Dash Prime

Travel Medical Plan

Care, Anywhere

Travel medical coverage for individuals traveling outside their home country, including limited coverage for pre-existing medical conditions, strictly subject to policy terms, conditions, limits, and exclusions

INTRODUCTION

Welcome to **Your** Dash Prime **Policy**. This **Policy** provides travel insurance benefits for individuals traveling outside of their **Home Country**.

In consideration of the payment of the **Premium** specified in the **Declaration of Insurance**, and subject to the **Terms**, Conditions, Exclusions, and **Endorsements** set out in or incorporated into the **Policy**, **We** agree to provide **You** with the cover and benefits described herein for **Medically Necessary Non-Elective Treatment**.

The **Policy** constitutes a binding legal contract between **Us** and **You**, the **Insured Person**. The **Declaration of Insurance**, including the accompanying **Policy**, **Application**, and any applicable **Endorsements**, serves as a summary and evidence of the insurance coverage provided under the **Master Policy**. It does not create, extend, alter, or vary the scope of cover beyond that which is provided under the express **Terms** of the **Master Policy**.

The insurance evidenced by the **Declaration of Insurance** is governed in all respects by the provisions of the **Master Policy**, together with **Your Policy**. It is **Your** responsibility to read the entire **Policy** carefully and retain it for **Your** records.

Certain words in this **Policy** have a specific meaning. Wherever words appear in bold in this **Policy**, they will have the meanings shown in the Definitions section.

All documentation and correspondence relating to this **Policy** will be written in English.

The **Master Policy** is underwritten by Skybridge Risk SPC which is authorized by the Financial Services Commission and regulated by the Anguillan FSC.

We recognize Dash MGA, LLC (**Plan Administrator**) as the manager of this **Policy** and as **Our** authorized agent for the purposes of receiving **Premium**, receiving and holding claims money prior to transmission, and receiving and holding **Premium** refunds prior to transmission.

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1. INFORMATION YOU HAVE GIVEN US

You are under a continuing obligation to provide complete, accurate, and truthful information to **Us**. This duty applies when **You** apply for, amend, extend, or renew this **Policy**, and continues throughout the **Period of Coverage**.

You must disclose all facts that are material to this insurance and notify **Us** promptly of any changes that may affect the **Terms**, conditions, or operation of this **Policy**. If **You** are unsure whether a fact is material, **You** must consult the **Plan Administrator** for clarification.

Failure to provide complete and accurate information, whether at the time of **Application** or during the **Period of Coverage**, may result in one or more of the following actions being taken, at **Our** discretion:

- This **Policy** being declared void;
- Cancellation of this **Policy**;
- Reduction or denial of cover under this **Policy**;
- Rejection or partial payment of any claim made under this

Policy. Accordingly, it is **Your** responsibility to:

- Review and verify that all information provided to **Us** is complete and accurate;
- Notify the **Plan Administrator** as soon as reasonably practicable of any inaccuracies or omissions;
- Ensure that the Schedule accurately reflects the cover and benefits **You** have requested;
- Comply at all times with **Your** obligations under this **Policy**.

Pre-Existing Conditions & Acute Onset of Pre-Existing Conditions Clause

This **Policy** provides coverage for **Pre-Existing Conditions & Acute Onset of a Pre-Existing Condition**, defined as a sudden and **Unexpected** recurrence of a previously diagnosed condition that requires immediate medical attention. Coverage applies only if:

- The condition was stable and under control prior to travel.
- Symptoms manifest suddenly and require urgent **Treatment** within 48 hours of onset.
- The insured has not been advised by a medical professional to seek **Treatment** or adjust medication in the 24 months prior to departure.

This benefit does extend to gradually worsening conditions, but does not extend to routine medical care, or conditions requiring ongoing **Treatment**. Any claims related to **Pre-Existing Conditions** must be assessed based on medical records and insurer discretion.

If **You** suffer from any form of heart disease or chronic lung disease**, You** are required to carry a copy of **Your** relevant medical records with **You** while traveling.

Failure to comply with these obligations may result in a denial or reduction of cover for any claims arising from or relating to such **Pre-Existing Conditions**.

2. IMPORTANT INFORMATION

ASSISTANCE

Customer Service:

For customer service, eligibility verification, or plan information, contact:

Dash MGA
230 SUNRISE AVE SUITE B – 247
PALM BEACH, FL 33480
Email: support@dashmga.com

CLAIMS

If **You** wish to make a claim under this **Policy**, please contact the **Claims Administrator**:

Claimsorted
169 Madison Ave
New York, NY, 10016, US
Email: Claims@claimsorted.com

A claim form may also be found at: www.dashmga.com/claims or https://dashmga.com/members/

There are certain Claims Conditions which **You** must comply with, please refer to the Claims

Conditions.

MEDICAL EMERGENCY ASSISTANCE

Medical Emergency assistance is available 24 hours a day, 365 days a year to assist **You** where possible with any **Medical Emergency** or **Emergency Medical Evacuation** covered under this **Policy**.

This service is provided by the **Claims Administrator**, who will liaise with **Your Doctor** in arranging **Your** admission to **Hospital**, emergency ambulance transfers and air evacuations where this is **Medically Necessary**.

Claimsorted is available 24-hours a day, 7 days a week, 365 days of the year:

International: +16465354908

WhatsApp / US: +16465354908

Email: help@claimsorted.com

You will need to provide the following information:

- Name of **Insured Person**;
- **Policy** number;
- Contact telephone number, fax number and/or e-mail;
- Location of **Insured Person**; and
- A description of the **Medical Emergency**.

CANCELLATION

Your Cancellation Rights:

You are entitled to cancel your policy anytime before the **policy effective date.** Upon such cancellation, **You** shall be entitled to a full refund of the **Premium** paid, and neither the **Company** nor **You** shall have any further rights, liabilities, or obligations under this **Policy**.

For cancellation of this **Policy**, please contact the **Plan Administrator**:

Email: operations@dashmga.com

Chat: https://dashmga.com/contact-us

Member Portal: https://dashmga.com/members/

Our Cancellation Rights

For **Our** cancellation rights, please refer to the General Conditions.

COMPLAINTS

If **You** wish to make a complaint regarding this **Policy**, please follow the procedure explained in the section for Making a Complaint.

DATA PROTECTION

For **Our** privacy notice, please refer to the section for Data Protection.

EXCLUSIONS AND CONDITIONS

This **Policy** contains certain Exclusions, General Conditions and Claims Conditions. Please refer to these sections for more details.

HOME COUNTRY

There is no cover within **Your Home Country**.

LAW AND JURISDICTION

This insurance contract, as evidenced by the **Master Policy** and **Certificate of Insurance**, is deemed issued and concluded in Anguilla. All disputes shall be subject to the exclusive jurisdiction of the courts of Anguilla, to which **You** expressly consent. This **Policy** is governed by the laws of Anguilla, and no part of the coverage shall be deemed to be located in any other jurisdiction.

BENEFIT LIMITS

Most sections of this **Policy** have limits on the maximum amount **We** will pay. Please refer to the Schedule of Benefits.

PRE-AUTHORIZATION

For certain benefits under this **Policy**, **You** must obtain **Pre-authorization** from the **Claims Administrator** before incurring any costs, and follow the procedure outlined in the **Claims Conditions**. This requirement applies, without limitation, to:

- **Hospital** admissions abroad as an **In-Patient** or **Out-Patient**;
- Specific **Treatments**, services, or medical supplies.

Please refer to the **Claims Conditions** for full **Pre-authorization** details.

Failure to obtain required **Pre-authorization** may result in denial of coverage or a reduced payment of **Your** claim.

SPORTS AND OTHER LEISURE ACTIVITIES

You may not be covered for **Injuries** sustained while participating in certain sports or activities that carry a heightened risk of harm. Please refer to the Exclusions section for full details.

VISA REQUIREMENTS

When required, **You** must have the appropriate visa in order to enter **Your Host Country**. Failure to obtain a valid visa(s) may result in **You** being denied entry into **Your Host Country** and invalidate **Your Policy**.

WHO IS COVERED

This **Policy** only covers **Insured Persons**, **Spouses**, and **Dependent** children who, at the **Effective Date**, are:

- Aged 10 days of age or over;
- Under 99 years of age;
- A person who has legally entered the **Host Country**; and

Coverage under this **Policy** is excess to any other valid and collectible insurance or benefit available through third parties. If **We** determine that any eligible benefits payable under this **Policy** are also covered under another plan, **We** will only pay the amount in excess of what is payable under such other plan and may seek to recover any expenses from that plan to the extent of **Your** eligibility for reimbursement.

3. DEFINITIONS

Certain words and phrases used in this **Policy** are defined below. Other words and phrases may be defined elsewhere in this **Policy**, including where they are first used.

Accident: An Unexpected occurrence directly caused by external, visible means and resulting in physical Injury to the Insured

Person during the period of cover. Accidents caused by a medical condition or pre-existing condition may be covered by those benefits.

Acute Onset of Pre-Existing Condition: A sudden and **Unexpected** outbreak or recurrence of a **Pre-Existing Condition** which occurs 1) spontaneously and without advance warning either in the form of a **Doctor's** recommendation or symptoms, is of short duration, is rapidly progressive, and requires urgent medical care; and 2) after the **Effective Date**. **Treatment** must be obtained within 24 hours of the sudden and **Unexpected** outbreak or recurrence.

