

The Company agrees to provide insurance, in exchange for payment of the required Premium. Coverage is subject to the Terms and Conditions described in the Policy. The Company and the Policyholder have agreed to all the Terms and Conditions of the Policy.

The Company hereby insures all persons whose Application has been accepted by Our administrator on behalf of the Company, subject to all the exclusions, limitations and provisions set forth in this Policy. Coverage is afforded only with respect to the Covered Person, the coverage, the amounts, and the limits specified in the Certificate issued to the Covered Person, for which Premium has been paid. All benefit amounts, coverage, monetary limits and sub-limits, and other amounts stated herein including Premium, are in USD (United States Dollars).

## SCHEDULE OF BENEFITS

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| MEDICAL MAXIMUM PER PERIOD OF INSURANCE                        | \$60,000, \$250,000, \$500,000, or \$1,000,000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| PRE-EXISTING CONDITION MEDICAL MAXIMUM PER PERIOD OF INSURANCE | \$20,000, \$25,000, \$30,000, \$40,000, or \$50,000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| DEDUCTIBLE PER PERIOD OF INSURANCE                             | \$250, \$500, \$1,000, \$2,500, or \$5,000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| PRE- EXISTING CONDITION DEDUCTIBLE PER PERIOD OF INSURANCE     | \$1,500, \$2,000, \$2,500, \$5,000, or \$10,000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| CO-INSURANCE PER PERIOD OF INSURANCE                           | 80% In Network / 60% Out of Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| STABLE PRE-EXISTING CONDITION                                  | Covered subject to limits and exclusions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| PRE-CERTIFICATION                                              | <p>Pre-certification is a general determination of Medical Necessity only.</p> <ul style="list-style-type: none"> <li>• Inpatient Hospitalization, Surgery or Surgical procedure: 50% reduction of Eligible Medical Expenses if Pre-certification requirements are not met.</li> <li>• Deductible is applied after reduction.</li> <li>• Coinsurance and Out of Pocket Maximum are applied to remainder of the reduced amount.</li> <li>• Interfacility Ambulance Transfer: No coverage if Pre-certification requirements are not met.</li> <li>• Emergency Medical Evacuation: No coverage if not approved by the Company.</li> <li>• Refer to the PRE-CERTIFICATION REQUIREMENTS provision for a complete list of services that require Pre-certification.</li> </ul> |
| HOSPITAL ROOM AND BOARD INCLUDING INTENSIVE CARE UNIT          | <p>\$20,000 Maximum</p> <p>\$15,000 Pre-Existing Conditions Limit</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| HOSPITAL ANCILLARY SERVICES                                    | <p>\$20,000 Maximum</p> <p>\$15,000 Pre-Existing Conditions Limit</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

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| HOSPITAL EMERGENCY ROOM                                                                                   | \$20,000 Maximum<br>\$15,000 Pre-Existing Conditions Limit<br>Emergency Room Sickness with no direct Hospital Admission - \$7,500 Pre-Existing Conditions Limit |
| CARDIAC CONDITIONS AND STROKE PER PERIOD OF INSURANCE                                                     | \$25,000 Maximum up to age 69<br>\$15,000 Maximum for ages 70 to 89                                                                                             |
| OUTPATIENT SURGICAL FACILITY                                                                              | Covered                                                                                                                                                         |
| PHYSICIAN'S SURGICAL TREATMENT                                                                            | Covered<br>\$15,000 Pre-Existing Conditions Limit                                                                                                               |
| PHYSICIAN'S NON-SURGICAL VISIT                                                                            | Covered                                                                                                                                                         |
| ASSISTANT PHYSICIAN'S SURGICAL                                                                            | Covered at 20% of the primary surgeon's eligible fee<br>\$5,000 Pre-Existing Conditions Limit                                                                   |
| ANESTHESIOLOGIST                                                                                          | Covered                                                                                                                                                         |
| CONSULTING PHYSICIAN                                                                                      | Covered                                                                                                                                                         |
| PRE-ADMISSION TESTS                                                                                       | Covered within 7 days of Admission                                                                                                                              |
| DIAGNOSTIC X-RAYS AND LAB SERVICES                                                                        | Covered                                                                                                                                                         |
| EMERGENCY MEDICAL TREATMENT OF PREGNANCY                                                                  | \$1,000 Maximum per Period of Insurance                                                                                                                         |
| URINARY TRACT INFECTION - For DIAGNOSIS AND TREATMENT                                                     | \$2,000 Maximum per Period of Insurance                                                                                                                         |
| PHYSICIAN'S VISIT                                                                                         | Covered                                                                                                                                                         |
| URGENT CARE VISIT                                                                                         | \$25 In Network / \$50 Out of Network<br>Not Subject to Deductible                                                                                              |
| WALK IN CLINIC VISIT                                                                                      | \$25 In Network / \$50 Out of Network<br>Not Subject to Deductible                                                                                              |
| PRESCRIPTION DRUGS AND MEDICATIONS                                                                        | \$50 per prescription up to a maximum of \$500 per Period of Insurance (must be prescribed by a Physician)                                                      |
| PHYSIOTHERAPY, PHYSICAL MEDICINE, CHIROPRACTIC                                                            | \$50 per visit up to a maximum of \$500 per Period of Insurance (must be prescribed by a Physician)                                                             |
| COVID, SARS-COV-2                                                                                         | Medically Necessary Treatment for COVID, SARS-CoV-2, and any mutation or variation of SARS-CoV-2 up to the maximum                                              |
| DENTAL TREATMENT FOR INJURY OF SOUND NATURAL TEETH DUE TO ACCIDENT                                        | \$250 per Period of Insurance                                                                                                                                   |
| AMBULANCE SERVICE                                                                                         | Covered                                                                                                                                                         |
| WHEELCHAIR OR HOSPITAL-TYPE BED RENTAL                                                                    | Covered                                                                                                                                                         |
| MECHANICAL EQUIPMENT RENTAL FOR TREATMENT OF RESPIRATORY PARALYSIS                                        | Covered                                                                                                                                                         |
| *EMERGENCY MEDICAL EVACUATION INCLUDING RETURN OF MINOR CHILDREN OR GRAND-CHILDREN OR TRAVELING COMPANION | \$20,000 per Period of Insurance                                                                                                                                |
| *REPATRIATION OF MORTAL REMAINS                                                                           | \$10,000 per Period of Insurance                                                                                                                                |

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| *ACCIDENTAL DEATH AND DISMEMBERMENT | \$20,000 Principal Sum– 24 Hour |
| **TRAVEL ASSISTANCE                 | Included                        |

\*Not subject to Deductible

\*\* This is a non-insurance service and is not a part of the insurance underwritten by Zurich Insurance Europe AG Belgian branch.

## GENERAL TERMS OF COVERAGE

### ELIGIBILITY

This Certificate of Coverage provides coverage to non-US citizens who reside outside the USA and are traveling outside of their Home Country to visit the United States. The Covered Person must purchase the coverage before leaving on their trip and arrive in the USA before traveling to other countries (certain countries may be restricted at different times). Coverage in countries outside the USA is available for up to 30 days during your Period of Insurance. This Certificate of Coverage is not available to any individual who is considered a Habitual Resident of the country or jurisdiction in which care is received.

It is the Covered Person's obligation to ensure eligibility and to provide all information relating to their eligibility. The failure to disclose or to otherwise withhold information pertaining to eligibility renders this coverage void and may be reported as fraud to the relevant authorities. If and whenever We discover that the Eligibility requirements have not been met, Our only obligation is refund of Premium. A 90 day Minimum Premium is required.

### EFFECTIVE DATE

An eligible person will be insured on the latest of the following dates: 1. the Covered Person's departure from Their Home Country; 2. the date and time the Covered Person completed an enrollment form and Their correct Premium is received; or 3. the Effective Date requested and shown on the Certificate of Coverage. However, this coverage shall never be effective and will be void if a person completes an enrollment form but does not depart their Home Country before receiving care for which a benefit is claimed.

### TERMINATION DATE

Coverage will end on the earliest of the: 1. date the Covered Person's return to Their Home Country, or 2. the day after the Termination Date shown on the Certificate of Coverage for which Premium has been paid; or 3. Three hundred and sixty-four (364) days after the Covered Person's original Effective Date; or 4. the date the Covered Person becomes a United States citizen or Habitual Resident in the US; or 5. the date the Covered Person is no longer eligible for this plan; or 6. the first date for which no corresponding Premium is timely received; or 7. the date specified by the Company in any notice of cancellation, forfeiture or rescission issued pursuant to or as a result of the circumstances described in the MISREPRESENTATION, FRAUDULENT CLAIMS and RIGHT OF RECOVERY.

### OPTIONAL EXTENSION PROCEDURES

If eligible, an extension notice will be sent to the Covered Person before the Period of Insurance ends and includes links to extend prior to the Termination Date. The Covered Person is subject to the following rules

at extension: In order to extend, the Period of Insurance must be initially purchased for a minimum of 90 days. If available, an extension period can be purchased: 1. at the Premium rate in force at the time of the extension; 2. for a minimum of 5 days; 3. for up to a maximum of 364 days, provided the Covered Person's Period of Insurance does not exceed 364 days in total. There are no grace periods for extension.

## CANCELLATION AND REFUND PROCEDURE PROVISIONS

A full cancellation and refund will be considered only if we receive a written cancellation request on or before the Coverage Effective Date. If we receive a written cancellation request after the coverage Effective Date, a partial cancellation and refund of Premium may be available, subject to the following conditions:

**Claims Filed:** If any claim has been submitted to us, the premium is deemed fully earned and is non-refundable.

**No Claims Filed:** If no claim has been submitted a cancellation fee of US\$50 will apply and only the premium attributable to unused coverage days beyond the initial 90-day minimum Premium Period is eligible for refund.

If a Premium refund is issued and it is later determined that a claim had been submitted on behalf of a Covered Person before the cancellation date, the Covered Person will be solely responsible for the full amount of that claim. Once the cancellation and any applicable refund of Premium have been processed, both the Company and the Covered Person will be released from all rights, obligations, and liabilities under this Certificate of Coverage.

## EXCESS INSURANCE

The coverage provided in this plan shall be in excess of all other valid and collectable insurance or indemnity and shall apply only when such other benefits are exhausted. In the event no other insurance exists, this coverage becomes primary. We reserve the right to review and potentially subrogate any undeclared coverage whether known or unknown to the Covered Person. The Covered Person agrees to cooperate with all efforts to coordinate benefits, and the failure to cooperate is a basis to limit or deny benefits that may be covered by other insurance.

## DISCLOSURES

The Covered Person must notify the Plan Administrator within 30 days of a change of address or domicile including a change of address that affects eligibility.

## TERMS AND CONDITIONS

All benefits payable are subject to the Medical Maximum Limits, any applicable Deductibles, and any sub-limits listed in the Schedule of Benefits.

## BENEFIT PERIOD

While the coverage is in effect, we will pay eligible Medical Expenses for 1) Injury or Sickness up to 180 days beginning on the first day of Diagnosis or Treatment of a covered Sickness or Injury. 2) Once the Pre-Existing Condition Maximum Limit is reached, no further benefits will be payable for Pre-Existing Conditions. 3) Upon

termination of the coverage, the Benefit Period shall discontinue on the date of termination, and the plan will no longer pay any Medical Expenses.

## STABLE PRE-EXISTING CONDITION BENEFIT

Notwithstanding any other provision of this Certificate, benefits are payable for covered Medical Expenses resulting from a sudden and unplanned recurrence or acute exacerbation of a Stable Pre-Existing Condition, provided such condition meets the requirements outlined in this section. Coverage applies only when immediate medical treatment is required to prevent serious deterioration of health. Except as specifically modified by this section, all other terms, conditions, exclusions, and limitations apply.

### Stability Requirement

A Pre-Existing Condition shall be considered Stable only if it meets the definition of Stable Pre-Existing Condition contained in the Definitions section of this Certificate of Coverage.

### Covered Stable Pre-Existing Condition Maximum Limit

Benefits for all eligible expenses related to Pre-Existing Conditions are subject to separate Deductible and Maximum Limits per Period of Insurance, as stated in the Schedule of Benefits. Once the Pre-Existing Condition Maximum Limit is reached then 1) no further benefits will be payable for Pre-Existing Conditions; and 2) coverage will remain in effect for all other eligible expenses unrelated to Pre-Existing Conditions.

### Stable Pre-Existing Condition Events

Expenses for a Pre-Existing Condition will be considered only when 1) the episode is sudden, unplanned, and first occurs after the effective date of coverage; 2) symptoms represent a sudden and unplanned recurrence or acute exacerbation of a Pre-Existing Condition, or the sudden onset of a complication directly resulting from that condition, beyond routine maintenance care or expected disease progression; and 3) treatment is Medically Necessary and cannot be reasonably delayed. Multiple episodes of a Pre-Existing Condition may be covered during the Period of Insurance, provided each episode results from a separate acute exacerbation; occurs after the Covered Person has been medically stabilized from the previous episode; is not a continuation of the same illness or course of treatment; is supported by appropriate medical records demonstrating a separate occurrence.

