



Best Doctors®

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International Insurance Consultants

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☐☐☐ **PREMIERPLUS™**
CONDITIONS OF COVERAGE

EFFECTIVE 1 JANUARY 2009

BEST DOCTORS INSURANCE LIMITED

WELCOME

Our goal is to give you the peace of mind and certainty that comes from being able to access the world's best medical advice, doctors and treatments. That means you always have the absolute reassurance that you are making the best choices to protect your health, your lifestyle and the people you love.

Remember that when you have a serious medical challenge, you can call on our unique InterConsultation™ service for a second opinion and consultation with leading specialists in the field. Their knowledge and guidance can make all the difference in the world, especially when you are facing life-changing decisions.

We have prepared this booklet to help you understand more about your entitlements and responsibilities. Please take the time to read it carefully.

Before you undertake any treatment that you expect to be covered, please contact Best Doctors Insurance Limited to check what your benefit entitlement will be.

Keep this booklet and your other Best Doctors Insurance Limited documents in a safe place where you will have them at hand if you need us. Our support and the world's best medical advice are only a phone call away.

Welcome to a world of medical excellence,

A handwritten signature in dark blue ink, reading "David Seligman". The signature is fluid and cursive, with a long horizontal stroke at the end.

David Seligman
CEO

☐☐☐ PREMIER**PLUS**[™]
CONDITIONS OF COVERAGE

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ART. 1 SUMMARY OF BENEFITS

Unless otherwise shown, benefits are per person, per policy year. All benefits are in American Dollars (USD).

Covered medical expenses are subject to being usual, customary and reasonable for the procedure and territory.

ITEM/SERVICE	WHAT'S COVERED (ONCE DEDUCTIBLE HAS BEEN MET)
Maximum benefit	♦ \$2,000,000 per person
Eligibility	♦ Up to age 70
Renewal	♦ Lifetime guarantee
Coverage	♦ Worldwide
Standard room	♦ 100% with no limit as to the number of days
Intensive care unit	♦ 100% with no limit as to the number of days
Temporary emergency cover	♦ \$25,000 for accidents occurred from the moment the application is approved and the payment is received, until the cover start date or 60 days later, whichever date comes first
Surgery and outpatient surgery	♦ 100%
Emergency room	♦ 100%
Diagnostic services	♦ 100%
Cancer treatment (chemotherapy/radiation)	♦ 100%
Dialysis	♦ 100%
Maternity	♦ \$5,000 per event, no deductible applies (option I, II and III only)
Inclusion of newborn	♦ Automatically included without underwriting if born from a covered maternity
Congenital conditions	♦ \$350,000 per lifetime when symptoms are manifested before age 18 ♦ \$1,000,000 per lifetime when symptoms are manifested after age 18
Transplants	♦ \$1,000,000 lifetime maximum and \$20,000 for living donor

ITEM/SERVICE	WHAT'S COVERED (ONCE DEDUCTIBLE HAS BEEN MET)
Physical therapy/rehabilitation	• 100%
Durable medical equipment	• 100%
Prescribed drugs	• 100%
Treatment of allergies	• 100%
AIDS	• \$250,000 lifetime maximum
Air ambulance	• \$50,000
Ground ambulance	• Unlimited
Repatriation	• \$5,000 in the event of death resulting from a covered hospitalization within the air ambulance benefit
Additional benefit	• In the event of death of the primary Insured, the dependents thereof will have free coverage for a period of two years, subsequent to the last paid period
Unique services	<ul style="list-style-type: none"> <li data-bbox="435 1073 1210 1161">• InterConsultation™: Confirmation of diagnosis and recommendation of the best treatment and specialists. Access to this benefit available regardless of deductible level or any exclusion you may have <li data-bbox="435 1170 1210 1292">• Personalized Services: Coordination of medical appointments, hospital admission, travel arrangements and accommodations when services are rendered outside of the Insured's country of residence. The Insured is responsible for all travel and accommodation costs

ART. 2 ACCEPTANCE OF THE INSURANCE

Best Doctors Insurance Limited (the 'Insurance Company'), agrees to pay you (the 'Insured') the benefits stated in this policy for any treatment, service or medical supply anywhere in the world. All benefits are subject to the terms and conditions of this policy.

Ten (10) day right to examine the policy

The Insured reserves the right to return this policy within ten (10) days after the receipt of the policy for a refund of all premiums paid, less an administrative fee of seventy-five dollars (\$75). The policy may be returned directly to the Insurance Company or to the Insured's Agent. If returned, the policy is considered null and void as though no policy had been issued. If not returned within such 10 days period any refund requested will be processed, pursuant to article 10.9.

Important notice about the application

This policy is issued based on the application and payment of the premium. If any information shown on the application is incorrect, incomplete, or if any information has been omitted, the policy may be rescinded, cancelled, or coverage may be modified, at the discretion of the Insurance Company.

ART. 3 COMMENCEMENT, PERIOD AND TERMINATION OF COVERAGE

The Insurance Company reserves the right to accept or deny any policy application. Coverage begins at 00:01 hours Eastern Standard time (USA) of the first (1st) day or the fifteenth (15th) day following the date that the Insurance Company approves the application and receives payment

of the premium. Coverage ends at 24:00 hours Eastern Standard time (USA) of the policy termination date.