Application: Means the form or set of forms completed and submitted by the applicant (or their authorized representative) to request insurance coverage under this plan. The **Application** includes all required personal, medical, and travel information as required by the insurer. The information provided in the **Application** forms the basis for the issuance of the insurance **Policy**, and any misrepresentation or omission will result in denial of claim and void coverage.

Child; Children: An **Insured Person** who at the **Effective Date** is at least ten (10) days old but less than eighteen (18) years of age.

Claim Administrator: Claimsorted; the entity responsible for managing and processing insurance claims on behalf of the insurer. This includes reviewing claim submissions, verifying documentation, determining coverage and eligibility, and coordinating payment or settlement of claims. A **Claims Administrator** may be an internal department of the insurance **Company,** or an external third-party administrator (TPA) contracted to handle these functions.

Company: The **Company**, as referred to in the **Master Policy**, is Skybridge Risk SPC. This insurance and its risks are underwritten by the **Company** as the insurer and carrier, and the **Company** is solely obligated and liable for the coverage and benefits provided by this insurance.

Co-pay: The amount the **Insured Person** is responsible for paying for each urgent care or walk-in clinic visit as specified in the Schedule of Benefits. This amount applies per eligible visit, irrespective of whether the **Deductible** has been met and does not count towards satisfying the **Deductible** amount. There is no **Deductible** requirement for urgent-care co-pay and benefits are paid as per the schedule.

Dangerous Occupations: Jobs or professions that expose the **Insured Person** to a higher risk of **Injury**, **Illness**, or death due to hazardous working conditions or activities. In the context of this **Policy**, **Dangerous Occupations** include, but are not limited to, roles involving work at significant heights, underground, with explosives, hazardous materials, heavy machinery, or in emergency services.

Declaration of Insurance: The **Declaration of Insurance** details the **Insured Person's** identity, **Policy** effective dates, chosen plan, maximum benefit limits, and deductibles. It forms part of the contract as described in the full **Policy** wording.

Deductible: The dollar amount of **Eligible Charges** that must be incurred as an out-of-pocket expense by each **Insured Person** per each **Accident** or **Illness** before benefit is paid on an expense incurred basis under the **Policy**.

Dependent: An **Insured Person's** lawful **Spouse** or an unmarried **child**, from age 14 days to age 18, who is chiefly dependent on the **Insured Person** for support. A **child**, for eligibility purposes, includes the **Insured Person's** natural **child**; adopted **child**, beginning with any waiting period pending finalization of the **child's** adoption; or a stepchild who resides with the **Insured Person** or depends on the **Insured Person** for financial support.

Doctor: A person who is a licensed practitioner of medical, surgical, or dental services, acting within the scope of their license in the jurisdiction where the services are rendered. The **Doctor** must not be the **Insured Person**, an **Immediate Family Member**, or anyone traveling with the **Insured Person**. The term excludes chiropractors, naturopaths, acupuncturists, or any person who is not licensed as a medical **Doctor** (M.D.), **Doctor** of osteopathy (D.O.), or equivalent recognized medical professional authorized by the competent authority to provide medical treatment or services for which benefits are payable under this policy.

Effective Date; Effective Date of Coverage: The date of coverage for the **Insured Person** begins under the **Terms** of the **Master Policy** as evidenced by the **Certificate of Insurance**.

Eligible Charges: Means the **Usual, Reasonable, and Customary Charges** for costs, and expenses incurred by **You** during the **Period of Coverage** for **Treatment,** services or medical supplies which are **Medically Necessary,** and which are covered by the **Policy**, as outlined in the Schedule of Benefits.

Emergency Medical Evacuation: **Emergency** transportation from the **Hospital** or medical facility where the **Insured Person** is located to a non-local **Hospital** or medical facility, recommended by the attending **Physician** who certifies, to a reasonable medical certainty, that the **Insured Person** has experienced:

- a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the **Insured Person**'s life or limb in danger if medical attention is not provided within twenty-four (24) hours;
- and where **Medically Necessary Treatment** cannot be provided locally, either in the facility of the attending **Physician** or another local facility.

Endorsements: Any amendments to an existing, bound **Policy** including but not limited to exclusions, additions, and modifications.

EST: United States Eastern Standard Time.

Home Country: A country from which the **Insured Person** holds a passport. If the **Insured Person** holds passports from more than one country, their **Home Country** will be the country that they have declared to Us in writing as their **Home Country** on the insurance application. **Home Country** also includes the **Insured Person's** country of permanent assignment or country of permanent residence.

Hospital: An institution which operates as a **Hospital** pursuant to law and is licensed in the state or country in which it operates. It must operate primarily for the treatment of sick or injured persons as inpatients and provide nursing services by **Registered Nurses** on duty or on call. It must have **Doctors** available at all times and provide organized facilities and equipment for diagnosis and treatment of acute medical conditions on its premises. It must not primarily be a long-term care facility, rehabilitation or extended care facility, nor a nursing, rest or convalescent home or place for the aged, drug addicts or abusers, alcoholics or similar establishment.

Host Country: The country or countries other than the **Home Country** that the **Insured Person** is traveling to or within.

Illness: A sickness, disorder, abnormality, malady, morbidity, affliction, disability, defect, handicap, deformity, birth defect, congenital defect, symptomatology, syndrome, malaise, infection, infirmity, ailment, disease of any kind, or any other medical, physical or health condition. Provided, however, that **Illness** does not include **Mental Health Disorders**. All **Illnesses** that exist simultaneously or which arise subsequent to a prior **Illness,** and which directly or indirectly relate to or result or arise from the same or related causes or as a consequence thereof or from one another are considered to be one Illness and covered to one maximum limit, include pre-existing conditions and their complications.

Immediate Family Member: **Your Spouse**, **Child**, brother, sister, parent, grandparent, or in-law.

Implant: Any device, object, or medical item that is surgically imbedded, inserted, or installed for medical purposes within or on a patient's body, including for orthotic or prosthetic reasons.

Injury: Accidental bodily harm sustained by an **Insured Person** that results directly and independently from all other causes from an **Accident**. All **Injuries** resulting or arising from the same **Accident** shall be deemed to be one **Injury**.

Inpatient: A person who has been admitted to and charged by a **Hospital** for bed occupancy for purposes of receiving **Inpatient Hospital** services. Generally, a patient is considered an **Inpatient** if billed by the **Hospital** for Charges as an **Inpatient** and formally admitted as an **Inpatient** with the expectation he will occupy a bed and (1) remain at least overnight or (2) is expected to need **Hospital** care for twenty-four (24) hours or more.

Insured Person: The person named as the **Insured Person** on the **Declaration of Insurance**, which along with the **Insured Person's Family** shall be beneficiaries under and to the **Master Policy**.

Intensive Care Unit: A cardiac care unit or other unit or area of a **Hospital** that meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations for Special Care Units or local equivalent.

Investigational: **Treatment** that includes drugs not yet released for distribution by the United States Food and Drug Administration and/or procedures or services which are still in the clinical stages of evaluation.

Local Ambulance Transport; Local Ambulance Expense: Transportation and accompanying **Treatment** provided by designated, licensed, qualified, professional **Emergency** personnel from the location of an **Accident** or acute **Illness** to a **Hospital** or other appropriate health care facility. **Local Ambulance Transport** does not include subsequent inter-facility transfers of admitted

patients.

Master Policy: The applicable **Master Policy** for the insurance **Policy** issued by the **Company** to the **Master Policyholder**, and under which insurance coverage and benefits are provided by the **Company** to the **Master Policyholder** and any such beneficiaries under the **Master Policy**, being the **Insured Person**, subject to the Terms thereof, and as outlined and evidenced by the **Policy** wording and subject to the Terms hereof. The **Company**, as insurance carrier and underwriter of the **Master Policy**, is solely liable and responsible for the coverage and benefits provided thereunder.

Master Policyholder: The applicable **Master Policy** for the insurance **Policy** issued by the **Company** is Dash MGA, LLC to whom the **Company** has issued to the **Master Policy**. The **Master Policyholder** is the only party which can make or request changes to the **Master Policy** and with whom the **Company** has contracted on the provision of insurance under the **Master Policy**. All **Insured Persons** shall hold a beneficial interest to the extent of their **Policy** in the **Master Policy**, but are not contractual parties to such insurance.

Maximum Limit: The cumulative total dollar amount of benefit payments and/or reimbursements available to an **Insured Person** under this insurance. When the **Maximum Limit** is reached, no further benefits, reimbursements, or payments will be available under this insurance. The **Maximum Limit** is paid on a once-per-sickness basis.

Medically Necessary; Medical Necessity: A **Treatment**, service, medicine or supply which is necessary and appropriate for the diagnosis or **Treatment** of an **Illness** or **Injury** based on generally accepted standards of current medical practice as determined by the **Company**. By way of example but not limitation, a service, **Treatment**, medicine or supply will not be considered **Medically Necessary** or a **Medical Necessity** if it is provided or obtained only as a convenience to the **Insured Person** or his/her provider; and/or if it is not necessary or appropriate for the **Insured Person**'s **Treatment**, diagnosis or symptoms; and/or if it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or **Treatment**.

