs, health insurance in your Country of Residence, an international insurance policy, worker's compensation insurance, automobile insurance (whether direct or third party), and/or disability coverage, and Services received are covered by any such policies/programs, benefits will be reduced under this Policy to avoid duplication of available benefits. In no event will more than 100% of the Allowable Charges and/or Maximum Benefit for the Covered Services be paid or reimbursed. It is the duty of the Insured Person to inform us of all other coverages. The Insurer has full right of Subrogation. To determine the primary policy, the following guidelines will be used:

- If an Insured Person has local coverage in the Country of Residence, the local coverage would be primary for the Services Incurred locally over this Policy. This Policy would be secondary, and our liability would only be the amount not covered by the primary insurer, subject to the satisfaction of any Cost Share amounts as stated in your Summary of Benefits.
- If the Insured Person has two international policies, the policy which has been in effect with the longest effective date would be primary.
- If no other international policy is available and the Insured Person travels outside the Country of Residence, this Policy would be primary.
- If two policies cover the Insured Person as an individual, the policy that has covered him/her for the longer period of time is the primary policy.

Subrogation

When Insurer pays for expenses that were the result of alleged negligence, or which arise out of any claim or cause of action which may accrue against any third party responsible for Injury or death to the Insured Person, the Insurer has the right to equitable restitution and will advance benefits if the Insured Person agrees to the following:

- The Insured Person and his/her attorney, for the exclusive benefit of the Insurer, must hold any settlement received in trust.
- The Insured Person will reimburse the Insurer out of the Insured Person's recovery for all benefits paid by Insurer. Insurer will be reimbursed in full prior to the Insured Person receiving any monies recovered from any party or their insurer as a result of a judgment, settlement or otherwise. The duty and obligation to reimburse the Insurer also applies to any money the Insured Person receives from any underinsured or uninsured motorist Policy of insurance. The Insured Person is obligated to repay the Insurer even if the Insured Person is not fully compensated or made whole from any money he/she receives. The Insured Person must include the Insurer's name as a co-payee on any settlement

check. Insurer is paying benefits in reliance upon the Insured Person's agreement to the terms contained in this section of this Policy.

- Insurer has the right to the Insured Person's full cooperation in any case involving the alleged negligence of a third party. In such cases, the Insured Person is obligated to provide us with whatever information, assistance and records we may require to enforce our rights in this provision. The Insured Person further agrees that in the event that the Insurer has reason to believe that it may have a Subrogation lien, we may require the Insured Person to complete a Subrogation questionnaire, sign an acknowledgment of the Insurer's Subrogation rights and an agreement to provide ongoing information before the Plan Administrator pays, or continues payments of claims according to its terms and conditions. Upon receipt of the requested materials, the Insurer will commence or continue payments of claims according to its terms and conditions provided that said payment of claims in no way prejudices the Insurer's rights.
- The Insurer may, but is not obligated to, take any legal action it sees fit against the third party or the Insured Person, to recover the benefits Insurer has paid. The Insurer's exercise of this right will not affect the Insured Person's right to pursue other forms of recovery, unless the Insured Person and his/her legal representative consent otherwise.
- In the event that the Insurer determines that a Subrogation recovery exists, the Plan Administrator retains the right to employ the services of an attorney to recover money due to Insurer. The Insured Person agrees to cooperate with the attorney who is pursuing the Subrogation recovery. The compensation that the Plan Administrator's attorney receives will be paid directly from the dollars recovered for the Insurer.
- The Insurer specifically states that it has no duty or obligation to pay a fee to the Insured Person's attorney for the attorney's Services in making any recovery on behalf of the Insured Person.
- The Insured Person is obligated to inform their attorney of the Subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Insurer receiving less than the full amount of its lien without the written approval of the Plan Administrator.
- The Insured Person further agrees that he/she will not release any third party or their insurer without prior written approval from the Plan Administrator, and will take no action which prejudices the Insurer's Subrogation rights.
- The Insured Person agrees to refrain from characterizing any settlement in any manner so as to avoid repayment of the Insurer's lien or right to Reimbursement.
- The Insurer retains discretionary authority to interpret this and all other Policy provisions and the discretionary authority to determine the amount of the lien.

  In the United States, the Insurer pays secondary to any and all personal insurance protection (PIP), medical payment to others (Med-Pay), no-fault coverage or governmental reimbursement programs, including, but not limited to, state crime victim compensation programs, which reimburse victims for crime-related expenses. The Insurer has no duty or obligation to pay any claims until PIP, Med-Pay or no-fault coverage or reimbursement to the Insured Person is exhausted. In the event that the Plan Administrator pays claims that should have been paid by PIP, Med-Pay or no-fault coverage or a state compensation program, then the Insurer has a right of recovery from the insurance carrier or Insured Person, as applicable.

Excess Insurance

No benefits are payable for any expense incurred for an Accident or Illness which has been paid or is payable by other valid and collectible insurance or governmental reimbursement programs. Benefits will only be paid under this Policy on the unpaid balances after the other insurance has paid or the allowable reimbursement has been made.

Facility of Payment

Whenever payments which should have been made by us are made by any other person, plan, or organization, we shall have the right, exercisable alone and in our sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts we shall determine to be required in order to satisfy our coverage obligations hereunder. Amounts so paid shall be deemed to be paid under this Policy and, to the extent of such payments, we shall be fully discharged from liability.

Claims Appeal Procedures

Insurer will provide a written explanation of the reason if it denies, in whole or in part, a claim for benefits under this Policy. If there is any question about the settlement or denial of a claim, the Insured Person will have the right to request a full and fair review of that claim. The process is as follows:

- Within sixty (60) days of receiving a claim denial, the Insured Person must write to the Insurer or Plan Administrator stating the reasons for the appeal and any additional information to support the claim.
- The Insured Person must include in the appeal the following information: the Policy number, the Insured Person's name for whom the claim was made, the Provider, the amount of the claim, the date of Service, and the date it was denied.
- The appeal will be reviewed by an independent external medical appeals reviewer and a recommendation provided to the Insurer. The cost of the independent external review may be at the Policyholder's expense depending upon the type of the review.
- Within an additional sixty (60) days of receiving the written appeal, the Insurer or Plan Administrator will notify the Insured Person by mail of the final decision and the specific reason for the decision. If a more extensive review is required, a final decision will be made within one hundred twenty (120) days from the date the appeal is received in writing by Insurer or the Plan Administrator.
- You must send copies of all correspondence regarding claim appeals to our Plan Administrator.

To File a Complaint

We aim to keep our customers satisfied; however, we understand that there are instances whereby we may not be able to meet your expectations. For a formal complaint, please contact us by post, telephone or e-mail.

WellAway Limited
c/o Compass Administration Services Ltd.
PO Box HM 2879
Hamilton HM LX
Bermuda
Phone: +1-855-773-7810
Email: enrollment@wellaway.com
Website: www.wellaway.com

Our Contact Numbers

For a ConciergeCare Counselor, to request Pre-Authorization, or to check on the status of a claim, we can be reached at the following numbers:

United States: +1-855-773-7810
International: +1-786-453-4008 (collect) or
E-mail: Conciergecare@payerfusion.com

For Enrollment inquiries: enrollment@wellaway.com
Phone: +1-441-296-0651