### Excluded Pre-Existing Condition Treatment

The following are not covered: 1) Routine or maintenance care, including scheduled physician visits, Elective or planned procedures, long-term disease management, medication refills not associated with a sudden and unplanned recurrence or acute exacerbation. 2) Treatment that was recommended prior to the Effective Date, or reasonably foreseeable at the time of travel. 3) Ongoing or continuous treatment without evidence of sudden and unplanned recurrence or acute exacerbation. 4) Dialysis, long-term rehabilitation, or custodial care. 5) Where travel was undertaken primarily for the purpose of receiving medical Treatment for a Pre-Existing Condition.

### Medical Necessity and Documentation

All Pre-Existing Condition Expenses must 1) be supported by Physician documentation describing the acute change in condition, and 2) demonstrate the Treatment was Medically Necessary and emergent or urgent in

nature and are required to stabilize the condition. Expenses will be evaluated based on clinical presentation and medical records, and not solely on diagnostic coding.

Relationship to Other Plan Provisions Payments under this section shall not extend or increase the overall Policy Maximum. Expenses must meet the definitions of both Medical Expense and Medically Necessary. This section does not provide coverage for services otherwise excluded herein.

#### Termination of Pre-Existing Condition Benefits

Pre-Existing Condition Benefits terminate upon the earliest of 1) exhaustion of the Pre-Existing Condition Maximum Limit; or 2) the Termination of the Period of Insurance.

### MEDICAL EXPENSE BENEFITS

If a covered Sickness or Injury occurs during the Period of Insurance, and the Covered Person requires medical or surgical Treatment, benefits are payable for the following Covered Expenses that are incurred during the Period of Insurance. The first Covered Expenses must be incurred within 30 days after the date of the covered Sickness or Injury or Sudden and Unplanned Recurrence of a Pre-Existing condition. No benefits will be paid for any expenses incurred which are in excess of the Usual and Customary Charge.

1. HOSPITAL ROOM AND BOARD HOSPITAL INTENSIVE CARE UNIT: the Usual and Customary Charge for a hospital semi-private room or the Allowable Charge for Medically Necessary Intensive Care Services when a Covered Person is Hospital Confined. (In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge), and general nursing care and the following additional facilities; services and supplies as Medically Necessary and approved and covered, meals and special diets (only for the patient). Use of operating room and related facilities, use of intensive care and related services. All Expenses in excess of any allowable rate are the responsibility of the Covered Person.
2. HOSPITAL ANCILLARY SERVICES: If Medically Necessary for the Diagnosis and Treatment of the Sickness or Injury for which a Covered Person is hospitalized, the following services are also covered: use of operation room and recovery room all approved medicines in the jurisdiction where treatment is being rendered; Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services; Surgical dressings; Laboratory testing; Durable Medical Equipment; Diagnostic x-ray examinations; Respiratory therapy rendered by a Physician or registered respiratory therapist; Physical and Occupational therapy (if covered) must be rendered by a Physician or registered physical or occupational therapist and relate specifically to the physician's written Treatment plan. Therapy must: Produce significant improvement in the Covered Person's condition in a reasonable and predictable period of time and be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist or be necessary to the establishment of an effective maintenance program. Maintenance itself is not covered. All Inpatient Ancillary benefits are paid in accordance with the current Schedule of Benefits.
3. HOSPITAL EMERGENCY ROOM.
4. CARDIAC CONDITIONS AND STROKE: up to the Maximum as stated in the Schedule of Benefits.
5. OUTPATIENT SURGICAL FACILITY.
6. PHYSICIAN'S SURGICAL TREATMENT: If multiple surgical procedures are required through the same incision, we will pay only one benefit, the largest of the procedures performed. If multiple surgical

procedures are performed during the same operative session but through different incisions, we will pay as shown in the Benefits Schedule for the most expensive procedure and 50% of the covered expense for the additional surgeries.

7. PHYSICIAN'S NON-SURGICAL VISIT: Physician non-surgical Treatment and examination expenses including the Physician's initial visit, each Medically Necessary follow-up visit and consultation visits when referred by the attending Physician.
8. ASSISTANT PHYSICIAN'S SURGICAL: if Medically Necessary, for professional services rendered, including Surgery provided, however, Charges by or for an assistant surgeon will be limited and covered at the rate of up to twenty percent (20%) of the Usual and Customary Charge of the primary surgeon; and provided, further, that the standby availability of a Physician or surgeon will not be deemed to be a professional service and is not eligible for coverage.
9. ANESTHESIOLOGIST: for pre-operative screening and administration of anesthesia during a Surgical Procedure.
10. CONSULTING PHYSICIAN: when requested by the attending Physician.
11. PRE-ADMISSION TEST: within 7 days of Admission.
12. DIAGNOSTIC X-RAYS AND LAB SERVICES: to include X-ray, laboratory and other diagnostic tests, biological anesthesia and oxygen services, inhalation therapy, and administration of blood products.
13. EMERGENCY MEDICAL TREATMENT OF PREGNANCY.
14. URINARY TRACT INFECTION DIAGNOSIS AND TREATMENT.
15. PHYSICIAN'S VISIT.
16. URGENT CARE VISIT.
17. WALK-IN CLINIC VISIT.
18. PRESCRIPTION DRUGS AND MEDICATIONS: for Treatment of a Covered Sickness or Injury, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs. Limited to a maximum ninety (90) days' supply of any one (1) prescription.
19. PHYSIOTHERAPY, PHYSICAL MEDICINE, CHIROPRACTIC: benefits provided on an Inpatient or Outpatient basis including Treatment and office visits connected with such Treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, adjustments, manipulation, or any form of physical therapy.
20. COVID, SARS-CoV-2 MEDICAL: Medically Necessary treatment for COVID, SARS-CoV-2, and any mutation or variation of SARS-CoV-2 up to the maximum as stated in the Schedule of Benefits.
21. DENTAL TREATMENT FOR INJURY OF SOUND NATURAL TEETH DUE TO ACCIDENT: Emergency dental Treatment, including x-rays, and restoration of Sound Natural Teeth when required and as a result of an Injury or to relieve pain due to an Accident. Routine dental Treatment is not covered.
22. AMBULANCE SERVICE: Medically Necessary for emergency ground or air ambulance transportation as required from the emergency site to the nearest Hospital able to provide the required level of care.
23. WHEELCHAIR OR HOSPITAL-TYPE BED RENTAL.
24. MECHANICAL EQUIPMENT RENTAL FOR TREATMENT OF RESPIRATORY PARALYSIS.

## PRE-CERTIFICATION REQUIREMENTS

Pre-certification is a general determination of Medical Necessity only, and all such determinations are made by the Company (acting through its authorized agents and representatives) in reliance and based upon the completeness and accuracy of the information provided by the Covered Person and/or their Relatives, guardians and/or healthcare providers at the time of Pre-certification. The Company reserves the right to challenge, dispute and/or revoke a prior determination of Medical Necessity based upon subsequent information obtained. Pre-certification is not an assurance, authorization, preauthorization, or verification of Treatment or coverage, a verification of benefits, or a guarantee of payment. The fact that Treatment or supplies are Pre-certified by the Company does not guarantee the payment of benefits, the availability of coverage, or the amount of or eligibility for benefits. The Company's consideration and determination of a Pre-certification request, as well as any subsequent review or adjudication of all medical claims submitted in connection therewith, shall remain subject to all of the Terms of this insurance, including exclusions for Pre-existing Conditions and other designated exclusions, benefit limitations and sub-limitations, and the requirement that claims be Usual and Customary Charge. Any consideration or determination of a Pre-certification request shall not be deemed or considered as the Company's approval, authorization, or ratification of, recommendation for, or consent to any diagnosis or proposed course of Treatment. Neither the Company nor the Plan Administrator (nor anyone acting on their respective behalf) has any authority or obligation to select Physicians, Hospitals, or other healthcare providers for the Covered Person, or to make any diagnosis or medical Treatment decisions on behalf of the Covered Person, and all such decisions must be made solely and exclusively by the Covered Person and/or their Immediate Family Member or guardians, Treating Physicians and other healthcare providers. If the Covered Person and their healthcare providers comply with the Precertification requirements of this coverage, and the Treatment or supplies are Pre-certified as Medically Necessary, the Company will reimburse the Covered Person for Eligible Medical Expenses up to the amount shown in the SCHEDULE OF BENEFITS incurred in relation thereto, subject to all Terms of this insurance. Eligibility for and payment of benefits are subject to all of the Terms of this insurance.

1. **SPECIFIC REQUIREMENTS:** The following must always be Pre-certified for Medical Necessity by the Company through the Plan Administrator before admission or receiving the Treatments and/or supplies: (a) Inpatient Hospitalization (b) Surgery or Surgical procedure.
2. **GENERAL REQUIREMENTS:** To comply with the Pre-certification requirements of this insurance for the Treatments and/or supplies or services listed in the SPECIFIC REQUIREMENTS provision, above, the Covered Person or their Physician or healthcare provider must perform all of the following: (a) contact the Company through the Plan Administrator at the contact information below and listed on the Covered Person's ID card as soon as possible and before the Treatment or supply is to be obtained (b) comply with the instructions of the Company and submit any information or documents required by the Company (c) notify all Physicians, Hospitals, and other healthcare providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company.
3. **LOSS OF COVERAGE/ BENEFITS FOR NON-COMPLIANCE OF PRE-CERTIFICATION REQUIREMENTS:** If the Covered Person or their healthcare providers do not comply with the Pre-certification requirements for the Treatment or supplies identified in the SPECIFIC REQUIREMENTS subparagraphs above, or if such Treatment or supplies are not Pre-certified then (a) Eligible Medical Expenses incurred with respect to said Treatment and/or supplies will be reduced by the amount shown in the BENEFIT SUMMARY (b) any Deductible will be subtracted from the remaining amount (c) Coinsurance will be applied.

4. **EMERGENCY PRE-CERTIFICATION:** In the event of an Emergency Hospital admission, Pre-certification must be completed within forty-eight (48) hours after the admission, or as soon as is reasonably possible.
5. **CONCURRENT REVIEW:** For Inpatient Treatment of any kind, the Company will Pre-certify a limited number of days of hospital confinement based upon the disclosed medical condition. Thereafter, Pre-certification must again be requested and approved if additional days of Inpatient Treatment are necessary.

## EMERGENCY MEDICAL EVACUATION

Subject to the applicable Maximum Limit set forth in the BENEFIT SUMMARY, and the other Terms of this insurance, including the EXCLUSIONS provision and the CONDITIONS AND RESTRICTIONS subparagraph below, the Company will reimburse the Covered Person for the following transportation costs, when the Company or Plan Administrator arranges such transportation, and expenses incurred by the Covered Person arising out of or in connection with an Emergency Medical Evacuation occurring while this coverage is in effect and during the Period of Insurance: (a) Emergency air transportation to a suitable airport nearest to the Hospital where the Covered Person will receive Treatment (b) Emergency ground transportation necessarily preceding Emergency air transportation and from the destination airport to the Hospital where the Covered Person will receive Treatment (c) Return ground and air transportation, upon medical release by the attending Physician, to the country where the evacuation initially occurred or to the Covered Person's Country of Residence, at the Covered Person's option.

**CONDITIONS and RESTRICTIONS:** To be eligible for coverage for Emergency Medical Evacuation benefits, the Covered Person must be in compliance with all Terms of this insurance. The Company will provide Emergency Medical Evacuation benefits only when the condition, Sickness, or Injury is covered under the Terms of this insurance.

The Company will provide Emergency Medical Evacuation benefits only when all of the following conditions and restrictions are met:

- (a) Medically Necessary Treatment cannot be provided locally.
- (b) transportation by any other means or methods would result in loss of the Covered Person's life or limb within twenty-four (24) hours, based upon a reasonable medical certainty.
- (c) Emergency Medical Evacuation is recommended by the attending Physician who certifies to the matters in subparagraphs (a) and (b), above.
- (d) Emergency Medical Evacuation is agreed to by the Covered Person or a Relative of the Covered Person.
- (e) Emergency Medical Evacuation is provided by designated, licensed, qualified, professional emergency personnel acting within the scope of such license and approved in advance and all arrangements are coordinated by the Company.
- (f) the condition, Illness, Injury or occurrence giving rise to the need for the Emergency Medical Evacuation:
  - (i) occurred outside the Covered Person's Country of Residence suddenly, Unexpectedly, and spontaneously, and without: (1) advance warning, or (2) advance Treatment, diagnosis or recommendation for Treatment by a Physician, or (3) prior manifestation of symptoms or conditions that would have caused a reasonably prudent person to seek medical attention prior to the onset of the Emergency (ii) was not a Pre-existing Condition unless otherwise expressly provided under the PRE-EXISTING CONDITION BENEFIT provision.