Mental or Nervous Disorders: Any mental, nervous, or emotional **Illness** which generally denotes an **Illness** of the brain with predominant behavioral symptoms; or an **Illness** of the mind or personality, evidenced by abnormal behavior; or an **Illness** or disorder of conduct evidenced by socially deviant behavior. **Mental or Nervous Disorders** include without limitation: psychosis; depression; schizophrenia; bipolar affective disorder; learning disabilities and attitudinal or disciplinary problems; any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases as published by the U.S. Department of Health and Human Services; and those psychiatric and other mental **Illness**es listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders published by the American Psychiatric Association. For purposes of this insurance, **Mental or Nervous Disorder** does include **Substance Abuse**.

Mortal Remains: The physical body of the **Insured Person** after death. In the context of this **Policy**, **Mortal Remains** refers to the bodily remains of the **Insured Person**.

Natural Disaster: Widespread disruption of human lives by disasters such as flood, drought, tidal wave, fire, hurricane, earthquake, windstorm, or other storm, landslide, or other natural catastrophe or event resulting in migration of the human population for its safety. The occurrence must be a disaster that is due entirely to the forces of nature and could not reasonably have been prevented.

Newborn: An infant from the moment of birth through the first thirty-one (31) days of life.

Non-Elective Treatment: Medically necessary treatment or procedures required due to an unexpected illness or injury that cannot be safely delayed without risking serious harm to the **Insured Person's** health. **Non-Elective Treatment** excludes elective or planned procedures and is covered only when urgent or **Emergency** care is needed.

Outpatient: A person who receives **Medically Necessary Treatment** by a **Physician** or other healthcare provider and is not an **Inpatient**, regardless of the hour that the person arrived at the **Hospital**, whether a bed was used, or whether the person remained in the **Hospital** past midnight.

Period of Coverage: The period beginning on the **Effective Date of Coverage** of this **Declaration of Insurance** and ending on the earliest of the following dates: (a) the termination date specified in the **Declaration of Insurance**; or (b) the termination date as requested by **Covered Person**. The **Period of Coverage** can be no more than the number of days shown in the Schedule of Benefits.

Physician: A practitioner who holds a degree in **Doctor** of Medicine or its equivalent and who holds a valid, unlimited license to practice medicine. Commissioned medical officers, and individuals licensed and legally authorized to provide health care or professional services including a: (a) psychologist; (b) psychiatrist; (c) dentist; (d) registered or licensed practical nurse; (e) certified nurse midwife or a certified direct entry midwife; (g) optometrist; (h) podiatrist; or (i) chiropractor may be considered a **Physician**. A **Physician** must be currently and appropriately licensed by the state or country in which the services are provided, and the services must be within the scope of that license, training, experience, competence, and health professions standards of practice. A person who is not authorized or able to prescribe controlled substances, drugs, medicine, or **Treatment** by the jurisdiction in which the person is acting in the usual course of professional practice; unfit to practice; and/or violates any statute, rule, regulation regulating the profession, or engages in the unlawful or unauthorized practice of medicine or osteopathic medicine is not a **Physician**.

Plan Administrator: The entity or organization appointed by the **Company** to administer the **Policy**, including but not limited to managing enrollment, coordinating benefits, processing claims, and providing assistance to **Insured Persons**. The **Plan Administrator** acts on behalf of the **Company** in all matters relating to the administration of the plan, and may be contacted for questions regarding coverage, claims, or plan benefits.

Policy: The terms on which the **Insured Person** shall receive benefits and the terms governing such, including the **Application**, **Declarations of Insurance**, **Policy** wording, schedules, **Endorsements**, **Riders**, and any attached documents issued by the **Plan Administrator**. The **Policy** specifies the extent to which your beneficial interest in the **Master Policy** is granted, including the scope of coverage, effective and expiration dates, covered benefits, exclusions, and the rights and responsibilities of both the **Company** and the **Insured Person**. The **Policy** is the definitive source for determining what is and is not covered under the plan and is relied upon for all claims and administrative decisions.

Pre-authorization: **Pre-authorization** means the process of obtaining prior approval from the **Claims Administrator** before receiving specific medical services, **Treatments**, or procedures while traveling outside **Your Home Country**. This requirement generally applies to significant or high-cost medical events, including planned **Hospitalizations**, surgeries, or advanced diagnostic tests such as MRI and CAT scans, necessitated by **Unexpected Illness** or **Injury**. The purpose of **Pre-authorization** is to verify that the proposed service is **Medically Necessary**, covered under the **Policy Terms**, and cost-effective, enabling the **Claims Administrator** to evaluate the **Treatment** plan, assist with care coordination, and negotiate rates with healthcare providers. **Pre-authorization** is not required for **Emergency Hospitalizations**; however, the insurance provider must be notified within a reasonable timeframe following such events. Failure to obtain **Pre-authorization** for services requiring it may result in financial penalties or denial of claims. **Pre- authorization** does not guarantee payment or claim reimbursement, as claims remain subject to review based on **Policy Terms** and **Medical Necessity**.

Pre-existing Condition: An **Illness**, **Injury**, **Mental Health Disorder** or other condition the **Insured Person** that with reasonable medical certainty within 12 months prior to the Effective Date of the Policy. **You** have exhibited symptoms that would have caused a prudent person to seek diagnosis, care, **Treatment**; advice, or **Treatment**; or 2) required taking prescribed drugs or medicines, will also be considered to be a **Pre-existing Condition**

Pregnancy; Pregnant: The process of growth and development within a woman's reproductive organs of a new individual from the time of conception through the phases where the embryo grows and the fetus develops to birth.

Premium: The payments required to effectuate and maintain the **Insured Person's** insurance coverage and benefits under this **Policy**, in the amounts and at the times ("Due Dates") established by the **Company** in its sole discretion from time to time.

Professional Athletics: A sport activity, including practice, preparation, and actual sporting events, for any individual or organized team that is a member of a recognized professional sports organization, is directly supported or sponsored by a professional team or professional sports organization, is a member of a playing league that is directly supported or sponsored by a professional team or professional sports organization; or has any athlete receiving for his or her participation any kind of payment or compensation, directly or indirectly, from a professional team or professional sports organization.

Registered Nurse: A professional nurse (R.N.) who is duly licensed and registered to practice nursing by the appropriate governmental authority in the jurisdiction where the services are provided. The **Registered Nurse** must not be an **Insured Person's Immediate Family Member**.

Relative: A parent, legal guardian, **Spouse**, son, daughter, or **Immediate Family Member** of the **Insured Person**.

Rider: Any exhibit, schedule, attachment, amendment, **Endorsement**, or other document attached to, issued in connection with, or otherwise expressly made a part of or applicable to, the **Master Policy**, this **Declaration of Insurance**, or the **Application**, as the case may be.

Routine Physical Exam: Examination of the physical body by a **Doctor** for preventative or informative purposes only, and not for the **Treatment** of any previously manifested, symptomatic, diagnosed or known **Illness** or **Injury**.

Self-inflicted: Action or inaction by the **Insured Person** that the **Insured Person** consciously understands will or may cause or contribute, directly or indirectly, to his or her personal **Injury** or **Illness**. **Self-inflicted** specifically includes failure of an **Insured Person** to follow his or her **Doctor's** orders, complete prescriptions as directed or follow any health care protocol or procedures designed to return or maintain his or her health.

Serious Illness: A medical condition or disease that is of such severity that it significantly impairs the **Insured Person's** health, daily functioning, or life expectancy, and typically requires urgent medical intervention. A **Serious Illness** generally includes, but is not limited to, conditions such as cancer, heart attack, stroke, major organ failure, or other life-threatening diseases as specified in the **Policy**. Diagnosis and eligibility for benefits must be confirmed by a **Doctor** or **Specialist**.

Specialist: Means a registered **Doctor** or medical practitioner, skilled in a generally accepted medical or surgical specialty or subspecialty, who currently holds a substantive consultant appointment in that specialty, which is recognised as such by the statutory bodies of the relevant country.

Spouse: An **Insured Person**'s legal **Spouse** or domestic partner. Such a relationship must have met all requirements of a valid marriage contract, domestic partnership, or civil union in the state where the parties' ceremony was performed.

Substance Abuse: Alcohol, drug or chemical abuse, misuse, illegal use, overuse or dependency.

Surgery or Surgical Procedure: An invasive diagnostic or **Surgical Procedure**; or the **Treatment** of **Illness** or **Injury** by manual or instrumental operations performed by a **Physician** while the patient is under general or local anesthesia.

Terms: **Terms**, provisions, conditions, definitions, **Deductibles**, limits, sub-limits, limitations, wordings, restrictions, requirements, qualifications and/or exclusions.

Terrorism: Criminal acts, including against civilians, committed with the intent to cause death or serious bodily **Injury**, or taking of hostages, with the purpose to provide a state of terror in the general public or in a group of persons or particular persons, intimidate a population, or compel a government of international organization to do or to abstain from doing an act.

Travel Warning: Published statement or web-site document issued by the United States Department of State, Bureau of Consular Affairs, Centers for Disease Control and Prevention, United Nations, World Health Organization, or similar government or non-governmental agency of the **Insured Person**'s **Home Country**, warning that travel to specific identified countries, regions, or locations is hazardous and is not advised.

Treated; Treatment: Any and all undertakings, services and/or procedures rendered or employed with respect to the management and/or care of an **Insured Person** for the purpose of identifying, testing for, analyzing, diagnosing, treating, curing, resolving, preventing, monitoring, attending to, caring for, controlling and/or combating any **Illness** or Injury or the symptoms or manifestations thereof, including without limitation: verbal or written advice, consultation, examination, discussion, diagnostic or laboratory testing or evaluation of any kind, pharmacotherapy or other medication, and/or **Surgery**.

Trip: Travel by air, land, or sea from the **Insured Person's Home Country**. It includes the period from the start of the **Trip** until its end provided the **Insured Person** is covered under the policy.

Unbundled Services: Means services and procedures separated for the purposes of billing that would ordinarily not be billed separately when performed by the same provider on the same patient on the same day.

Unexpected: Sudden, unintentional, and unforeseen.

Usual, Reasonable, and Customary Charges: URC Charges are the amounts generally billed in the geographic area for comparable services, medications, or supplies. To determine URC, the Company may review provider charges, prevailing rates from similar providers, reimbursement data from other payors, regional and national benchmarks, provider skill and resource requirements, time and complexity of the service, the severity of the condition treated, and any other information the

Company reasonably considers relevant.

We, Our, Us: means the insurance **Company** underwriting this insurance or its authorized agent.

You, Your, Yours: means the **Insured Person**.

4. SCHEDULE OF BENEFITS

Subject to the **Terms** of this **Policy** as shown in the **Declaration of Insurance**, the following **Policy** options are available to the **Insured Person** while outside his/her **Home Country** and offer the following benefits and coverage arising out of **Injury** or **Illness** incurred while in the **Host Country**. All benefits offered under this **Policy** require **Pre-authorization** from the **Claims Administrator**.

MEDICAL EXPENSE BENEFITS Paid after United Healthcare Repricing (between 40-90%)			
Total Annual Maximum for all Accident or Illness Expense Benefits	$100,000 (Age 0-99)	$150,000 (Age 0-69)	$250,000 (Age 0-69)
Accident & Illness Deductible	$100, $250, $500, $1,000, $2,500, $5,000		
Pre-Existing Maximum for Worsening Conditions and Acute Onset	$50,000	$75,000	$125,000
Pre-Existing Deductible	$750, $2,500		
Inpatient Benefits			
Room & Board Charges:	$1,800 per day up to 20 days	$2,000 per day up to 20 days	$1,800 per day up to 20 days
ICU Room & Board Charges:	$2,500 per day up to 7 days	$2,600 per day up to 7 days	$2,500 per day up to 7 days
Doctor Surgical Expenses:	Up to $5,000	Up to $6,000	Up to $5,000
Anaesthetics:	Up to $1,300	Up to $1,400	Up to $1,300
Assistant Surgeon	Up to $1,300	Up to $1,400	Up to $1,300
Doctor Non-Surgical Treatment, Examination, and Specialist Expenses	$110 per visit, 1 visit per day	$130 per visit, 1 visit per day	$110 per visit, 1 visit per day
Consultation visitors when requested by a doctor	Up to $450	Up to $500	Up to $450
Pre-admission tests within 14 days before Hospital Admission:	Up to $1,100	Up to $1,200	Up to $1,100
Admission:	Up to $1,100	Up to $1,200	Up to $1,100
Outpatient Benefits			
Surgical Room and Supply Expenses:	$1,800 per day up to 20 days	$2,000 per day up to 20 days	$1,800 per day up to 20 days
Doctor Surgical Expenses:	Up to $5,000	Up to $6,000	Up to $7,000
Anesthetics:	Up to $1,300	Up to $1,400	Up to $1,300
Assistant Surgeon Expenses:	Up to $1,300	Up to $1,400	Up to $1,300
Doctor Non-Surgical Treatment/Examination Expenses:	$110 per visit, 1 visit per day	$130 per visit, 1 visit per day	$170 per visit, 1 visit per day
X-rays, laboratory procedures:	Up to $650	Up to $750	Up to $1,000
CAT Scan, PET Scan or MRI:	Up to $1,300	Up to $1,800	Up to $2,000
Hospital Emergency Room:	Up to $500	Up to $1,000	Up to $2,000
Prescription Drug Expenses:	Up to $150	Up to $150	Up to $300
Ambulance Expenses:	Up to $450	Up to $700	Up to $450
Rehabilitative braces or appliances:	Up to $1,100	Up to $1,500	Up to $1,100
Dental Treatment (Injury Only):	Up to $500	Up to $550	Up to $500
Physical and Occupational Therapy: Inpatient and Outpatient	Up to $50 per visit 1 visit per day 10 visits maximum	Up to $60 per visit 1 visit per day 10 visits maximum	Up to $50 per visit 1 visit per day 10 visits maximum

The following benefits are not subject to a **Deductible** but cannot exceed the Maximum Limit. The benefits offered under the **Policy**

shown in the **Declaration of Insurance** shall be as follows:

ADDITIONAL BENEFITS SCHEDULE

Maximum Limits per Period of Coverage per Insured Person	
Benefits	**Limits**
Trip Interruption	Economy Ticket up to $1,000 Due to death/**Illness** of **Immediate Family** or disaster at home.
Emergency Medical Evacuation	Up to $15,000 Must be approved in advance and coordinated by the **Claims Administrator**.
Repatriation of Mortal Remains	$12,500 Maximum Limit for return of the Insured Person's Mortal Remains or ashes to Country of Residence or $1,500 Maximum Limit per Insured Person for preparation, local burial or cremation of the Insured Person's Mortal Remains at the place of death. Must be approved in advance and coordinated by the Claims
Accidental Death Principal Sum	$20,500 per Insured

5. YOUR BENEFITS

A. MEDICAL

The **Effective Date of Coverage** under the Medical Benefits section is the date specified in the **Declaration of Insurance**.

We will reimburse **Eligible Charges** for **Medically Necessary, Non-Elective Treatment** in connection with the medical expenses outlined below, provided they relate to an eligible medical condition suffered or sustained by the **Insured Person** during the **Period of Coverage**.

1) Hospital Room and Board

What is covered

1) **We** will reimburse **Eligible Charges** for **Hospital** accommodation, meals, and nursing

care. What is not covered

2) **We** will not reimburse charges for **Unbundled Services** or personal items, including but not limited to telephone calls, newspapers, or guest meals.

2) Medical Expenses

What is covered

a. **Treatment**, services, medical supplies, and **Usual, Reasonable and Customary Charges** rendered by **Doctor**, **Specialist**, Consultants, Surgeons, Anesthetists, or Nurses.

   i. If an **Injury** or **Illness** requires multiple **Surgical Procedures** performed through a single incision, **We** will pay only one benefit—corresponding to the procedure with the highest eligible cost.

   ii. If multiple **Surgical Procedures** are performed during the same operative session through separate incisions, **We** will reimburse the full **Eligible Charges** for the costliest procedure and 50% of the **Eligible Charges** for each additional procedure, as set out in the Schedule of Benefits

b. Charges incurred for (see benefits schedule for full list):

   i. Ambulance service to or from a **Hospital**;

   ii. **Outpatient** diagnostic X-rays, laboratory procedures and tests

   iii. Laboratory tests

   iv. Radiological procedures

   v. Anesthetics and their administration

   vi. Blood, blood products, artificial blood products, and the transfusion thereof

   vii. Rental of mechanical equipment for **Treatment** of respiratory paralysis

   viii. Pre-admission testing

   ix. **Outpatient** injections when administered in a **Doctor's** office

   x. Consultation visits

c. Expenses include **Treatment** and office visits connected with such **Treatment** when prescribed or performed by a **Doctor**, including:

i. Medicines or drugs administered by a **Doctor** or that can be obtained only with a **Doctor's** written prescription

ii. Dental charges for **Injury** to sound, natural teeth

B. ADDITIONAL BENEFITS

1) Trip Interruption

Benefits will be paid, up to the amount shown in the Schedule of Benefits, for the cost of expenses related to the return travel to your **Home Country** which must be organized by the **Claims Administrator**.

Trip Interruption must be due to an **Accident** or **Illness** to **You**, or the death of an **Immediate Family Member** while **You** are on **Your Trip**.