(g) The Company will cover reimbursement for the above-described costs and expenses and will arrange Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary Treatment to prevent the Covered Person's loss of life or limb.

The Covered Person may select a different Hospital in their Country of Residence at their option, but in such event the Covered Person shall be solely responsible for all costs and expenses in excess of the amounts that would have been incurred had the Covered Person used the nearest qualified Hospital. If a Hospital other than the nearest qualified Hospital is selected by the Covered Person, then the attending Physician, Covered Person or a Relative of the Covered Person shall certify to the Company the Covered Person's understanding and acknowledgement of such responsibility for excess costs and expenses in addition to the matters set forth in the CONDITIONS AND RESTRICTIONS subparagraph, above. In all cases the Company will make the necessary arrangements for the Emergency Medical Evacuation and will use its best efforts to arrange with independent, third-party contractors any Emergency Medical Evacuation within the least amount of time reasonably possible.

By acceptance of this Certificate of Coverage and request for Emergency Medical Evacuation benefits hereunder, the Covered Person understands, acknowledges and agrees that the timeliness, duration, occurrences during and outcome of an Emergency Medical Evacuation can be directly and indirectly affected by events and/or circumstances that are not within the supervision or control of the Company, including but not limited to: the availability, limitations, physical condition, reliability, maintenance and training schedules and procedures and performance or non-performance of competent transportation equipment, supplies and/or staff of such third-party contractors; delays or restrictions on flights or other modes or means of transportation caused by mechanical problems, government officials, telecommunications problems, non-availability of routes, Destination and/or other travel, geographical or weather conditions; and other acts of God and unforeseeable and/or uncontrollable occurrences.

The Covered Person agrees to release and to hold the Company, the Plan Administrator and their agents and representatives harmless from, and agrees that the Company, the Plan Administrator and their agents and representatives shall not be held liable or responsible for, any delays, losses, damages, further Injuries or Illnesses, or any other claims that arise from or are caused in whole or in part by the acts or omissions of such independent third-party contractors or their agents, employees or representatives, or that arise from or are caused in whole or in part by any acts, omissions, events or circumstances that are not within the direct and immediate supervision and control of the Company, the Plan Administrator and/or their authorized agents and representatives, including without limitation the events and circumstances set forth above.

The Covered Person further agrees that upon seeking an Emergency Medical Evacuation, he or she will cooperate fully as required by the CONDITIONS AND GENERAL PROVISIONS, COOPERATION provision. Failure to so cooperate and/or failure to use or accept Emergency Medical Evacuation once it has been arranged by the Company or Plan Administrator will require the Covered Person to reimburse the Company for costs incurred for any Emergency Medical Evacuation that was arranged, but not used, by the Covered Person. Furthermore, the Covered Person may be required to arrange for payment of any subsequent

Emergency Medical Evacuation and seek reimbursement thereafter for eligible costs associated with that subsequent Emergency Medical Evacuation.

## RETURN OF MINOR CHILDREN OR TRAVELING COMPANION

If the Covered Person is the only person traveling with minor Dependent children who are under the age of 21, or with a Travel Companion, and the Covered Person who is outside their Country of Residence, suffers a Sickness or Injury and must be Hospital Confined for at least 48 consecutive hours, or are medically evacuated to another location, benefits are payable for the cost of the Dependent or Travel Companion's one way economy airfare ticket and/or ground transportation ticket to Their Home Country. All transportation arrangements must be made by the most direct and economical route and conveyance possible and may not exceed the usual level of charges for similar transportation in the locality where the expense is incurred. The return must occur during the Covered Person's Hospitalization. The Company will deduct from the return transportation benefits payable hereunder the value, if any, of the unused commercial airline return ticket(s) possessed by or for the benefit of the Child or Traveling Companion at the time of the Covered Person's Hospitalization. The Covered Person and/or the Child/Traveling Companion must first attempt to receive credit for or deduct toward the costs of the return trip. Benefits will not be paid unless all expenses are approved in advance by Us, The Company will not provide any benefits, reimbursements or coverages for any costs or expenses incurred by the Covered Person and/or by the Child/Traveling Companion for a return trip, if any, to the original location of the Child/Traveling Companion at the time of the Hospitalization.

## REPATRIATION OF MORTAL REMAINS

In the event of the death of the Covered Person during the Period of Insurance as a result of a Sickness or Injury covered under this insurance while the Covered Person is outside of their Country of Residence, the Company will reimburse the authorized personal representative or the estate of the Covered Person up to the amount shown in the Schedule of Benefits for the costs and expenses incurred to return the Covered Person's Mortal Remains to their Country of Residence and thereafter to the place of burial or other final disposition (not including any costs of burial or other disposition); provided, however, that the Company must approve all costs and expenses related to the return of the Covered Person's Mortal Remains in advance as a condition to the availability of this benefit. Covered Expenses include Expenses for embalming or cremation; the least costly coffin or receptacle adequate for transporting the remains; transporting the remains by the most direct and least costly conveyance and route possible and pre-approved by the Assistance Provider. Benefits will not be payable unless We authorize in writing or by an authorized electronic or telephonic means all expenses in advance. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar personal burial preferences.

## ACCIDENTAL DEATH & DISMEMBERMENT – 24 Hour

Accidental Death and Dismemberment will apply to Covered Accidents incurred by a Covered Person. If Injury to the Covered Person results in any one of the losses shown below within 90 days from date of the Covered Accident, We will pay the Benefit Amount shown below for that loss. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Covered Accident.

| COVERED LOSS                                                              | BENEFIT AMOUNT        |
|---------------------------------------------------------------------------|-----------------------|
| Loss of Life                                                              | 100% of Principal Sum |
| Loss of Hands (Both), Loss of Feet (Both), or Loss of Sight of One Eye    | 100% of Principal Sum |
| Quadriplegia                                                              | 100% of Principal Sum |
| Paraplegia                                                                | 75% of Principal Sum  |
| Hemiplegia                                                                | 75% of Principal Sum  |
| Loss of Hand, Loss of Foot, or Loss of Sight of One Eye (any one of each) | 50% of Principal Sum  |
| Uniplegia                                                                 | 25% of Principal Sum  |
| Loss of Thumb and Index Finger of the same hand                           | 25% of Principal Sum  |

Exposure and Disappearance Benefit – Benefits are payable if a Covered Person is exposed to the elements after the forced landing, stranding, sinking, or wrecking of a vehicle in which they were traveling. The Covered Person is presumed dead if they are in a vehicle that disappears, sinks, or is stranded or wrecked and Their body is not found within six (6) months of the Covered Accident.

## PUBLIC HEALTH EMERGENCY

Subject to all other Terms of this insurance, in the event of a Public Health Emergency of International Concern, Epidemic, Pandemic, other disease outbreak, or Natural Disaster, that may affect an Covered Person's health, the Company will cover an Illness or Injury incurred during the Period of Insurance and caused by the Public Health Emergency of International Concern, Epidemic, Pandemic, other disease outbreak, or Natural Disaster when, prior to the issuance of a Travel Warning for the Destination Country or a Global Travel Warning: (1) the Effective Date of Coverage has occurred; and (2) the Covered Person has arrived in the Destination Country or Affected Area.

In the event that the applicable Travel Warning is removed for the Destination Country or Affected Area, coverage for an Illness or Injury incurred during the Period of Insurance after the Travel Warning is removed, which was caused by the Public Health Emergency of International Concern, Epidemic, Pandemic, other disease outbreak, or Natural Disaster will be considered by the Company the same as any other Illness or Injury, subject to all other Terms and conditions of this insurance.

## EXCLUSIONS

Except as expressly provided for in Benefit Summary, all Charges, Cost, expenses and/or claims incurred by the Covered Person, and directly or indirectly relating to or arising or resulting from or in connection with any of the following acts, omissions, events, conditions, expenses, consequences, Treatment (including diagnosis, consultations, tests, examinations and evaluations related thereto), services and/or supplies are expressly excluded from coverage under this insurance, and the Company shall provide no benefits or reimbursements and shall have no liability obligation for any coverage thereof or thereafter:

1. Pre-Existing Conditions: Expenses incurred resulting directly or indirectly from or relating to any Pre-existing Condition are excluded from coverage under this insurance except and unless the Charges

resulted directly from a sudden and unplanned recurrence or Acute Exacerbation of a Stable Pre-Existing Condition, in which case the charges will be covered only according to the Terms of PRE-EXISTING CONDITION Benefit provision.

2. Any condition that requires immediate medical attention within five (5) days following the Effective Date unless the Charges resulted directly from a sudden and unplanned recurrence or Acute Exacerbation of a Stable Pre-Existing Condition, in which case the charges will be covered only according to the Terms of PRE-EXISTING CONDITION Benefit provision.
3. Expenses incurred a) for any potentially fatal condition diagnosed before the Effective Date; b) any condition for which the Covered Person is traveling to seek medical Treatment; c) traveling against the advice of a Physician, while on a waiting list for Inpatient Hospital or clinic treatment.
4. Expenses incurred for any condition directly or indirectly related to or caused by cancer, dialysis, or any ongoing or preventative care associated therewith. This exclusion applies notwithstanding the PRE-EXISTING CONDITION BENEFIT provision.
5. Expenses incurred for Chronic, Congenital, congenital anomalies, or recurrent Sicknesses and conditions arising out of or resulting therefrom, except to the extent expressly covered under the PRE-EXISTING CONDITION BENEFIT provision.
6. Expenses incurred for complications, consequences, or Treatment arising from or related to a) any Treatment, Sickness, Injury, or supply received prior to the effective date of coverage under this insurance; b) any condition, Treatment, Injury, Sickness, or supply excluded from coverage or otherwise not covered under this insurance; or c) complications due to any Sickness or Injury not covered under this insurance.
7. Expenses incurred for any sexually transmitted or venereal disease; and/or any testing for the following: HIV, Vaccine induced seropositivity to the AIDS virus, AIDS related Sicknesses, ARC Syndrome, AIDS. This exclusion includes Charges for any Treatment or supplies for a Covered Person who was HIV + on or before the Initial Effective Date of this insurance, whether or not the Covered Person had knowledge of their HIV status prior to the Effective Date, and whether or not the Charges are incurred in relation to or as a result of said status. As well as conditions arising or resulting directly or indirectly from HIV, AIDS virus, AIDS related Sickness, ARC Syndrome, AIDS and/or any other Sickness arising or resulting from any complications or consequences of any of the foregoing conditions.
8. Expenses incurred for the Treatment of hernia; Dengue Fever; Osgood-Schlatter's Disease; osteochondritis; osteomyelitis.
9. Expenses incurred related to any medical examination, treatment and surgical intervention which are not administered in a licensed healthcare institution.
10. Expenses incurred at a Hospital or Facility when the Covered Person checks themselves out Against Medical Advice (AMA) of their Physician and leaves before reaching a Medically Necessary specified endpoint of Treatment or when the Sickness or Injury worsens after the Covered Person Left or discharged from the Facility Against Medical Advice.
11. Expenses incurred related to medical examination where no Sickness has been diagnosed or Accident has been ascertained; for any visit to a medical provider that does not result in a covered Diagnosis code after medical review or testing and for non-specified pain.
12. Expenses incurred services, supplies, or treatment expenses which are non-medical in nature.
13. Expenses incurred for Elective Surgery or Treatment of any kind

14. Expenses incurred for Surgeries, Treatment or supplies which are Investigational, Experimental and for research purposes.
15. Expenses incurred Treatment not administered or ordered by a Physician.
16. Expenses incurred Treatment not Medically Necessary for the Diagnosis, care or Treatment of the physical condition involved. This also applies when and if they are prescribed, recommended, or approved by the attending Physician.
17. Expenses incurred for: a) nonprescription drugs, medicines, vitamins, food extracts, nutritional supplements, IV vitamin therapy, or herbal therapy; b) drugs or medicines not prescribed by a Physician; c) drugs, medications, biological products, Durable Medical Equipment (DME), devices, supplies, services, surgeries, or procedures not approved by the United States Food and Drug Administration (FDA); or d) drugs or medicines considered "off-label" use.
18. Expenses incurred for: a) immunizations, vaccinations, routine or preventive examinations, wellness screenings, laboratory testing, or diagnostic imaging where there is no objective indication of disease, illness, Injury, or impairment of health; or b) Genetic Medicine, genetic testing, surveillance testing, genetic counseling, wellness screening procedures, gene therapy, prophylactic surgery, risk assessment, or treatment associated with genetic testing or genetically predisposed conditions.
19. Expenses incurred for: a) eye refractions, eye examinations for corrective lenses, or fitting of corrective lenses unless required as a result of a covered accidental bodily Injury; b) refractive eye surgery performed primarily to correct nearsightedness, farsightedness, or astigmatism; or c) contact lenses, hearing aids, wheelchairs, braces, appliances, artificial limbs, orthopedic braces, orthotic devices, orthoptics, visual therapy, visual training, artificial eyes, larynx devices, examinations, prescriptions, repairs, or replacements relating thereto.
20. Expenses incurred any non-surgical Sickness or Treatment of the feet, including without limitation: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; Treatment of weak, strained, flat, unstable, or unbalanced feet; metatarsalgia, bone spurs, hammer toes or bunions; and any Treatment or supplies for corns, calluses, or toenails.
21. Expenses incurred for childbirth, pre-natal care, delivery, post-natal care, and care of Newborns, including complications of delivery and/or of newborns, birth control, artificial insemination, treatment for fertility or impotency, sterilization or reversal thereof, or abortion.
22. Expenses incurred or Treatment for a) cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is Medically Necessary and is directly related to and follows a Surgery which was covered under this insurance; b) modification of the physical body in order to change or improve or attempt to change or improve the physical appearance or psychological, mental or emotional well-being of the Covered Person; c) weight modification or any Inpatient, Outpatient, Surgical or other Treatment of obesity; d) hair loss, including without limitation wigs, hair transplants or any drug that promises to promote hair growth, whether or not prescribed by a Physician.
23. Expenses incurred for suicide or attempted suicide, intentional self-injury, while under the effect of intoxicating liquors or drugs.
24. Expenses incurred for any mental or nervous disorders or rest cures.
25. Expenses incurred any Substance Abuse Disorder or any Injury or Sickness sustained as a result of being under the influence of or due wholly or partly to the effects of alcohol, liquor, intoxicating substance, narcotics or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician.