2) Emergency Medical Evacuation

We will pay **Emergency Medical Evacuation** benefits up to the **Maximum Limit** shown in the Benefits Schedule for **Eligible Charges** related to **Your** medical evacuation if:

- **You** experience a **Medical Emergency** during **Your Trip**;
- **You** require **Emergency Medical Evacuation**; and
- **You** are traveling on a covered **Trip**.

a. Covered Evacuation Expenses Include**:**

i. Medical Transport: expenses for transportation under medical supervision **Treatment** to the nearest **Hospital** or **Treatment** facility for **Medically Necessary Treatment** where **You** will receive **Treatment** in the event of **Your Medical Emergency** and upon request of the **Doctor** designated by the **Claims Administrator** in consultation with the local attending **Doctor**.

ii. Dispatch of a **Doctor** or **Specialist**: Travel expenses and on-site medical services for a **Doctor** or **Specialist**, if, based on the information available, **Your** condition cannot be adequately assessed to evaluate the need for transport or evacuation and a **Doctor** is dispatched by the **Claims Administrator** to **Your** location to make the assessment.

iii. Return of **Dependent Child(ren)**: expenses to return each **Dependent Child** under age 18 to their principal residence if (a) **You** are 18 or older, (b) **You** are the only person traveling with the **Child**(ren), and (c) **You** suffer a **Medical Emergency** requiring **Hospital** confinement.

iv. Escort Services: expenses for an **Immediate Family Member** or companion traveling with **You** to join **You** during Your **Emergency Medical Evacuation** to a different **Hospital**, **Treatment** facility.

b. **Conditions for Payment of Benefits:**

Benefits for these **Eligible Charges** will only be paid if:

i. The **Doctor** ordering the **Emergency Medical Evacuation** certifies that the severity of **Your Medical Emergency** necessitates it;

ii. All transportation arrangements for the **Emergency Medical Evacuation** are made using the most direct and cost-effective route and conveyance possible;

iii. The charges are **Medically Necessary** and do not exceed typical costs for similar transportation, **Treatment**, services, or supplies in the area where the

expense is incurred.

iv. Covered Evacuation Expenses do not include charges that would not have been made if there were no insurance.

c. **Authorization Requirements**

Benefits will not be paid unless **You** have received **Pre-authorization** of all expenses in advance through written, electronic, or telephonic **Pre-authorization**, and the services are provided by the **Claims Administrator**. If **You** refuse a recommended Medical Evacuation, **We** will not be responsible for any medical expenses incurred after the date of the recommendation.

3) Repatriation of Mortal Remains

In the unfortunate event of the **Insured Person's** death while traveling, the **Claims Administrator** will arrange and cover the costs, up to the limit specified in the selected plan, for the repatriation of remains to the **Insured Person's** country of origin. This includes providing a provisional casket suitable for international transport and handling necessary documentation. Costs related to transportation or cremation within the country of residence, funeral home expenses, or any casket other than the one used for repatriation are explicitly excluded.

If the beneficiary opts for cremation instead of repatriation of remains, the **Claims Administrator** will cover the **Usual, Reasonable, and Customary Charges** of cremation performed locally in the **Host Country**, including the associated paperwork and legal documentation required by local authorities. This benefit is available up to the **Maximum Limit** stated in the Schedule of Benefits for preparation, local burial, or cremation.

Cremation is provided in lieu of repatriation, and no additional benefit will be paid for transporting ashes unless explicitly stated elsewhere in this **Policy**.

The **Claims Administrator** will not provide services or reimburse any expenses under this benefit if the death results from suicide, alcohol or drug consumption. In addition, this benefit does not cover any transportation or return expenses for accompanying **Immediate Family Member**, nor does it include ceremonial, memorial, or funeral-related costs beyond those directly associated with the cremation procedure itself.

4) Accidental Death and Dismemberment Benefits

This benefit applies to **Insured Persons** up to the age of 69 whose death is caused by a sudden, **Unexpected**, and unintended event, resulting from a bodily **Injury**. This means the death must be the direct result of an **Accident**, not from a **Pre-Existing Condition**. The payment of the insured sum will be made to the **Insured Person's** legal heirs once the corresponding legal documentation of their country of origin has been presented.

6. EXCLUSIONS

These set out the Exclusions to cover under this **Policy**. The following Exclusions apply to the whole of this **Policy**.

1. **We** will not pay any claim under this **Policy** which would result in **Us** being exposed to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.
2. **We** will not provide cover for any benefits for any loss or Injury that is caused by or results from:
   a. Intentionally **Self-inflicted Injury**; suicide or attempted suicide.
   b. War/Extreme Acts of Violence:

i. War, or any act or war (whether declared or not), invasion, act of foreign enemy

hostilities, warlike operations, civil war;

ii. Mutiny, riot, strike, military or popular uprising, insurrection, rebellion, revolution, military or usurped power, civil commotion;

iii. Attempted overthrow of government, any act directed towards overthrow of government or influencing any overthrow by violence; martial law or state of siege;

iv. Any use of or exposure to any radiological, chemical, nuclear or biological weapons or any other radiological, chemical, nuclear or biological events; or

v. Confiscation or nationalization; requisition or destruction of or damage to property by or under the order of any government or local authority.

vi. **Your** breaking or failing to comply with any law whatsoever.

vii. Any act of **Terrorism.** For the purpose of this **Endorsement** an act of **Terrorism** means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

viii. Commission of, or active participation in a riot, civil commotion assuming the proportions of or amounting to an uprising or an insurrection.

c. An **Accident** or **Illness** that occurs while **You** are on active-duty service in the military, naval or air force of any country or international organization. Upon receipt of proof of service, **We** will refund any **Premium** paid for this time.

d. Piloting or serving as a crewmember in any aircraft or watercraft.

e. Riding in any aircraft or watercraft except as a fare-paying passenger on a regularly scheduled or charter airline.

f. **Your** commission of, or attempt to commit, a felony.

g. Sickness, disease or **Mental Health Disorder**, bacterial or viral infection, or medical or surgical treatment thereof which results in the amputation of an extremity; coverage provided under dismemberment benefit

h. **You** being legally intoxicated as determined according to the laws of the jurisdiction in which the **Injury** occurred.

In addition, **We** will not pay Medical Expense Benefits for any loss, treatment, or services resulting from:

i. Routine physicals and care of any kind.

j. Routine dental care and treatment.

k. Cosmetic surgery, except for reconstructive surgery needed as the result of an **Injury** resulting from an **Accident**.

l. Eye refractions or eye examinations for the purpose of prescribing corrective lenses or for the fitting thereof; eyeglasses, contact lenses, and hearing aids.

m. Services, supplies, or treatment including any period of **Hospital** confinement which is not recommended, approved, and certified as **Medically Necessary** and reasonable by a **Doctor**, or expenses which are non-medical in nature.

n. Treatment or service provided by a private duty nurse.

o. Treatment by any **Immediate Family Member** or member of **Your** household.

p. Expenses incurred during travel for purposes of seeking medical care or treatment.

q. Expenses incurred for services provided by any government **Hospital** or agency, or government sponsored plan for which, and to the extent that, **You** are eligible for reimbursement.

r. Any treatment provided under any mandatory government program or facility set up for treatment without cost to any individual.

s. Custodial care.

t. Calculus of gallbladder and nephroscopy.

u. Services or expenses incurred in **Your Home Country**.

v. Elective treatment, exams or surgery; elective termination of pregnancy.

w. Expenses for services, treatment or surgery deemed to be experimental or which are not recognized and generally accepted medical practices in the United States or in the **Host Country**.

x. Expenses payable by any automobile insurance policy without regard to fault.

y. Organ or tissue transplants and related services.

z. Any expense paid or payable by any other valid and collectible group insurance plan.

aa. **Injury** or **Illness** for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation, whether United States federal or foreign law.

bb. Any **Illness** or **Injury** sustained while taking part in:

- i. **Dangerous Occupations**;
- ii. athletic or sporting activities engaged in by **You** solely for recreational, entertainment or fitness purposes;
- iii. **Amateur Athletics**, **Professional Athletics**, athletic activity that is sponsored or sanctioned by any collegiate sanctioning or **Governing Body**, or the International Olympic Committee;

cc. Adventure sports and activities:

- i. Abseiling;
- ii. BMX;
- iii. Bobsledding;
- iv. Bungee jumping;
- v. Canyoning;
- vi. Caving;
- vii. Hot air ballooning;
- viii. Jungle zip lining;
- ix. Parachuting;
- x. Paragliding;
- xi. Parascending;
- xii. Rappelling; and
- xiii. Sky diving.

dd. Extreme sports and activities:

i. Aviation piloting a commercial or non-commercial aircraft; or engaged in any lesson, practice session or training exercise during which the **Insured Person** is training to become a pilot or attempting to earn a license, permit, certification, and/or authorization to pilot commercial or non-commercial aircraft;

ii. BASE jumping;

iii. Big game hunting;

iv. Hang gliding;

v. Heli-skiing;

vi. Luge;

vii. Motocross (MOTO-X);

viii. Mountaineering above an elevation of 4500 meters; or mountaineering activities where specialized climbing equipment, ropes or guides are normally used by a prudent person but were not used;

ix. Racing of any kind, including but not limited to by horse, motor or other vehicle (of any type), or motorcycle;

x. Rodeo activities;

xi. Ski jumping;

xii. Snow skiing, snowboarding or snowmobiling where **You** are in violation of applicable laws, rules or regulations of a ski resort, out of bounds or in unmarked or unpatrolled areas; taking part in backcountry skiing; taking part in skiing off-piste;

xiii. Sub aqua pursuits below a depth of 50 meters; and

xiv. Trekking above an elevation of 4500 meters.

ee. Expenses incurred for services related to the diagnostic treatment of infertility or other problems related to the inability to conceive a **child**, including but not limited to, fertility testing and in-vitro fertilization.

ff. Orthopedic shoes or devices, or expenses incurred in connection with weak, strained or flat feet, corns, calluses or toenails.

gg. Expenses incurred for birth control including surgical procedures and devices.

hh. Expenses related to any rental or purchase of durable medical equipment.

ii. Birth defects and congenital anomalies, or complications which arise from such conditions.

jj. Sexually transmitted diseases or immune deficiency disorders and related conditions.

kk. Care or treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection, or any illness or disease arising from these medical conditions.

ll. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions, except to the extent otherwise provided in the **Policy**.

mm. **Mental Health Disorders**.

nn. Expenses incurred for any condition directly or indirectly related to or caused by cancer, dialysis, or on-going and preventive care.

oo. Alcohol and **Substance Abuse**.

pp. Expenses incurred for cataract surgeries, eye sickness or treatments.

qq. **Pre-existing Conditions**, unless otherwise provided in the **Policy**. If coverage is provided, it must be as a result of **Acute Onset of a Pre-existing Condition**.

rr. Any sickness which was known or unknown to the **Insured Person** which requires immediate medical attention within 2 days after the policy **Effective Date**.

ss. Exercise programs, whether or not prescribed by a **Doctor**.

tt. Failure to keep a scheduled appointment.

uu. Dialysis, Eye Sickness, or Cancer treatment

vv. Any treatment which is not **Medically Necessary**, or costs which are in excess of the **Usual, Reasonable and Customary** amounts.

ww. Epidemic and pandemic or other disease outbreaks when prior to the **Effective Date**, warning or Alert Level 3 or higher was issued by the US Center for Disease, Control and Prevention.

xx. Medical expenses related to complications or consequences of a treatment or condition not covered by this **Policy**.