26. Expenses incurred for a) organ, tissue, or marrow transplants; or b) any efforts to keep a donor alive or donor-related expenses associated with a transplant procedure.
27. Expenses incurred for Treatment or supplies for a) wear and tear of teeth due to cavities and chewing or biting down on hard objects, such as but not limited to pencils, ice cubes, nuts, popcorn, and hard candies. b) for Dental Injury without associated face, skull, neck and/or jaws c) Dental Injury or that can be evaluated and Treated in a dental office. d) or Dental services which provide oral care maintenance including tooth repair by fillings, root canals, tooth removal and x-rays; e) temporomandibular joint (TMJ), craniomandibular syndrome, chronic TMJ pain, orthognathic surgery, Le-Fort Surgery, or splints, or f) any dental treatment, except as specifically provided for hereunder.
28. Expenses incurred for: a) private duty nursing; b) custodial care; c) educational, rehabilitative, skilled nursing, or nursing care; or d) hospice care.
29. Expenses incurred for: a) massage therapy, biofeedback, acupuncture, music therapy, occupational therapy, recreational therapy, sleep therapy, speech therapy, or vocational therapy; b) treatment of sleep disorders, including sleep apnea; c) exercise or fitness programs or equipment; or d) Treatment provided by or at the direction or recommendation of a chiropractor, unless ordered in advance by a Physician.
30. Expenses incurred for any Sickness or Injury sustained while participating in any activity where such activity is undertaken in disregard of or against the recommendations, Treatment programs, or medical advice of a Physician or other healthcare provider.
31. Expenses incurred for any Sickness or Injury sustained while taking part in, practicing or training for, participating in: a) a Professional or Semi-Professional Sport; b) an amateur, club, intramural, interscholastic or intercollegiate sport or athletic activities that are sponsored by any governing body or authority; c) activities designated as Adventure Sports, which include, but are not limited to the following: abseiling; BMX; bobsledding; bungee jumping; canyoning; caving; hot air ballooning; jungle zip lining; parachuting; paragliding; parascending; rappelling; skydiving; spelunking; and windsurfing. d) Extreme Sports, which include but are in no way limited to the following (and include any combination or derivative of the following): BASE jumping; big game hunting; cave diving; cliff diving; downhill mountain biking and racing; extreme skiing; freediving; free flying; free running; free skiing; freestyle scootering; gliding; heli-skiing; ice canoeing; ice climbing; kitesurfing; mixed martial arts; motocross; motorcycle racing; motor rally; mountaineering or trekking above elevation of 3500 meters; parkour; piloting a commercial or non-commercial aircraft; powerbocking; scuba diving; sub aqua pursuits; snowmobile racing; truck racing; whitewater kayaking or whitewater rafting Class VI and higher difficulty; and wingsuit flying; e) while taking part in snow skiing, snowboarding, or snowmobiling where the Covered Person is in violation of applicable laws, rules, or regulations of a ski resort, out of bounds or in unmarked or unpatrolled areas; backcountry skiing, skiing off-piste; f) Collision Sports; g) athletic or recreational activities where the Covered Person is not physically or medically fit or does not hold the necessary qualifications to engage in said activities; g) any sporting, recreational or adventure activity where such activity is undertaken against the advice or direction of any local authority or any qualified instructor or contrary to the rules, recommendations, and procedures of a recognized Governing Body for the sport or activity.
32. Expenses incurred for any artificial or mechanical devices designed to replace human organs temporarily or permanently after termination of Inpatient status except as covered under MECHANICAL EQUIPMENT RENTAL FOR TREATMENT OF RESPIRATORY PARALYSIS.

33. Expenses incurred for Treatment paid for or furnished under a) any other individual or group insurance policy, employer-sponsored medical plan, medical prepayment plan, or mandatory government program; or b) any workers' compensation law or similar benefit program.
34. Expenses incurred for care or Treatment in the Covered Person's Country of Residence.
35. Expenses incurred not presented to the Company for payment by way of a completed Proof of Claim within ninety (90) days from the date such Charges are incurred.
36. Expenses incurred in excess of Usual and Customary Charges.
37. Expenses or fees incurred or for a) the completion of Medical Claim Forms b) failure to keep a scheduled appointment. c) due to fluctuations in exchange rates or for any bank charges the Covered Person incurs when a check, bank transfer, or payment is received from the Company.
38. Expenses incurred any Treatment, service or supply not specifically covered by this insurance.
39. Expenses incurred for which the Covered Person would not be responsible for in the absence of this insurance.
40. Expenses incurred for Treatment or supplies that are not incurred, obtained, or received by a Covered Person during the Period of Insurance.
41. Expenses incurred Treatment performed or provided by a Relative of the Covered Person or provided by a person who resides or has resided with the Covered Person or in the Covered Person's home.
42. Expenses incurred for any Sickness or Injury resulting from or occurring during the commission of a violation of law by the Covered Person, including, without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations.
43. Expenses incurred for Sickness or Injury incurred in the Destination Country, Affected Area, or Country of Residence as a result of a Public Health Emergency of International Concern, Epidemic, Pandemic, other disease outbreak, or Natural Disaster, which may affect a Covered Person's health, unless coverage is expressly provided under the PUBLIC HEALTH EMERGENCY provision of this insurance.
44. Expenses incurred for the ordinary cost of a one-way airplane ticket used in the transportation back to the Covered Person's country where an air ambulance benefit is provided.
45. Expenses incurred for any travel, transportation and/or accommodations, except as otherwise expressly provided for under RETURN OF MINOR CHILDREN OR GRAND-CHILDREN OR TRAVELING COMPANION.
46. The Company shall not be liable for and will not provide coverage or benefits for any claim or Charges incurred with respect to any Sickness, Injury, death and dismemberment, or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising or incurred in connection with or as a result of any of the following acts or occurrences: (a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war (b) mutiny, riot, strike, military or popular uprising, insurrection, insurgency, rebellion, revolution, military or usurped power (c) any act of any person acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the Government de jure or de facto or to the influencing of it by violence of any type (d) martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege (e) any use of radiological, chemical, nuclear or biological weapons or any other radiological, chemical, nuclear or biological events of any type (including in connection with an act of Terrorism). Any claim, Charges, Sickness, Injury or other consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether or not directly or indirectly, proximately or remotely occasioned by, or contributed to by, traceable to, or arising in connection

with, any of the said occurrences shall be deemed and considered to be consequences for which the Company shall not be liable under this insurance, except to the extent that the Covered Person shall prove that such claim, Charges, Sickness, Injury or other consequence happened independently of the existence of such abnormal conditions and/or occurrences.

47. The Company shall not be liable for any claim or Charges, Sickness, Injury, or other consequence, whether directly or indirectly, proximately, or remotely occasioned by, contributed to by, or traceable to or arising in connection with any act of Terrorism. Further, the Company shall not be liable for and will not provide any coverage or benefits for any claim, Charges, Sickness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with the following: (a) the Covered Person's active and voluntary planning or coordination of or participation in any act of Terrorism (b) any act of Terrorism that takes place in a location, post, area, territory or country for which a Travel Warning or Emergency Travel Advisory was issued or in effect on or within six (6) months prior to the Covered Person's date of arrival in said location, post, area, territory or country (c) any act of Terrorism that takes place in a location, post, area, territory or country for which a Travel Warning or Emergency Travel Advisory becomes effective or is in effect on or after the Covered Person's date of arrival in said location, post, area, territory or country, and the Covered Person unreasonably fails or refuses to heed such warning and thereafter remains in said location, post, area, territory or country.
48. The Company will not cover any person as under this insurance, if such cover would result in the Company 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 the United States of America.

## DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document.

"Accident" means a sudden, Unexpected, and unintended event directly caused by external, visible means and resulting in physical Injury to the Covered Person.

"Adventure Sports" means Activities undertaken for the purposes of recreation, an unusual experience or excitement. These activities are typically undertaken outdoors and involve a medium degree of risk including, but not limited to abseiling; BMX; bobsledding; bungee jumping; canyoning; caving; hot air ballooning; jungle zip lining; parachuting; paragliding; parascending; rappelling; skydiving; spelunking; and windsurfing.

"Affected Area(s)" Any and all countries, states, provinces, territories, cities, or other areas experiencing ongoing transmission of an Epidemic, Pandemic or other disease outbreak, or Natural Disaster.

"Against Medical Advice, Discharge Against Medical Advice" means against Medical Advice, or AMA, sometimes known as DAMA, Discharge Against Medical Advice, is a term used with a patient who checks themselves out of a Hospital against the advice of their Treating Physician.

"AIDS" means Acquired Immune Deficiency Syndrome.

"Amateur Athletics" means an amateur or other non-professional sporting, recreational, or athletic activity that is organized, sponsored and/or sanctioned, and/or involves regular or scheduled practices, games and/or competitions. Amateur Athletics does not include athletic activities that are non-organized, non-Collision, and engaged in by the Covered Person solely for recreational, entertainment or fitness purposes.

"Ancillary Services" means All Hospital services for a patient other than room and board and professional services. Laboratory tests and Radiology are examples of Ancillary Services.

"Application" means the fully answered and electronically signed individual enrollment form submitted by or on behalf of the Covered Person for acceptance into, coverage under this insurance plan, and which information shall become part of this insurance.

"Assistance Provider" means On Call International.

"Authorization for Release of Medical Information" means a written authorization by the Covered Person for health providers to release medical records and information regarding their past and current Treatment.

"Cardiac Conditions" means medical conditions related to coronary disease, hypertension, high cholesterol/hyperlipidemia, congestive heart failure, arrhythmias, cardiomyopathy, valvular heart disease, Congenital heart disease, and rheumatic heart disease. For the purpose of this definition a heart attack and myocardial infarction fall under the definition of Cardiac Conditions.

"Certificate of Coverage" means the applicable certificate issued by the Company to the Assured, and under which insurance coverage and benefits are provided by the Company to the Covered Person, subject to the terms thereof, and as outlined and evidenced by this certificate and subject to the Terms hereof. The Company, as insurance carrier and underwriter of the certificate, is solely liable and responsible for the coverage and benefits provided thereunder.

"Charges" means any cost, fee or tax incurred for Medical Expenses incurred in the Treatment of an Injury or Sickness.

"Claimant" means the Covered Person or Provider.

"Coinsurance" means Our share of payment of Medical Expenses at the percentage specified in the Schedule of Benefits contained herein and not including any applicable Deductibles or Out-of-Pocket Maximums.

"Copayment" means the amount the Covered Person is responsible to pay for each Urgent Care or Walk-in Clinic visit.

"Collision Sports" means a sport in which the participants purposely hit or collide with each other or inanimate objects, including the ground, with great force and including, but not limited to the following (or other similar style) sports: American football, boxing, hockey, lacrosse, full contact martial arts, rodeo, rugby, and wrestling.

"Common Carrier" means a company or organization that holds itself out to the public as engaging in the business of transporting persons from place to place by air, rail, bus and/or water for compensation, offering its scheduled services to the public generally, and is licensed by a recognized and approved government authority to transport fare-paying passengers. The term Common Carrier does not include private car, taxi, rideshare, motorcar, motorcycle, or limousine services, or transportation by animal or human means (for example, by horse, camel, elephant, or rickshaw).

"Company" means Zurich Insurance Europe AG Belgian branch. This Certificate of Coverage 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 Certificate of Coverage.

"Congenital" means any abnormality, deformity, disease, Sickness, Injury, or medical condition present at birth, whether diagnosed or not.

"Congenital Disorder" means any abnormality, deformity, disease, Illness, Injury, or medical condition present at birth, whether diagnosed or not.

"Covered Accident" means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Certificate of Coverage for which benefits are payable.

"Covered Expenses" means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by the Certificate of Coverage. Coverage must remain continuously in force from the date of the Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service, or supply, which gave rise to the expense or the charge, was rendered or obtained.

"Covered Loss" or "Covered Losses" means an accidental death, dismemberment or other Injury covered under the Certificate of Coverage.

"Covered Person" means any Insured and Dependent for whom the required Premium is paid (herein also referred to as "You" or "Your" or "They" or "Their").

"Deductible or Pre-ex Deductible" means the dollar amount, as selected on the Application, and specified in the Declaration, that the Covered Person must pay of ELIGIBLE MEDICAL EXPENSES per Period of Insurance prior to receiving benefits or coverage under this Certificate of Coverage, and not including any applicable Coinsurance. The Deductible is applied to the first eligible claim processed.

"Destination Country" means all the geographical areas that the Covered Person is traveling to or within, other than the primary place of residence declared on the Application as the Country of Residence.

"Diagnosis" means the result of examination or test by a licensed physician providing a specific international CPT or ICD10 code. Failure to obtain a covered Diagnosis will result in the denial of the claim.

"Durable Medical Equipment (DME)" means exclusively the following items: a standard basic hospital bed and/or a standard basic wheelchair.

"Effective Date or Effective Date of Coverage" the date the coverage begins. See EFFECTIVE DATE.

"Elective Surgery or Treatment" means any Treatment or Surgery that is elected by the Covered Person, a Physician, or a medical provider, which is scheduled in advance, is not urgent, and does not involve a Medical Emergency or can be postponed until the Covered Person returns to their Habitual Residence.

"Emergency" means a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Covered Person's life or limb in danger if medical attention is not provided within twenty-four (24) hours, based upon a reasonable medical certainty. Immediate medical intervention and attention is required as a result of a severe, life threatening or potentially disabling condition.

"Emergency Medical Evacuation" means Emergency transportation from the Hospital or medical Facility where the Covered Person is located to a non-local Hospital or medical Facility following the recommendation by the attending Physician who certifies, to a reasonable medical certainty, that the Covered Person has experienced: (a) a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Covered Person's life or limb in danger if medical attention is not provided within twenty-four (24) hours; and (b) where Medically Necessary Treatment cannot be provided locally, either in the Facility of the attending Physician or another local Facility.

"Emergency Use Authorization (EUA)" means a temporary authorization issued by the U.S. Food and Drug Administration (FDA) to allow the use of unapproved medical product, service, a Surgery or Surgical Procedure, prescription medication, drug, biological product, Durable Medical Equipment (DME) or device; or by allowing an otherwise unapproved use or application of an approved medical product, service, Surgery or Surgical Procedure, prescription medication, drug, biological product, Durable Medical Equipment (DME) or device.

"Epidemic" means the occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time.

"Extreme Sports" means any high-risk non-team sport or recreation activity that is dangerous and if performed optimally, even by the highly skilled, risks loss of life or limb. Extreme Sports often involve speed, height, a high level of physical exertion and/or highly specialized gear.

"Facility" means a licensed health care entity such as a Hospital or clinic.

"Genetic Medicine" means the study of the etiology, pathogenesis, and natural history of diseases and disorders that are fully or partially genetic in origin and the application of genetics to medicine or to medical practice, including the prevention, screening, diagnosis, surveillance, and Treatment of these diseases.

"Global Travel Warning" means a published statement, warning or advisory, including any website document, issued by the United States Centers for Disease Control & Prevention (CDC), United States Department of State, United States Bureau of Consular Affairs, or similar government or non-governmental agency of the Covered Person's Country of Residence or Destination Country, warning that any global

travel (travel anywhere) poses serious risks to health, safety and security or exposes the Covered Person to a greater likelihood of life-threatening risks, including all United States Department of State global advisories or global warnings Levels "3 - reconsider travel" and "4 -do not travel" and CDC global advisories or global warnings Level "3 – avoid nonessential travel" or any higher level. When multiple government or non-governmental agencies have issued different levels of warnings or advisories, the highest warning or advisory applicable to the Covered Person's Country of Residence or Destination Country will be considered for coverage under this Certificate of Coverage. For the avoidance of doubt, a Global Travel Warning covers all Affected Areas, including the United States of America and all of its territories.

"Grandchild; Grandchildren" means a family member who is at least fourteen (14) days old but less than nineteen (19) years of age.

"Habitual Residence; Habitual Residency" means the country in which the Covered Person resides or is their usual place of abode, or any country to which the Covered Person pays income taxes based upon employment in that country, at time of purchase. In the event there is more than one Country of Residence under the above-listed criteria, the Country of Residence is the country meeting the above-listed criteria and listed by the Covered Person as their Country of Residence on the Application.

"HIV or "HIV +" means Human Immunodeficiency Virus or laboratory evidence of being positive for Human Immunodeficiency Virus infection.

"Home Country or Country of Residence " means the country in which the Covered Person maintains their current primary residence or usual place of abode and any country to which the Covered Person pays income taxes based upon employment in that country. In the event there is more than one Country of Residence under the above-listed criteria, the Country of Residence is the country meeting the above-listed criteria and listed by the Covered Person as their Country of Residence on the Application.

"Hospice; Hospice Care" means care, Treatment, services, supplies, medications, or equipment provided under a hospice program or for the purpose of palliative, supportive, comfort, or end-of-life care for a terminally ill person.

"Hospital" means an institution that: 1. operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2. provides 24-hour nursing service by Registered Nurses on duty or call; 3. has a staff of one or more licensed physicians available at all times; 4. provides organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5. is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6. is not a place solely for drug addicts, alcoholics, or the aged or any separate ward of the Hospital.

"Hospital Confined" means an overnight stay as a registered resident bed-patient in a Hospital.

"Illness" means Sickness.

"Immediate Family Member" means the Spouse, parent, parent-in-law, grandparent, child, Grandchild, brother, sister, fiancé, such person being related to the Covered Person.

"Incident" Any situation in which the Terms and conditions of the Certificate of Coverage are activated for either a Sickness, Accident, or Injury.

"Injury" means accidental bodily harm sustained by a Covered Person that results, directly and independently from all other causes, from a Covered Accident. 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.

"Inpatient" means 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 that person will occupy a bed and (a) remain at least overnight or (b) is expected to need Hospital care for twenty-four (24) hours or more.

"Intensive Care Unit" means an area or unit of a Hospital that meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations for Special Care Units.

"Interfacility Ambulance Transfer" means movement of the patient locally within the United States from one licensed health care Facility to another licensed health care Facility via air or land ambulance (examples: Hospital to Hospital, clinic to Hospital). The Interfacility Ambulance Transfer must be Medically Necessary and Pre-certified in advance to be an Eligible Medical Expense.

"Investigational" means any Treatment that includes drugs, procedures, or services that are still in the clinical stages of evaluation and not yet approved for use by the U.S. Food and Drug Administration (FDA) including an Emergency Use Authorization by the FDA.

"Maximum Limit" means the cumulative total dollar amount of benefit payments and/or reimbursements available to a Covered Person under this Certificate of Coverage. When the Maximum is reached, no further benefits, reimbursements or payments will be available under this Certificate of Coverage.

"Medical Emergency" means a condition caused by an Injury or Sickness that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

"Medically Necessary; Medical Necessity" means 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 Covered Person or their provider; and/or if it is not necessary or appropriate for the Covered 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" means any mental, nervous, or emotional Sickness which generally denotes a Sickness of the brain with predominant behavioral symptoms; a Sickness of the mind or personality, evidenced by abnormal behavior; or a Sickness 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; and those psychiatric and other mental Sicknesses listed in the current edition of the Diagnostic and Statistical Manual for Mental.

"Missing Person" means a Covered Person who disappeared for an unknown reason and whose disappearance was reported to the Appropriate Authority(ies).

"Mortal Remains" means the bodily remains or ashes of a Covered 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.

"Outpatient" means 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.

"Pandemic" means a global outbreak of a disease.

"Physician/Doctor" means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

"Period of Insurance" the period beginning on the Effective Date of this Certificate of Coverage and ending on the earliest of the following dates: (a) the termination date specified in the Declaration; or (b) the termination date as determined in accordance with the termination provision. The Period of Insurance can be no less than ninety (90) days and no more than twelve (12) consecutive months.

"Pre-certification; Pre-certify" means a general determination of Medical Necessity only, made by the Company in reliance and based upon the completeness and accuracy of the information provided by the Covered Person and/or the Covered Person's healthcare or medical service providers, guardians, Relatives and/or proxies at the time thereof. Pre-certification is not an assurance, authorization, pre-authorization or verification of coverage, a verification of benefits, or a guarantee of payment.

"Pre-Existing Condition" means any Injury, Illness, Sickness, disease, Mental or Nervous Disorder, condition or ailment that, with reasonable medical certainty, existed at the time of Application or at any time during the three (3) years prior to the Effective Date of this insurance, whether or not previously manifested, symptomatic, known, diagnosed, Treated, or disclosed to the Company prior to the Effective Date, and including any subsequent Chronic or recurring complications or consequences thereof.

For purposes of the PRE-EXISTING CONDITION BENEFIT provision, the Company may require medical records, prescription history, physician statements, or other documentation reasonably necessary to establish that the condition met the requirements of a Stable Pre-Existing Condition.

"Pregnancy; Pregnant" means 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 fetus develops to birth.

"Premium" means the payments required to effectuate and maintain both the Covered Person's insurance coverage and other non-insurance benefits under this plan, in the amounts and at the times established by the Company

"Professional Sports" means a sport activity, including practice, preparation, and actual sporting events, for any individual or organized team that is a member of a recognized professional or semi-professional sports organization; is directly supported or sponsored by a professional or semi-professional team or professional or semi-professional sports organization; is a member of a playing league that is directly supported or sponsored by a professional or semi-professional team or professional or semi-professional sports organization; or has any athlete receiving for their participation any kind of payment or compensation, directly or indirectly, from a professional or semi-professional team or professional or semi-professional sports organization.

"Proof of Claim" means a duly completed and signed claim form, authorization to release medical information, Physician, Hospital, and other healthcare provider's statement detailing the cost and services rendered and proof of payment for services rendered. Refer to the PROOF OF CLAIM provision for further details.

"Public Health Emergency of International Concern" means a formal declaration by the World Health Organization (WHO) of an extraordinary event which is determined to constitute a public health risk through the international spread of disease, Epidemic, Pandemic and potentially requires a coordinated international response.

"Quarantine" means Your strict isolation imposed by a Government authority or Physician to prevent the spread of disease. An embargo preventing You from entering a country is not a Quarantine.

"Radiology" means specialty services that use medical imaging to diagnose and Treat an Illness or Injury seen within the body. Imaging techniques used in Radiology include x-ray, radiography, ultrasound, computed tomography (CT), nuclear medicine, including positron emission tomography (PET), and magnetic resonance imaging (MRI).

"Registered Nurse" means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." after their name.

"Related Costs" means food, lodging and, if necessary, physical protection for the Covered Person during the Transport to the Nearest Place of Safety.

"Relative" means a parent, legal guardian, spouse, son, daughter, grandchild, or Immediate Family Member of the Covered Person.

"Routine Physical Examination" means an examination of the physical body by a Physician for preventative or informative purposes only, and not for the Treatment of any previously manifested, symptomatic, diagnosed or known Sickness or Injury.

"Self-inflicted" means an action or inaction by the Covered Person that the Covered Person consciously understands will or may cause or contribute, directly or indirectly, to their personal Injury or Sickness. Self-inflicted specifically includes failure of a Covered Person to follow their Doctor's orders, complete prescriptions as directed, or follow any health care protocol or procedures designed to return or maintain their health.

"Sickness" means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs Medical Expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"Sound Natural Teeth" means natural teeth which are the following: Free of active or chronic clinical decay; have at least 75% bony support; functional in the arch; not excessively weakened by multiple dental procedures; whole; not restored with amalgams, resin, or composite; without impairment, periodontal, or other conditions; not in need of services other than for accidental dental Injury; intact with a root, pulp, no decay, with no missing tooth structure due to fracture.

"Spouse" Means a Covered Person's legal Spouse or domestic partner. Such relationship must have met all requirements of a valid marriage contract, domestic partnership, or civil union in the state or Country of Residence where the parties' ceremony was performed.

"Stable Pre-Existing Condition" means a diagnosed illness, disease, or other medical condition that, during the ninety (90) days immediately preceding the Effective Date:

1. Has not required hospitalization or emergency medical treatment;
2. Has not experienced an acute deterioration requiring immediate medical intervention;
3. Has not been the subject of a Physician's recommendation for surgery or other major medical intervention; and
4. Has not required a material change in treatment due to deteriorating of the condition.