If **We** determine the benefits paid under the **Policy** are eligible benefits under any benefit plan, **We** may seek to recover any expenses covered by another plan to the extent that **You** are eligible for reimbursement.

7. GENERAL CONDITIONS

These are the conditions of this **Policy** that **You** need to meet as **Your** part of the contract. If **You** do not meet these conditions, the **Policy** may be voided (treated as if it never existed), or may be cancelled, or may not provide full cover, or **Your** claim under the **Policy** may be rejected or not fully paid.

Please read the General Conditions carefully.

1) Acceptance

We have the right to refuse to accept an **Application** from any person who does not meet the eligibility criteria of the **Master Policy**.

2) Assignment, Change, Waiver

This **Policy** cannot be assigned, and any of the **Terms** of this **Policy** cannot be changed or waived, without **Our** prior written consent.

3) Our Right to Cancel

The **Company** reserves the right to cancel any and all coverage under this **Policy** under the following circumstances:

- The **Company** may elect to cancel coverage for all **Insured Person**s, provided the **Company** gives no less than seven (7) days advance written notice by mail to the **Insured Person**'s last known residence or mailing address of its intent to exercise such option.
- Termination of coverage will be effective at 12:01 AM **EST** on the date specified in the notice of cancellation or as otherwise determined pursuant to the **Policy** provisions, including but not limited to misrepresentation, fraudulent claims, or failure to meet eligibility requirements.
- Upon such cancellation, neither the **Company** nor the **Insured Person** shall have any further rights, liabilities, or obligations under this insurance for the affected coverage period, except as accrued prior to the termination date.

4) Eligibility for Insurance

This **Policy** is only available to **You** if **You** meet the requirements below:

a. Residential

We will provide cover for an **Insured Person** who is not a US citizen and their **Home Country Please Note**: If **You** no longer meet the eligibility requirements set forth in this section, then this
Policy will automatically terminate.

b. Age

You, Your Spouse and **Your Dependent Child** must be at least 10 days of age, and under 69 years of age at the **Effective Date**. Each person in the Class of Eligible Persons is eligible to be insured on the **Effective Date** of the **Policy**, or the day they become eligible, if later. **We** maintain the right to investigate whether eligibility requirements are met. If **We** discover the eligibility requirements are not met, no insurance will be provided for that person and **Our** only obligation is to issue pro-rata refund from the date ineligibility is discovered to the end of the policy period.

5) Entire Agreement

This **Policy,** together with the **Application**, the Schedule of Benefits, the **Policy** wording, the **Declaration of Insurance,** and any **Endorsements**, is the entire agreement between **You** and **Us** and must be read together.

6) Fraud

If **You** make a fraudulent claim under this **Policy**:

a. **We** are not liable to pay the claim;

b. **We** may recover from **You** any sums paid by **Us** to **You** in respect of the claim; and

c. **We** may, by notice in writing to **You**, treat this **Policy** as having been cancelled with effect from the time of the fraudulent act.

7) Changes in Law and Taxation

We shall have the right to change the **Terms** of this **Policy**, including the **Premium**, if at any time, there is a change to the law, regulatory requirements, tax or government levies.

8) Misrepresentation and Non-Disclosure

a. In deciding to accept the **Application** and to provide this **Policy**, **We** have relied on the information **You** have given **Us**. **You** must take care that all information provided to **Us** is complete and accurate.

b. If **We** establish that **You** deliberately or recklessly provided **Us** with false or misleading information, **We** will treat this **Policy** as if it never existed and not pay any claim.

c. If **We** establish that **You** carelessly provided **Us** with false or misleading information, **We** may:

   i. Treat this **Policy** as if it never existed and not pay any claim;

   ii. Amend the **Terms** of this **Policy** and apply these **Terms** as if they were already in place;

   iii. Reduce the amount **We** pay on a claim; or

   iv. Cancel this **Policy** in accordance with **Our** cancellation rights.

9) Premium Payment

a. **You** must pay the **Premium** before the **Effective Date**.

b. **We** will not provide any cover under this **Policy** unless **You** have paid the **Premium.**

10) Reasonable Care and Precautions

You shall take reasonable care and precautions:

a. To prevent any **Injury** or **Illness** which may be covered under this **Policy**; and

b. To minimise any potential claim under this **Policy**.

11) Pre-authorization; Pre-authorize

The **Claims Administrator** will determine **Medical Necessity** solely based on the completeness and accuracy of the information provided by the **Insured Person** and/or their **Doctors**, healthcare providers, guardians, **Relatives**, or representatives at that time. **Pre-authorsation** is not an approval, authorization, **Pre-authorization**, verification of coverage or benefits, nor a guarantee of payment to the facility.

12) Extension of Policy

a. **You** may request to extend your **Policy** beyond the initial coverage period, subject to the following **Terms.**

   i. **You** may request an extension for a total **Policy** period of a minimum 2 days and up to, but not exceeding, 364 days from the original **Policy** start date;

   ii. No single **Policy**, including all extensions, may be in effect for more than 364 days in total. After this period, coverage under this **Policy** cannot be further extended;

   iii. **We** have the right to refuse any request for an extension on any lawful basis;

   iv. If **We** agree to extend this **Policy**, subject to the **Terms** and conditions of the new **Policy:**

      1. Any extension is subject to **Your** continued eligibility under this **Policy**.

      2. **You** will take care to provide **Us** with complete and accurate answers to any questions **We** may ask, and **You** must tell **Us** about any changes which have occurred since this **Policy** started or since the last extension date.

      3. **We** will write to **You** with **Our** extension **Terms** and provide **You** with an extension **Premium** notice before the extension date.

      4. The extension **Premium** must be received by **Us** before the extension date.

      5. No extension is in effect until such time as **We** confirm that the extension has been accepted in writing by **Us**.

b. Once the maximum allowable coverage period of 364 days (including any extensions) has elapsed, this **Policy** may not be extended. You will not be eligible to obtain a new **Policy** for the same risks or coverages following the expiry of this **Policy**, regardless of the circumstances. This non-renewal condition will be strictly enforced through the purchase and extension process.

c. **You** may not extend this **Policy** if the **Period of Coverage** has lapsed or ended for any reason. However, **You** can apply for a new **Policy** by submitting a new **Application** which **We** will consider in the normal way.

13) Notice of Amendment

We reserve the right to make changes, additions, or deletions to this **Policy**, including any attached **Endorsements**, at any time during the **Period of Coverage**. Any such amendment will be communicated to **You** in writing, either by post to **Your** last known address or by email to an email address provided at the **Effective Date**.

You will be given at least 30 days' advance notice before any changes take effect. The notice will set out

the full details of the proposed changes, including the nature and scope of the amendment, the **Effective Date**, and a clear statement of **Your** right to cancel this **Policy** in accordance with **Your** statutory rights.

If **You** do not exercise **Your** right to cancel within the notice period, the changes will be deemed accepted and will take effect on the date specified in the notice.

14) Third Party Rights

The Contracts (Rights of Third Parties) Act 1999, or any subsequent amendment, shall not apply to this **Policy**. Only **You** and **Us** can enforce the **Terms** of this **Policy**. This **Policy** may be changed or cancelled without the consent of any third party.

15) Waiver

Any waiver by **Us** of any term or condition of this **Policy** will not prevent **Us** from relying on such term or condition in other instances.

16) Policy Structure

By purchasing coverage and benefits through this **Policy**, **You** acknowledge that you are purchasing a beneficial interest in the **Master Policy**. This **Policy** provides benefits and coverage through a beneficial interest in a contract of insurance (the **Master Policy**); it is not a contract of insurance itself, and as such, may not attract the same rights and remedies as if the **Policy** were a contract of insurance. If you require further details on your beneficial interest in the **Master Policy**, please contact the **Plan Administrator**.

8. CLAIMS CONDITIONS

The **Claim Administrator** is responsible for scheduling appointments for customers with appropriate providers. In the event that the **Claims Administrator** is unable to secure an appointment with a suitable provider, **You** shall have the right to select and visit a provider of **Your** choosing.

These are the Claims Conditions of this **Policy** that **You** need to meet as **Your** part of the contract. If **You** do not meet these conditions, this **Policy** may be voided (treated as if it never existed), or may be cancelled, or may not provide full cover, or **Your** claim under this **Policy** may be rejected or not fully paid.

You must provide notification of a claim within 30 days of an **Accident** or loss. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify **You** and **Your Policy** Number.

1) **Medical Evaluation**

We have the right to request further tests and/or independent medical evaluation where **We** reasonably decide that a medical condition being claimed for may be directly or indirectly related to an Exclusion.

2) Medical Management

Services Pre-authorization

Please read this section carefully before obtaining any **Treatment**, service or supply.

a. For many benefits under this **Policy**, **You** must notify the **Claims Administrator** and obtain **Pre-authorization** before undergoing any **Treatment** or before being admitted to **Hospital.**

    i. **Pre-authorization** must be obtained before any of the following **Treatment**, service or supply:

        1. For all cover under the Medical Benefits section:

            a. **Inpatient** or **Out-Patient** admission in **Hospital**;

            b. **Treatment**, services or medical supplies of any kind in **Hospital**;

c. Surgery in **Hospital** or in a surgical centre;

d. Urgent Care, **Doctor** Visit;

e. **Outpatient** MRI and CAT scans, echocardiogram (ECG), endoscopy, gastroscopy, colonoscopy and cystoscopy;

2. For cover under the International **Emergency** Care and Assistance section:

a. **Emergency Medical Evacuation**;

b. Costs of transportation of **Your Mortal Remains**; or costs of preparation, local burial or cremation of **Your Mortal Remains**.

c. Any other covered medical services

b. Any decision that the **Claim Administrator** makes on **Pre- certification** is based on the completeness and accuracy of the information provided by **You** or on **Your** behalf at the time of the **Pre-authorization**.

c. The **Claim Administrator** has the right to change or revoke a previous decision on **Pre-authorization** if the information it has changes.

d. For purposes of **Pre-authorization**, notice to the **Claims Administrator** may be made by **You**, the **Hospital**, **Your Doctor** or a **Relative**.

e. **We** understand that it may not be possible for **You** to notify the **Claims Administrator** in advance of an **Emergency** admission to **Hospital**. If this should happen, **You** must notify the **Claims Administrator** and obtain **Pre-authorization** within **48 hours** or as soon as reasonably possible after such **Emergency** admission.

f. If **You** are not **Pre-authorized**, or if **You** fail to comply or co-operate with the **Pre-authorization** requirements, subject to the **Terms** and conditions of this **Policy, We** may deny all cover for **Your** claim or **We** may not pay **Your** claim in full.

g. Where **Pre-authorization** is required, **You** must follow the following procedure**:**

i. Please contact the **Claims**

Administrator: Claimsorted

Email: Claims@claimsorted.com

h. Please contact the **Claims Administrator** as soon as possible within 7 days before admission or before the **Treatment**, service or supply is obtained;

i. For **Emergency Hospital** admission, **Pre-authorization** must be obtained within 48 hours after admission, or as soon as is reasonably possible;

j. Please comply with the **Claims Administrator's** instructions and submit any information or documentation required by the **Claims Administrator**; and

k. Please notify all **Doctors** or **Specialists**, **Hospitals** and other **Treatment**, service or supply providers that this **Policy** contains **Pre-authorization** requirements and please ask them to co-operate fully with the **Claims Administrator**.

l. Any **Pre-authorization** will be confirmed to **You** in writing. A verbal confirmation from the **Claims Administrator** is considered pre-approval when writing is not possible. If **You** are in doubt, please contact the **Claims Administrator**.

3) Concurrent / Continuing Review

a. While You are an **Inpatient** in **Hospital**, the **Claims Administrator** has the right to carry an ongoing review of **Your Treatment** to make sure that **You** are not receiving unnecessary **Treatment** and to help assure quality medical care.

b. When **You** are first admitted as an **Inpatient**, the **Claims Administrator** will approve a limited number of days of confinement based on the eligible medical condition.

c. After that, if additional days of **Inpatient** are necessary, **Your** continued stay in **Hospital** must be reviewed and approved by the **Claims Administrator**.

4) Medical Case Management

a. The **Claims Administrator** has the right to make recommendations in respect of any **Treatment**, service or supply with respect to an eligible medical condition.

b. Such recommendations will be based on the **Claims Administrator's** assessment of and collaboration with **You**, **Your Relatives, Doctors** or other **Treatment,** service or supply providers, to help ensure a well-coordinated continuity of care.

c. **You** are under no obligation to accept or follow any of the **Claims Administrator's** recommendations.

d. If **You** do not accept or follow any of the **Claims Administrator's** recommendations, **You** agree that **We** shall not be held liable or otherwise responsible for any **Treatment**, service or supply provided to **You** except for the payment of **Eligible Charges** under the **Terms** and conditions of this **Policy**.

e. After the **Claims Administrator** has notified **You** of its recommendations, **We** may, at **Our** sole option and discretion, pay for **Treatment**, service or medical supplies, which may not be covered under this **Policy**, but which may be beneficial to **You**.

5) Notice of Claims

a. In the event of a claim, **You** should give notice to:

Claimsorted
mail: claims@claimsorted.com

b. A claim form may be obtained at https://www.dashmga.com/claims or completed online via the Dashmga portal at www.dashmga.com/members

c. Upon receiving notice of a claim under this **Policy** from **You** or on **Your** behalf, the **Claims Administrator** may provide **You** with a claim form to complete.

d. All decisions regarding **Your** eligibility for benefits and coverage under this **Policy** will be made after the completed claim form is submitted to the **Claims Administrator** and **We** have had the opportunity to review and investigate the claim. **We** reserve the right to make the final determination of benefits once full proof of the claim has been provided to **Us**.

6) Assistance and Co-operation

a. **You** are required to provide all reasonable assistance and fully cooperate with **Us** in managing any claim under this **Policy**. Failure to do so may result in the suspension of **Your** claim or a partial or full denial of payment.

b. **You** must, at **Your** own expense, provide all documents, medical reports, and other materials **We** reasonably request. Failure to do so may result in suspension of **Your** claim or a partial or full denial of payment. **We** reserve the right to review all evidence related to **Your** claim as often and whenever reasonably necessary.

c. **Pre-authorization**, may be required for certain medical services, **Treatments**, or procedures. The purpose of **Pre-authorization** is to verify that the proposed service is **Medically Necessary** and is covered under the **Policy Terms**. Failure to obtain **Pre-authorization** for services requiring it may result in financial penalties or denial of claims. **Pre-authorization** does not guarantee payment or claim reimbursement, as claims remain subject to review based on

Policy Terms and **Medical**

Necessity.

7) Settlement of Claims

a. All settlement of claims is in accordance with the **Terms** and conditions of this **Policy**, including the applicable **Deductible**.

b. **You** may choose to have any reimbursement of **Your** claim paid in any currency (but not cryptocurrency) provided that:

c. Any payment will be converted to the equivalent amount in the currency of this **Policy**.

d. **We** will apply the Bank of England exchange rate in effect as follows:

   i. For claims filed and approved **Eligible Charges**: on the date on which **You** paid for **Your Treatment**, service or supply, or, if **Your Treatment**, service or supply was over a period of time, on the date that **We** processed payment;

   ii. For claims submitted and approved for the Accidental Death Principal Sum: on the date of **Your** death;

e. **We** are not liable for any loss resulting from currency exchange fluctuations or for any bank fees **You** may incur when receiving payment from **Us**.

f. If **You** are under the age of 18, **We** will make any payment for claims to the parent or guardian who signed **Your Application**.

8) Payment of Claims

a. At **Our** option, **We** may pay **Eligible Charges** directly to:

   i. The **Treatment**, supply or service provider; or

   ii. Payment to **You** may be made by cheque, electronic funds transfer, direct deposit to **Your** VISA or MasterCard, or by mailing a cheque to **Your** last known address.

b. Where **We** pay or arrange to pay **Eligible Charges** directly with the **Treatment**, service or supply provider, **You** are responsible for direct payment of the **Deductible** amounts, and any non-**Eligible Charges** to the **Treatment**, supply or service provider.

c. Where **We** do not pay or arrange to pay **Eligible Charges** directly with the **Treatment**, service or supply provider, **You** will be responsible for paying the provider directly and then seeking reimbursement from **Us**.

9) Right of Recovery

a. If **We** overpay any benefit under this **Policy** for any reason, **We** reserve the right to recover the overpaid amount promptly from **You** or, where applicable, from the third party who received the overpayment.

b. If **You**, or the relevant third party, do/does not promptly make any such refund to **Us:**

   i. **We** may reduce or deduct the amount due from any future claim under this **Policy**;

   ii. **We** may cancel this **Policy** by giving 30 days' notice in writing to **Your** last known mailing address or **Your** e-mail address at the **Effective Date**.

10) Subrogation

a. **You** must notify **Us** without undue delay of any claim or right of action **You** may have against any third party arising from the circumstances that gave rise to a claim under this **Policy**.

b. **You** are required to take all reasonable steps to pursue such third-party claims and to keep **Us** informed in writing of any material developments. **We** reserve the right, at **Our** sole discretion

and in **Your** name, to initiate legal proceedings or take other action against any third party to recover any amounts paid under this **Policy**.

c. **We** shall have full authority over the conduct and settlement of any such proceedings or claims.

d. **You** must provide **Us** with all assistance and documentation **We** may reasonably require in connection with the pursuit of any such recovery.