Material change in treatment means initiation of a new prescription medication, a significant increase in medication dosage or frequency due to deteriorating of the condition, recommendation for surgery or other major medical intervention, or initiation of a new course of treatment because of deteriorating of the condition.

Routine follow-up care, maintenance medications taken as prescribed, prescription refills, routine monitoring, preventative care, or treatment changes made solely to maintain, titrate, or optimize therapy without evidence of deteriorating shall not constitute a material change in treatment.

"Stacked Insurance" means purchasing the same or like insurance product through the Company, for the same area of coverage, for the same or similar coverage period, and for the same coverage intent to increase a claims payment.

"Stroke" means a loss of blood flow to part of the brain, which causes damages to brain tissue. Types of strokes include but are not limited to Ischemic stroke, Hemorrhagic stroke, and transient ischemic attack (TIA).

"Substance Abuse Disorder" means alcohol, drug or chemical abuse, misuse, illegal use, overuse, or dependency.

"Superbill" means an itemized list of all services provided to the Covered Person by a Physician or medical provider.

"SureGo claim form" means a form which allows the Covered Person to request reimbursement or direct payment for medical services obtained.

"Surgery; Surgical Procedure" means an invasive diagnostic or surgical procedure, or the Treatment of Sickness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

"Termination Date" means the date coverage ends. See TERMINATION DATE.

"Terms" means all Terms, provisions, conditions, definitions, Deductibles, Coinsurance, limits, sub-limits, limitations, wordings, restrictions, requirements, qualifications and/or exclusions that bind the Covered Person as set forth in the Certificate of Coverage, Application.

"Terrorism" means 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 or international organization to do or to abstain from doing an act.

"Transport" or "Transportation" means the most efficient and available method of conveyance. Where practical, Economy Fare will be utilized. If possible, the Covered Person's common carrier tickets will be used.

"Traveling Companion" means a person or persons with whom the Covered Person has coordinated travel arrangements, shares the same accommodations as the Covered Person, and intends to travel with the Covered Person during the Trip.

"Travel Warning Emergency Travel Advisory" means a published statement, warning or advisory, including any website document, issued by the United States Centers for Disease Control & Prevention (CDC), United States Department of State, United States Bureau of Consular Affairs, or similar government or non-governmental agency of the Covered Person's Country of Residence or Destination

Country, warning that travel to Affected Areas poses serious risks to health, safety and security or exposes the Covered Person to a greater likelihood of life-threatening risks, including all United States Department of State Travel Advisories or Warnings Levels "3 - reconsider travel" and "4 -do not travel" and CDC Travel Advisories or Warnings Level "3 – avoid nonessential travel" or any higher level. When multiple government or non-governmental agencies have issued different levels of warnings or advisories, the highest warning or advisory applicable to the Covered Person's Country of Residence or Destination Country will be considered for coverage under this insurance. For the avoidance of doubt, a Travel Warning covers all specified Affected Areas, including the United States of America as applicable.

"Treated; Treating; Treatment" means any and all services and procedures rendered in the management and/or care of a patient for the purpose of identifying, diagnosing, treating, curing, preventing, controlling and/or combating any Sickness or Injury, including without limitation: verbal or written advice, consultation, examination, discussion, diagnostic testing or evaluation of any kind, pharmacotherapy or other medication, and/or Surgery.

"Treating Physician" means a Physician providing Treatment to a Covered Person.

"Unexpected" means sudden, unintentional, not expected, and unforeseen.

"Trip" means travel by air, land, or sea from the Covered Person's Home Country.

"Universal Billing Form" means UB 04 and CMS 1500 forms, which are standard and uniform forms in the healthcare industry to submit insurance claims to health insurance companies for reimbursement.

"Urgent Care Clinic or Walk-In Clinic" means a standalone Facility or a Facility located inside a Hospital that staffs Physicians, nurse practitioners (NP) or physician assistants (PA) for Injuries or Sicknesses which are not life-threatening.

"Usual and Customary Charge" means a typical and reasonable amount of reimbursement for similar services, medicines, or supplies within the area in which the Charge is incurred. In determining the typical and reasonable amount of reimbursement, the Company may, in its reasonable discretion, consider one or more of the following factors, without limitation: the amount charged by the provider; the amount charged by similar providers or providers in the same or similar locality; the amount reimbursed by other payors for the same or comparable services, medicines or supplies in the same or similar locality; whether the services or supplies were unbundled or should have been included in the allowance of another service; the amount reimbursed by other payors for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or service as compared to the length of time required to perform other similar services; the length of time required to perform the procedure or service as compared to national standards and/or benchmarks; the severity or nature of the Illness or Injury being Treated; and such other factors as the Company, in the reasonable exercise of its discretion, determines are appropriate.

"We," "Our," "Us" means Zurich Insurance Europe AG Belgian branch.

## FAIR PROCESSING AND PRIVACY NOTICE

### Purpose and Scope of this Notice

Zurich Insurance Europe AG Belgian branch ("The Company") values Your business and Your trust. In order to administer insurance policies and provide You with effective customer service, We must collect certain information including nonpublic personal information about our customers and Claimants. Nonpublic personal information means information that allows someone to identify or contact You. We are committed to protecting such information and We will comply with all applicable federal and state laws and regulations. This notice describes how We collect, use, and share Your information, Your rights with respect to insurance products issued by the Company and Our legal duties and privacy practices. State laws require that We provide this notice. Please review this notice and keep a copy of it for Your records. This notice applies to you because you have taken out international health insurance coverage and have been issued with a summary of benefits through the Certificateholder, AMD Global Trust ("Certificateholder"). For the purposes of your plan summary, Trawick International GmbH is an appointed agent who acts on behalf of us. Your Coverage is underwritten by Zurich Insurance Europe AG Belgian branch.

### What type of information do we obtain about you?

The personal information we obtain about you may include:

- Name, address, phone number, email.
- Gender
- Marital status
- Date and place of birth
- Government identification numbers - National Insurance, Social Security, passport, tax, driver's license
- Banking information – account and credit card details
- Coverage benefits (medical, travel, disability)
- Visa information
- Family information – Spouse/co-habiting partner, dependent(s)/child(ren)
- Health information/medical history
- Travel history/information.
- Claims/Coverage numbers

Please note that, in the context of claims, we may ask for further or different types of personal information depending on the claim. For example, your travel arrangements and your location at the time your claim arose.

### How do we obtain information about you?

We obtain personal information about you from the Certificateholder in the following instances:

- When you take out your Coverage: we underwrite your Coverage in conjunction with our appointed agent, Trawick International, GmbH.
- When you bring a claim pursuant to the terms of your Coverage: we manage any claims that you bring under your Certificate of Coverage. To manage your claims, we engage with our claim's handler, SureGo Administrative Services, Inc., who oversees the claims handling process on our behalf.
- We may also collect or obtain information about you from your family members, credit reference agencies, anti-fraud databases, sanctions lists, relevant government agencies, including US

government databases/information and those who may be involved in a claim – Claimants, witnesses, experts, adjusters, and others.

- Where you provide personal information to us other than your own (via our appointed agent, Trawick International, GmbH), you confirm that you will explain to the person(s) in question that you have provided his/her personal information to us (via our appointed agent, Trawick International, GmbH ) and that he/she understands that his/her personal information will be processed in line with this notice.

Why do we obtain your personal information? We may collect your personal information for the following purposes:

- Account setup, including background checks
- Evaluating risks to be covered
- Customer service communications
- Payments to/from individuals
- Managing insurance or reinsurance claims
- Defending or prosecuting legal claims
- Investigating or prosecuting fraud
- Complying with legal or regulatory obligations

What is the legal basis for us obtaining your personal information?

When we process your personal information, we do so on the following grounds:

- To perform the terms of your Certificate of Coverage
- To pursue our legitimate interests: to train our staff in how to perform their duties/our services, to improve our service, to conduct statistical analysis, to enhance our product offerings and to assist in regulatory inquiries. Before processing your personal information to pursue our legitimate interests, we carefully assess the impact of our processing activities on your rights and freedoms. On balance, we consider that our legitimate interests do not override your rights and freedoms which require the protection of your personal information
- To comply with laws or regulations to which we are subject
- To exercise, establish or defend legal claims or proceedings to which you may be a party
- When we process special categories of your personal information (e.g., health information), we do so on the following grounds:
  - For the purposes of your Certificate of Coverage, where it is necessary and proportionate, subject to suitable and specific measures being taken to protect your personal information
  - To exercise, establish or defend legal claims or proceedings to which you are or may be a party.

Who receives your personal information?

We will share your personal information with various representatives of Zurich Insurance Europe AG Belgian branch along with our appointed agent, (Trawick International, GmbH) and claims handler (SureGo Administrative Services) affiliates, reinsurers, agents, or contractors.

Where does your information go?

If you are ordinarily resident in the European Economic Area (EEA), you should be aware that we may need to transfer your personal information to some of our recipients (e.g., our appointed agent (Trawick International, GmbH), claims handler (SureGo Administrative Services) and affiliates). Some of these recipients are located outside the EEA in countries which may not have laws that protect your personal information in the same way as the data protection laws in the EEA. Where these transfers occur, we ensure that: (a) they do not occur without our prior written authority (where applicable); and (b) an appropriate transfer mechanism or agreement is in place to protect your personal information (e.g., the

European Commission's Standard Contractual Clauses, the EU-US Data Privacy Framework or the Swiss-EU Privacy Shield). For more information on these transfers, please contact the Data Protection Officer.

How long do we keep your information?

We will keep your personal information only so long as is necessary to provide service to you under your Coverage. Specifically, we will keep your information for so long as a claim may be brought under your Coverage, or where we are required to keep your personal information to satisfy legal or regulatory obligations.

Your Rights

Under certain circumstances, you have the right:

- To receive a copy of the personal information we have collected from you
- To receive further details of the use we make of your personal information
- To update or correct the personal information we hold about you
- To require us to delete any personal information we no longer have a lawful purpose to use
- To restrict our use of your personal information
- To object to our processing of your personal information
- To transfer your personal information from us to another provider
- If you are not satisfied with our processing of your personal information, file a complaint with the appropriate supervisory authority.

There are specific circumstances where we may need to restrict the rights described above, in order to safeguard the rights of others (e.g., individuals), the public interest (e.g., the prevention or detection of crime) or our interests (e.g., to maintain legal privilege).

How to Contact Us

Address any questions regarding our privacy practices or this Notice to:

Trawick International Inc.

Post Office Box 2284 Fairhope Alabama USA 36533

888-301-9289

## CLAIM PROCEDURES

All claims must be submitted within 90 days of the date of service. All claims **MUST BE ON A FULLY COMPLETED** claim form including medical history sections. A claim form must be completed and provided for each medical condition. Providers should submit claims using the Universal Billing Form.

**EXPLANATION OR VERIFICATION OF BENEFITS:** In the event of any verbal or telephone inquiry, every attempt will be made to help the Covered Person and their healthcare providers and suppliers understand the status, scope and extent of available benefits and coverage under this insurance, provided, however, that no statement made by any agent, employee or representative of the Company or the Plan Administrator will be deemed or construed as an actionable representation, promise or estoppel or will create any liability against the Company or the Plan Administrator or be deemed or construed to bind the Company or to modify, replace, waive, extend or amend any of the Terms of this Certificate of Coverage, unless expressly set forth in writing and signed by an authorized agent or representative of the Company. Actual eligibility determinations, benefit verifications, final coverage decisions, claim adjudications, final payments, reimbursements of benefits, or claims shall be determined and adjudicated only after or at the time a proper and complete Proof of Claim is

submitted (as the case may be), an opportunity for reasonable investigation and/or review is provided, cooperation required hereunder received, and all facts and supporting information, including relevant data, information and medical records when deemed necessary or appropriate by the Company, are presented in writing. Appealed claims may be further investigated and/or reviewed. The Terms and Conditions govern all available coverage and payments made or to be made. If a definite answer to a specific benefits or coverage question is required for any reason, the Covered Person or their healthcare providers may submit a written request to the Company, including all pertinent medical information and a statement from the attending Physician (if applicable), and a written reply will be sent by the Company and kept on file. If the Company elects to verify generally and/or preliminarily to a provider or the Covered Person that an Injury, Sickness, diagnosis or proposed Treatment is or may be covered under this insurance, or that benefits for same are or may be available as outlined in this Certificate of Coverage, any such verification of benefits does not guaranty either payment of benefits or the amount or eligibility of benefits. Final eligibility determinations, coverage decisions, claim appeals and actual reimbursement or payment of claims or benefits are subject to all Terms of this insurance, including without limitation filing a proper and complete Proof of Claim and complying with the COOPERATION provision.

**GOVERNING JURISDICTION:** All claims arising under this insurance shall be governed by the Laws of Cayman Islands whose courts alone shall have jurisdiction in any dispute arising hereunder.

**NOTICE OF CLAIM:** A Claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 90 days after any loss covered by the Certificate of Coverage occurs. If the Claimant or Covered Person is incapacitated within the 90 days after the loss, it must be given as soon as reasonably possible. This notice should identify the Covered Person and the Certificate Number. All claims must be submitted within 90 days from date of incident, or they will be denied. Reasonable circumstances may exist in which this is not always possible. Any submissions after 90 days will be reviewed by Us to determine if the delay is reasonable.

**CLAIM FORMS:** Upon receiving written notice of claim, We will provide claim forms to the Claimant within 15 days. If We do not furnish such claim forms, the Claimant will satisfy the requirements of written Proof of Claim by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss and give authorization to release medical records.

**PROOF OF CLAIM:** (a) A Proof of Claim shall not be effective and will not satisfy the Terms of this insurance unless it includes all the following: (i) a duly completed, timely submitted and signed SureGo Claim Form for each new Sickness or Injury diagnosis unless the Company waives such requirement in writing (ii) an Authorization for Release of Medical Information when specifically requested by SureGo (iii) all original Universal Billing Forms, Superbill and statements of service rendered from Physicians, Hospitals, and other healthcare or medical service providers involved with respect to the claim (iv) all original receipts for any costs, prescription medications, fees or expenses that have been incurred or paid by, or on behalf of, the Covered Person with respect to the claims, including without limitation all original receipts for any cash and/or credit card payments. The provider of service's full name, address, telephone number (including area/country code), date of service, description of service (applicable

procedure codes), and diagnosis codes must be included on the receipts. (v) If the claims are submitted electronically, copies of the above items are acceptable; however, the Company reserves the right to request the original documents. Other documents that may be requested are proof of travel, copy of passport, and other documents to support the claim.

**TIMELY FILING REQUIREMENTS:** The Covered Person and/or Physician, Hospital and other healthcare and medical service providers and suppliers shall have ninety (90) days from the date a claim is incurred to submit a complete Proof of Claim. The Company at its option may pend resolution and adjudication of submitted claims and/or may deny coverage due to any of the following: (i) SureGo's receipt of an incomplete Proof of Claim (ii) failure to submit any Proof of Claim (iii) Covered Person's, Physician's or Hospital's failure to submit a timely Proof of Claim (c) The Company may require the Covered Person to sign an Authorization for Release of Medical Information to request medical records on their behalf or supply us with additional documentation as deemed necessary to make a benefit determination based on the submitted Proof of Claim. The Covered Person and/or Physician, Hospital and other healthcare and medical service providers and suppliers shall have 90 days or the time allowed by the PPO Network, from the date of the request to submit the requested information. If the information is not received within the designated time period, previously submitted and subsequent claims will be denied.

**PROOF OF ELIGIBILITY:** A Covered Person must provide Us or Our authorized representative with written proof of ELIGIBILITY as outlined in this Certificate of Coverage, at time of Claim. Proof of Eligibility is required prior to any processing of a Claim.

**COOPERATION:** The Covered Person and their Physicians, Hospitals and other healthcare and medical service providers and suppliers shall undertake to cooperate fully with the Company and the Plan Administrator in reviewing, investigating, adjudicating, considering an appeal of, and/or administering any claim for benefits under this insurance, including granting full right of access to all relevant, pertinent or related records, medical documentation, medical histories, reports, laboratory or test results, x-rays, and all other available evidence relating to or affecting the review, investigation, adjudication or administration of the claim. The Company at its own expense shall have the right and opportunity to examine all evidence related to a claim when and as often as it may reasonably require during the pendency of a claim hereunder. The Company at its option may suspend or pend adjudication of a claim and/or may deny benefits and/or coverage for a claim when any of the following has occurred: (a) a refusal to so cooperate (b) an unreasonable delay in such cooperation (c) any other act or omission on the part of the Covered Person and/or their healthcare providers which hinders, delays, impairs or otherwise prejudices the performance of the Company's obligations under this insurance. Time Payment of Claims: Benefits for loss covered by the Certificate of Coverage, other than benefits that require periodic payment, will be paid not more than 60 days after We receive proper written proof of such loss.

**PAYMENT OF CLAIMS:** If the Covered Person dies, any death benefits or other benefits unpaid at the time of the Covered Person's death will be paid to the beneficiary. If no beneficiary is on record with Us or Our authorized agent, payment will be made to the first surviving class of the following to the Covered Person's: 1. Spouse; 2. children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian); 3. mother or father; 4. estate. All other benefits due and not assigned will be paid to the Covered Person if living. Otherwise, the benefits may, at our option, be paid: 1. according to the

beneficiary designation; or 2. to the Covered Person's estate. If a benefit due is payable to: 1. the Covered Person's estate; or 2. the Covered Person or a beneficiary who is either a minor or is not competent to give a valid release for the payment, We may pay any amount due to some other person. The other person will be one who we believe is entitled to the payment and who is related to the Covered Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith. We may pay benefits directly to any Hospital or person rendering covered services unless the Covered Person requests otherwise in writing. The Covered Person must make the request no later than the time he or she files a written Proof of Claim.

**RIGHT OF RECOVERY:** In the event of overpayment by the Company of any claim for benefits under this insurance, for any reason, including without limitation because of any of the following: (a) all or part of the claim was not incurred by or paid by or on behalf of the Covered Person (b) the Covered Person or any of the Covered Person's Relatives, whether or not the Relative is or was a Covered Person under this insurance plan, is repaid or is entitled to be repaid for all or part of the claim in accordance with the conditions and other insurance provision, for defective equipment or medical devices covered under a warranty, or by or from a source other than the Company (c) all or part of the claim was not eligible for payment or coverage under the Terms of this insurance (d) all or part of the claim was paid or reimbursed based on an incorrect or mistaken application of benefits under this insurance (e) all or part of the claim has been excused, waived, abandoned, forfeited, discounted or released by the provider (f) the Covered Person is not liable or responsible as a matter of law for all or part of a claim. The Company shall have the right to receive a refund and to recover the amount of overpayment from the Covered Person and/or the Hospital, Physician and/or other provider of services or supplies (as the case may be). The amount of the refund and recovery for overpayment of claims shall be the difference between the amount actually paid by the Company and the amount, if any, that should have been paid by the Company under the Terms of this insurance. For all other overpayments, the amount of the refund and recovery shall be the amount overpaid. If the Covered Person, Hospital, Physician, or other provider of services or supplies does not promptly make any such refund to the Company, the Company may, in addition to any other rights or remedies available to it (all of which are reserved): (i) reduce or deduct from the amount of any future claim that is otherwise eligible for coverage or payment under this insurance, to the full extent of the refund due to the Company; and/or (ii) cancel this Certificate of Coverage and all further coverage of the Covered by giving thirty (30) days advance written notice by mail to the Covered Person at their last known residence or mailing address and offset against the amount of any refund of Premium due the Covered Person to the full extent of the refund due to the Company.

**ASSIGNMENT, CHANGE OR WAIVER:** Notwithstanding any law, statute, judicial decision or rule to the contrary that may be or may purport to be otherwise applicable within the jurisdiction, locale or forum state of any healthcare or medical service provider, no transfer or assignment of any of the Covered Person's rights, benefits or interests under this insurance shall be valid, binding on or enforceable against the Company or Plan Administrator unless first expressly agreed and consented to in writing by the Company. Any such purported transfer or assignment not in compliance with the foregoing Terms shall be void ab initio and without effect as against the Company or Plan Administrator, and the Company shall have no liability of any kind under this insurance to any such purported transferee or

assignee with respect thereto. The Terms of this Certificate of Coverage shall not be waived or modified except by the express written agreement of the Company.

**BENEFICIARY:** The Covered Person may designate a beneficiary. The Covered Person has the right to change the beneficiary at any time by written (or electronic and telephonic) notice. If the Insured is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when We or Our authorized agent receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change. The Primary Covered Person is the beneficiary for any covered Dependent.

**INSOLVENCY:** The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors or dissolution of the Assured or any Covered Person shall not impose upon the Company any liability or obligation other than that specifically included in this insurance.

**SUBROGATION CLAUSE:** The Covered Person shall undertake to pursue in their own name and stead, and to fully cooperate with the Company in the pursuit and prosecution of, any and all valid claims that the Covered Person may have against any third-party who may be liable or responsible for any loss or damage arising out of any act, omission or occurrence that results or may result in a loss payment, provision of benefits or coverage of claim by the Company under this insurance and to fully account to the Company for any amounts recovered or recoverable in connection therewith, on the basis that the Company shall be reimbursed and entitled to recover first in full for any sums paid or to be paid by it before the Covered Person shares in any amount so recovered, regardless of whether or not the Covered Person has been made whole or has been fully compensated for their injuries. The Covered Person further agrees and understands that the Company requires the Covered Person to complete a subrogation questionnaire, sign an acknowledgment of the Company's subrogation rights and sign an agreement before the Company considers paying, or continues to pay, any claims. Should the Covered Person fail to so cooperate, account or prosecute any valid claims against any such third-party or parties, and the Company thereupon or otherwise becomes liable or otherwise obligated to make payment under the Terms of this insurance, then the Company shall be fully subrogated to all rights and interests of the Covered Person with respect thereto and may prosecute such claims in its own name as subrogee. The Covered Person's submission of Proof of Claim or acceptance of coverage or benefits under this insurance shall be deemed to constitute an authorization, consent, and assignment of such subrogation rights by the Covered Person to the Company. The Covered Person agrees that the Company has a secured proprietary interest in any settlement proceeds the Covered Person receives or may be entitled to receive. The Covered Person understands and agrees that the Company is entitled to a constructive trust interest in the proceeds of any settlement or recovery. The Covered Person agrees to include the Company as a co-payee on any settlement check or check from any third party or insurer. The Covered Person agrees he/she will not release any party or their insured without prior written approval from the Company and will take no action that prejudices the Company's rights. The Covered Person is obligated to inform their legal representative of the Company's rights and lien and to make no distributions from any settlement or judgment that will in any way result in the Company receiving less than the full amount of its lien without the written approval of the Company. Any amount recovered by the Company in accordance with the foregoing shall first be used to pay in full the costs and expenses

of collection incurred by the Company, including reasonable attorneys' fees, and for reimbursement to the Company for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts recovered shall be paid to the Covered Person or other persons lawfully entitled thereto, as applicable. In the event that the Covered Person receives any form or type of settlement and either fails or refuses to abide by the Terms of this insurance contract, in addition to any other remedies the Company may have, the Company retains a right of equitable offset against future claims.

**OTHER INSURANCE:** The Company shall not be liable or obligated to provide any coverage or benefits or to pay or reimburse any claim under this insurance if there is any other insurance, membership benefit, workers' or workplace compensation coverage program or other government programs, reimbursement or indemnification coverage, right of contribution, recoupment or recovery, contract, or any other third-party obligation or liability for provision of benefits ("Other Coverage") that would, or would but for the existence of this insurance, be available or obligated to provide such benefit or to pay or reimburse or provide indemnity for such claim, except in respect of any excess beyond the amount payable or provided under such Other Coverage had this insurance not been effected. Notwithstanding the foregoing, the Company shall not be liable or obligated to provide any benefit or to pay or reimburse any claim for any Covered Person in respect to Treatment or supplies furnished by any program or agency funded by any government or government authority.

The Company reserves the right to cancel any and all coverage if it is determined a Covered Person has Stacked Insurance.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death unless the law forbids it. We will pay the cost of the examination or autopsy.

**APPEALING A CLAIM:** In the event the Company denies all or part of a claim, the Covered Person shall have ninety (90) days from the date that the notice of denial was mailed to the Covered Person's last known residence or mailing address within which to appeal the determination. The Covered Person must file an appeal prior to bringing any legal action under the contract of insurance. The Covered Person should submit a written request for an appeal along with comments, all relevant, pertinent, or related documents, medical records and other information relating to the claim. The appeal must be sent to: SureGo Administrative Services Attn: Benefit Review 30466 Sgt. E.I. Thomas Boots Drive, Suite 205, Spanish Fort, AL 36527. The Company's review will consider all comments, documents, records and other information submitted by the Covered Person relating to the claim without regard to whether such information was submitted or considered in the initial claim determination. Upon receipt of a written appeal, the Company shall have an opportunity for further reasonable investigation and/or review as set forth in the **CONDITIONS AND GENERAL PROVISIONS, EXPLANATION OR VERIFICATION OF BENEFITS** provision and will respond in writing as soon as reasonably practicable, and in any event within ninety (90) days from receipt thereof.