11) Explanation or Verification of Benefits

a. **We** and the **Claims Administrator** will make reasonable efforts to assist **You** and any provider of **Treatment**, services, or supplies in understanding the scope and extent of the benefits and coverage available under this **Policy**.

b. If **You** require a definitive interpretation of any benefit or coverage provision, **You** may submit an inquiry to the **Plan Administrator**. If **You** request it, the **Plan Administrator** will provide **You** a written response.

c. No statement or representation made by **Us** or the **Claims Administrator** shall be deemed to modify, waive, or amend any term or condition of this **Policy** unless such modification, waiver, or amendment is expressly set out in a Notice of Endorsement or other written instrument issued by **Us**.

12) Incurral Period

a. **Eligible Charges** must be incurred within 30 days from the date of the initial occurrence of the **Illness** or **Injury** while this policy is in force. Only **Eligible Charges** that are rendered or received within this 30-day incurral period will be considered for reimbursement under this policy. Any **Treatment**, service, or expense incurred after the expiration of the 30-day period from the date of the covered event will not be eligible for coverage, even if the underlying condition commenced during the policy period

9. CLAIMS PROCEDURES

1) General

a. All claims should be submitted to the **Claims Administrator** with a fully completed claim form, original invoices, receipts and all other supporting documents within 30 days, or as soon as reasonably possible, of **Your Treatment**.

b. **We** may deny cover for any claim submitted after this time.

c. **You** are required to adhere to all **Pre-authorization** procedures; failure to do so may result in a reduction or denial of **Your** claim payment.

d. **We** will provide **You** with a personalized membership card that includes essential contact information and addresses. Please ensure that **You** keep this card with **You** at all times.

e. **Insured Persons** are required to notify the **Claims Administrator** within 7 days for non-**Emergency** situations, 48 hours for **Emergency** situations, and 24 hours for travel Insurance requests. If in need of Insurance, regardless of their geographical location, the **Insured Person** should contact the **Claims Administrator**.

The **Claims Administrator** can be reached email per the contact details below: Email: claims@claimsorted.com

f. It is the obligation of the **Insured Person** to always call to report the **Emergency**. In case the

Insured Person cannot do it personally, any companion, friend or **Relative** can do it, but the call or notice must be made no later than within 7 days for non-Emergency situations, 48 hours for **Emergency** situations, and 24 hours to travel Insurance requests. For cases in which the **Insured Person** is unable to communicate with the **Claims Administrator**, they must report the medical facts as soon as practicable. Failure to comply with this rule entails automatic loss of any right to claim by the **Insured Person**.

2) Emergency Admissions

a. In the event of an **Emergency Hospital** admission, **You** must contact the **Claims Administrator** as soon as possible after **Your** admission.

b. **You** will need to provide full details of **Your** medical condition and **Treatment**, including the date(s) and name(s) of any procedures (if known), as well as the name of the **Doctor** overseeing **Your Treatment**.

c. Where **Pre-authorization** is required, **You** must obtain approval from the **Claims Administrator** prior to undergoing any **Treatment** or being admitted to the **Hospital**

d. If it is not possible for **You** to notify the **Claims Administrator** before an **Emergency** admission to the **Hospital** to obtain **Pre-authorization**, **You** must inform the **Claims Administrator** and obtain **Pre-authorization** within 48 hours, or as soon as reasonably possible following the **Emergency** admission.

e. Any failure to obtain such **Pre-authorization** may result in the **Claims Administrator** denying all cover for **Your** claim, or the **Claims Administrator** not paying **Your** claim in full.

3) Emergency Doctor Visits (Outpatient Only)

a. If **You** pay for any **Treatment**, service or supply which **You** receive as an **Outpatient**, then **You** should submit all charges and a claim form to the **Claims Administrator** in accordance with the **Terms** and conditions of this **Policy**.

b. **You** should fill in the section that is assigned to **You** on the claim form, and date and sign the claim form.

c. Please attach all original supporting documentation, invoices and receipts to the claim form and send it to the **Claims Administrator**.

4) Claim Criteria

a. **You** may only claim for:

b. **Treatment**, service or supply actually given during a **Period of Coverage**; and

c. **Eligible Charges** which **You** incur before the Expiry Date or the Cancellation Date, whichever is the earlier.

You may claim for benefit from the start of the **Treatment** or service or from the date that **You** received the supply, until the time when it is medically confirmed that the **Treatment** or service or supply is no longer necessary or until this **Policy** is no longer in force, whichever is the earlier.

If **You** claim subsequently for a new course of **Treatment** or service or new supply which is not connected with the earlier **Treatment**, service or supply, the subsequent **Treatment**, service or supply will be treated as a new claim under this **Policy**.

10. DATA PROTECTION

1) Protecting Your Data

Protecting **Your** privacy is very important to **Us**.

2) Personal Data You Provide to Us

If **You** provide **Us** with personal data about other people to be insured on this **Policy**, such as Family or friends, **You** agree to obtain their agreement and notify them of **Our** use of their personal data.

3) How We Use Your Personal Data

We will use **Your** personal data to arrange **Your** insurance contract with **Us** and for other related insurance purposes such as to administer this **Policy**, handle claims and manage extensions of this **Policy**. **We** may also use **Your** personal data for modelling or statistical purposes and underwriting decisions made via automated means.

4) Special Categories of Personal Data

Some personal data is defined by the current Data Protection legislation as special categories of sensitive personal data such as information about health. **We** may collect such data from **You** for insurance purposes where permitted by relevant legislation. **We** will only use this data for the specific purpose **You** supplied it and to provide the services described in this **Policy**.

5) Who We Share Your Information With

We may share **Your** personal data with other insurance market participants that **You** have not had direct contact with. These can include other insurers, intermediaries, reinsurers, **Claims Administrators**, loss adjusters and solicitors. **We** may also disclose certain personal data to **Our** service providers, contractors, agents and group **Companies** that perform activities on **Our** behalf. These transfers would always be made in compliance with relevant Data Protection legislation.

We do not disclose the information to anyone else except:

a. Where **We** have **Your** permission;

b. Where required or permitted to do so by law;

c. To credit reference;

d. To other **Companies** that provide a service to **You** or **Us**.

We may transfer **Your** data to insurance market participants which are located outside of **Your Home Country**. These transfers would always be made in compliance with relevant Data Protection legislation.

6) Data Retention and Erasure

We will not keep **Your** data for longer than is necessary for the purposes for which the data is processed and for compliance with legal or regulatory obligations.

7) Your Rights

If **You** have any questions about **Our** use of **Your** personal data, **You** should contact **Our** Data

Protection Officer. In certain circumstances **You** have the right to request that **We**:

a. Provide more detail on how **We** use **Your** personal data;

b. Provide **You** with a copy of **Your** personal data that **You** provided to **Us**;

c. Correct inaccurate information **We** hold about **You**;

d. Delete **Your** data;

e. Provide an electronic copy of **Your** personal data to another data controller.

If **You** ask **Us** to delete **Your** data, **We** may no longer be able to provide **You** with insurance services

or deal with any claims, but **We** may still be required to process data about **You** for legal or regulatory

reasons.

Our Contact Details

Dash MGA
230 SUNRISE AVE SUITE B – 247
PALM BEACH, FL 33480
Support@dashmga.com

If **You** are not satisfied with the way **We** have handled **Your** personal data **You** have the right to complain to a supervisory authority in **Your Home Country**, place of work or place of the alleged infringement.

For more information on how **We** process **Your** personal data, refer to: www.dashmga.com/privacy-**Policy**

11. MAKING A COMPLAINT

1) **Complaints Procedure**

We will do everything possible to ensure that **You** receive a high standard of service. If **You** are not satisfied with the service received, please contact **Us**. When **You** contact **Us,** please give **Us Your** name and contact telephone number. Please also quote this **Policy** and/or claim number and the type of **Policy You** hold.

2) **Making Your Complaint**

If **Your** complaint relates to the sale or administration of this **Policy**, please contact;

Dash MGA
Legal Department
230 SUNRISE AVE SUITE B – 247
PALM BEACH, FL 33480

3) If **Your** complaint relates to a claim on this **Policy**, please contact:

We expect that the majority of complaints will be quickly and satisfactorily resolved at this stage, but if **You** are not satisfied, **You** can take the issue further.

4) **Our Promise to**

You We will:

a. Acknowledge all complaints;

b. Investigate thoroughly;

c. Keep **You** informed of progress within a reasonable time;

Notice:

This insurance is not subject to and does not provide certain insurance benefits required by the United States' Patient Protection and Affordable Care Act ("PPACA"). This coverage is not a general health insurance product but is intended for use in the event of a sudden and **Unexpected** event while traveling outside **Your Home Country**. PPACA requires certain US citizens or US residents to obtain PPACA compliant health insurance, or "minimum essential coverage." PPACA also requires certain employers to offer PPACA compliant insurance coverage to their employees. Tax penalties may be imposed on U.S. residents or citizens who do not maintain minimum essential coverage, and on certain employers who do not offer PPACA compliant insurance coverage to their employees. In some cases, certain individuals may be deemed to have minimum essential coverage under PPACA even if their insurance coverage does not provide all of the benefits required by PPACA. **You** should

consult **Your** attorney or tax professional to determine whether the **Policy** meets any obligations **You** may have under PPACA.