**SERVICE OF SUIT; VENUE; CHOICE OF LAW:** No action or proceeding of any kind can be brought by a Covered Person to recover on the contract of insurance prior to the later of (a) expiration of sixty (60)

days after written Proof of Claim has been furnished in accordance with the contract of insurance or (b) exhaustion of one (1) appeal under the CONDITIONS AND GENERAL PROVISIONS, APPEALING A CLAIM provision above. No action or proceeding can be brought after the expiration of three (3) years after the time written Proof of Claim is required to be furnished under the contract of insurance. The contract of insurance between the Covered Person and the Company, as evidenced by this Certificate of Coverage, shall be deemed issued, finalized, and made in Cayman Islands. Sole and exclusive jurisdiction and venue for any action or proceeding of any kind relating to or arising from this insurance and/or the Terms and conditions of this Certificate of Coverage (including any amendment thereto) shall be in Grand Cayman, Cayman Islands for which the Company and the Covered Person expressly consent. The subjects, risks and benefits of insurance evidenced by this Certificate of Coverage are not intended or considered by the Covered Person or the Company (or the Plan Administrator) to be resident, located, or performed in any particular State of the United States. Cayman law shall govern all rights and claims relating to or arising from this insurance and/or this Certificate of Coverage (including any amendment thereto).

In the event of the failure of the Company to provide benefits or pay or reimburse any amount claimed to be due under this insurance, the Company, at the request of the Covered Person and upon receipt of lawful process or summons, will submit to the jurisdiction of a court of competent subject matter jurisdiction located in Cayman Islands, provided there exists an independent statutory and constitutional basis for in personal jurisdiction over the Company in said court and by said forum State. The Company and the Covered Person consent to *personam* jurisdiction and venue in the Grand Cayman, Cayman Islands (assuming that federal jurisdiction is otherwise appropriate and lawful). The Company reserves the right, acting by and through the Plan Administrator or otherwise, to initiate and pursue actions for declaratory judgment and/or other appropriate relief with respect to the validity, binding effect, administration of and/or any dispute, claim, or controversy relating to or arising from this insurance. In any suit instituted by or against the Company or the Covered Person pursuant to the Terms of this provision, the Company and the Covered Person will abide by the final decision of such Cayman Islands court or of any appellate court in the event of an appeal. Nothing in this provision constitutes or should be deemed, considered, or understood to constitute a waiver of the Company's or the Covered Person's rights to oppose venue or jurisdiction in any forum other than the Grand Cayman, Cayman Islands, or all of which rights are expressly reserved and retained.

In the event that the Company is the prevailing party in any litigation, arbitration, or other proceeding of any kind relating to or arising from this insurance and/or the Terms and conditions of this Certificate of Coverage (including any amendment thereto), regardless of the nature of the claim, the Company shall be awarded its reasonable attorney fees, and costs and expenses incurred in addition to any compensatory damages or other remedies in law or equity.

**WAIVER OF ANY RIGHT TO JURY TRIAL: THE COMPANY AND THE COVERED PERSON EACH KNOWINGLY, VOLUNTARILY, AND IRREVOCABLY WAIVE ANY RIGHT TO A TRIAL BY JURY FOR ANY CLAIM, DEMAND, ACTION, OR PROCEEDING OF ANY KIND, WHETHER SOUNDING IN CONTRACT, TORT, OR OTHERWISE, RELATING TO OR ARISING FROM: (I) THIS INSURANCE; AND/OR (II) THIS CERTIFICATE OF COVERAGE, INCLUDING ANY AMENDMENT THERETO. THE COMPANY AND THE COVERED PERSON EACH KNOWINGLY, VOLUNTARILY, AND IRREVOCABLY AGREE THAT SUCH CLAIM, DEMAND, ACTION, OR**

PROCEEDING SHALL BE EXCLUSIVELY PRESENTED TO AND DETERMINED SOLELY BY THE COURT AS THE TRIER OF FACT, AND NOT BEFORE A JURY. NO ATTEMPT SHALL BE MADE TO CONSOLIDATE, BY COUNTERCLAIM OR OTHERWISE, ANY ACTION OR PROCEEDING WITH ANY OTHER ACTION OR PROCEEDING IN WHICH THERE IS A TRIAL BY JURY OR IN WHICH A JURY TRIAL CANNOT OR HAS NOT BEEN WAIVED. THE COMPANY AND THE COVERED PERSON EACH AGREE THAT A COPY OF THIS PROVISION MAY BE FILED WITH ANY COURT AS WRITTEN EVIDENCE OF THE AGREEMENT OF THE WAIVER OF ANY RIGHT TO TRIAL BY JURY.

**CLAIM SETTLEMENT:** Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have previously been paid by or on behalf of the Covered Person at the time of the Company's favorable adjudication thereof will be reimbursed by the Company directly to the Covered Person, by check, at their last known residence or mailing address. While this insurance is in effect, in order to effectuate proper administration, the Covered Person shall promptly notify the Company of any change in such addresses. Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have not been paid by or on behalf of the Covered Person at the time of adjudication will be paid by the Company by check or electronic funds transfer to the Covered Person at their last known residence or mailing address, or, at the sole option and discretion of the Company (but without obligation to do so), and as an accommodation to the Covered Person, directly to the provider(s), as applicable. All claim settlements, payments and reimbursements are subject to the insurance plan shown in the Declaration and all other Terms of this insurance. No healthcare or medical service provider or supplier, or any other third-party, shall have any direct or indirect interest, claim or right of action against the Company under this Certificate of Coverage, the Declaration or the Master Certificate of Coverage, whether by purported assignment of benefits, subrogation of interests or otherwise, unless first expressly agreed and consented to in writing by the Company, and notwithstanding the Company's exercise or failure to exercise any option or discretion under this provision regarding the method of claim payment. No such provider, supplier or other third-party is intended to have or shall have any rights as a third-party beneficiary under this Certificate of Coverage, or the Declaration.

**LEGAL ACTIONS:** No lawsuit or action in equity can be brought to recover on the Certificate of Coverage: 1. before 60 days following the date Proof of Claim was given to Us; or 2. After 3 years following the date Proof of Claim is required.

**ARBITRATION:** No claim for benefits for which liability, eligibility, or coverage under this insurance has been denied in whole or in part by the Company nor any other dispute or controversy arising under or related to this insurance shall be arbitrable or subject to arbitration under any circumstances or for any reason.

**NOT IN LIEU OF WORKERS' COMPENSATION:** The Certificate of Coverage is not Workers' Compensation coverage. It does not provide Workers' Compensation benefits.

**ECONOMIC OR TRADE SANCTIONS:** Any payments under this Certificate of Coverage will only be made in full compliance with all United States of America economic or trade sanction laws or regulations, or activity of the Covered Person would violate any applicable trade or economic sanctions law or

regulation, including, but not limited to, sanctions, laws, and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"). Therefore, any expenses incurred, or claims made involving travel that is in violation of such sanctions, laws and regulations will not be covered under this Certificate of Coverage. For more information, You may consult the OFAC internet website at

<https://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx>

**ELECTRONIC COMMUNICATION:** 1. Consent to receive insurance related documents and communications, including but not limited to, your Certificate of Coverage documents, disclosures, notices, explanation of benefits (EOB), claims documentation, as well as termination and cancellation or non-renewal notices, electronically to the email address you provide to us through the online application process instead of receiving these records in a paper format from us. 2. Agree and acknowledge that your consent is provided and/or obtained in connection with a transaction affecting interstate/international commerce subject to the Electronic Signatures in Global and National Commerce Act and the Uniform Electronic Transactions Act, or a similar electronic transactions law, as adopted by state law. 3. Agree that the document(s) delivered to you electronically shall have the same meaning and effect as if you were provided a paper document, whether or not you choose to view the document(s), unless you previously withdrew your consent, by written notice, to receive documents via electronic means. Electronic document(s) are considered received by you at the date and time you complete your purchase, and unless we receive notice that the email notification was not delivered to you at the email address you provided.

**MISREPRESENTATION:** Any false representation, incomplete information, misleading statement, misstatement, omission, concealment or fraud, whether or not innocently made, either in the Covered Person's Application or in relation to any claim form, statement, certification or warranty made by the Covered Person or their representatives, agents or proxies, whether in writing or otherwise, to the Company or the Plan Administrator or their respective agents, employees or representatives, or in connection with the making of any claim under this insurance, shall render the Declaration and this Certificate of Coverage null and void and all claims and benefits under this insurance shall be forfeited and waived.

**FRAUDULENT CLAIMS:** A person who knowingly and with intent to defraud the Company files a statement of claim containing any false, incomplete, or misleading information may be prosecuted for a felony or similar charge under the applicable laws. If any claim or request for benefits under this insurance shall knowingly be in any respect false, incomplete, misleading, concealing, fraudulent or deceitful or if the Covered Person or anyone acting for or on their behalf under this insurance knowingly uses any false, incomplete, misleading, concealing, fraudulent or deceitful statements regarding the Covered Person, the insurance contract and all coverage thereunder may be cancelled, voided, rescinded and terminated by the Company in its sole and absolute discretion, and the Company shall have no obligation or liability for any such benefits, coverage or claims.

## CONTACT INFORMATION

### CLAIMS ADMINISTRATOR

SureGo Administrative Services

PO Box 2069 Fairhope AL 36533

Click here to [Submit Your Claim Online](#)

For claim status or questions Toll Free: 833-313-5651 Direct: 251-322-7443

Claim submission [claims@mysurego.com](mailto:claims@mysurego.com) Claim Status [info@mysurego.com](mailto:info@mysurego.com)

SUREGO PRE-CERTIFICATION Toll Free: 844-723-0324 or email [precert@mysurego.com](mailto:precert@mysurego.com)



### PLAN ADMINISTRATOR

Trawick International

PO Box 2284 Fairhope AL 36533

Toll Free: 888-301-9289 Direct: 251-661-0924

Email: [info@trawickinternational.com](mailto:info@trawickinternational.com)



## 24/7 TRAVEL ASSISTANCE SERVICES

The Travel Assistance program features a variety of emergency travel-related services that include Medical Monitoring Medical and Hospital Admission Guarantee. Travel assistance services are provided by an independent organization and not by the Company. There may be times when circumstances beyond The Assistance Provider's control hinder their endeavors to provide travel assistance services. They will, however, make all reasonable efforts to provide travel assistance services and help you resolve your emergency situation.

TOLL FREE: 833-425-5101 (within the United States and Canada)

COLLECT: 603-952-2686 (from all other locations)

## SUBSCRIPTION AGREEMENT

I hereby apply to be a Covered Person of the AMD Global Trust established in the Cayman Islands (the "Trust") and to participate in the insurance coverage extended by Zurich Insurance Europe AG, Belgian branch (the "Insurer") to Covered Persons under the Trust (the "Coverage"). I understand that the 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 my Home Country (for purposes of this Agreement, Home Country means the Country of Residence is the country in which the Covered Person maintains their current primary residence or usual place of abode and any country to which the Covered Person pays income taxes based upon employment in that country. In the event there is more than one Country of Residence under the above-listed criteria, the Country of Residence is the country meeting the above-

listed criteria and listed by the Covered Person as their Country of Residence on the Application). I understand that the Coverage extended to me will terminate upon my return to my Home Country. I understand that the liability of the Insurer as underwriter of the Coverage is as provided in the Certificate of Coverage.

By acceptance of Coverage and/or submission of any claim for benefits, the Covered Person ratifies the authority of the undersigned to so act and bind the Covered Person.

The Covered Person undertakes to make all Premium payments as they fall due in respect of the Coverage extended. AMD Global Trust (the "Trustee") shall not be responsible for the administration of such payments. If the Covered Person fails to make any Premium payment due in respect of the Coverage extended, subject to the discretion of the Insurer, such Coverage will terminate.

The Covered Person hereby confirms the accuracy of all information and validity of all representations and warranties provided to the Trustee in connection with its participation in the Plan and/or the subscription for the insurance coverage, howsoever provided, including the terms of this Subscription Agreement, (together "Representations & Warranties"). The Covered Person acknowledges that certain of such information will be relied upon by the Insurer as Provider of the Coverage and that any inaccuracy therein may result in the invalidity of such Coverage as it relates to the Covered Person, the loss of Coverage and all monies paid in relation thereto. The Covered Person hereby undertakes to inform the Trustee of any change to any matter that forms the subject of any of the Representations & Warranties. The Covered Person hereby undertakes to indemnify and hold harmless the Trustee against any loss or damage (including attorney's fees) occasioned by any inaccuracy in any Representations & Warranties or failure to advise the Trustee of any change in any matter that forms the subject of any of the Representations & Warranties. The Covered Person agrees that the Trustee shall be entitled to rely on and to act in accordance with any written instruction purported to be provided by the Covered Person and the Covered Person hereby undertakes to indemnify and hold harmless the Trustee against any loss or damage (including attorney's fees) occasioned by the Trustee acting in accordance with any such instruction.

Payments under the terms of the Coverage shall be paid by the Insurer to the Covered Person or directly to a Provider if assignment of benefits has been authorized. The Trustee shall not be responsible for the administration of such payments.

I confirm that I have satisfied myself in that the Coverage is appropriate for me and that I meet the Eligibility criteria.