The coverage has a duration period of twelve (12) months and shall be renewed automatically for a similar period of time with the corresponding premium payment subject to the definitions, conditions and other provisions of the policy.

ART. 4 ELIGIBILITY

The Insured or eligible dependent(s) must comply with the following requirements:

- 4.1 Not reside physically in the United States when applying for coverage.
- 4.2 Be at least eighteen (18) years of age (except for eligible dependents or unless authorized by the parents or legal guardian). The maximum age required at the time of applying for coverage is seventy (70) years of age. There is no maximum age for renewal of the policy and coverage of the Insured will continue under the same terms and conditions. A complete medical evaluation will be required for applicants sixty-four (64) years of age or older.

Coverage for eligible dependents

Eligible dependents are the Insured's spouse, natural born children, legally adopted children, stepchildren, or children to whom the Insured has been appointed legal guardian by a court of competent jurisdiction.

Coverage for dependents remains in effect until the following policy anniversary date after having reached 18 years old if single. Coverage for dependents older than 18 years of age may remain effective if they are full time

students at an accredited school and until the following policy anniversary date, upon the dependent's 24th birthday.

The Insurance Company reserves the right to request a student certification from the university or college in which the student is enrolled.

If a dependent child marries, discontinues being a full-time student, or if a dependent spouse ceases to be married to the Insured by reason of divorce or annulment, coverage for such a dependent will terminate on the policy termination date.

Dependents that are covered under a policy with the Insurance Company, and who are otherwise eligible for coverage under their own individual policy, will be approved without being subject to underwriting for the same conditions and restrictions under the prior policy. The application for these dependents must be received before the anniversary and/or end of the grace period of the prior policy.

For newborn dependents under covered maternity, notification must be received within the first thirty (30) days of birth and any additional premium required must be paid in full. If the infant is not properly enrolled within a period of thirty (30) days, acceptable proof of insurability must be submitted to the Insurance Company.

For adopted children, or those under guardianship or legal protection, legal documents establishing kinship are required.

ART. 5 INSURED'S RESPONSIBILITY

Deductible

- 5.1 One (1) deductible per Insured per policy year, maximum two (2) deductibles per family.
- 5.2 If the deductible has been applied in the country of residence and medical services are rendered in the United States where the deductible is higher, the difference between the deductibles will be the Insured's responsibility.
- 5.3 Any charges incurred by the Insured during the last three (3) months of the policy year, which are used to satisfy that policy year's deductible, will be carried over and applied towards the Insured's deductible for the following year.

ART. 6 POLICY PROVISIONS

- 6.1 **Anesthesiologist fees:** Coverage for anesthesiologist fees are limited to the lesser benefit of the following:
 - a) Thirty percent (30%) of the usual, customary and reasonable principal surgeon's fee for the surgical procedure in question; or
 - b) Thirty percent (30%) of the approved fees for the principal surgeon for the surgical procedure; or
 - c) One hundred percent (100%) of the usual, customary and reasonable anesthesiologist fees; or
 - d) Special rates established or contracted by the Insurance Company for an area, country or determined provider.

- 6.2 **Assisting physician/surgeon fees:** Coverage for assisting physician/surgeon fees are limited to the lesser benefit of the following:
- Twenty percent (20%) of the approved fees for the principal surgeon for the procedure; or,
 - If more than one assisting physician/surgeon is required, the maximum coverage for all assisting physicians/surgeons shall not exceed twenty percent (20%) of the principal surgeon's fee for the actual surgical procedure; or,
 - One hundred percent (100%) of the usual, customary and reasonable fees for the surgical procedure in question; or,
 - Special rates established or contracted by the Insurance Company for an area, country or determined.
- 6.3 **Benefits for unique services:** As an additional supplement, the Insured has access to the unique services of the Insurance Company: "InterConsultation™" and "Personalized Services".
- 6.4 **Benefit for death of primary policyholder or Insured:** In the event of death of the primary Insured, the dependents will have additional free coverage for a period of two (2) years, subsequent to the last paid period of the policy.
- 6.5 **Congenital and hereditary disorders:**
- The lifetime maximum benefit for any congenital and hereditary disorder that manifest themselves before the Insured's eighteenth (18th) birthday is three hundred fifty thousand dollars (\$350,000) per person, including any benefit already paid on an existing policy or rider, including the deductible.
 - The lifetime maximum benefit for any congenital and hereditary disorders that manifest themselves on or after the Insured's eighteenth (18th) birthday and subsequent to the policy anniversary date is one million dollars (\$1,000,000) per person, including deductible.
- 6.6 **Coverage during the waiting period:** This policy contains a thirty (30) day waiting period. During this time, coverage will apply only to illnesses or injuries caused by an accident occurring during this period, or from a disease of infectious origin that is first manifested during this period. Any condition or symptom that is not caused by an accident or illness of infectious origin that is manifested during this period will be excluded.
- 6.7 **Coverage for reconstructive and/or cosmetic surgery:** Benefits will be paid only when the surgery is:
- Medically necessary and essential for the treatment of an illness or injury that occurs while the Insured is covered and such condition is a benefit under this policy.
 - Required in relation to an injury caused by an accident or a deformity that occurs for the first time while the Insured is covered.
 - Required for the treatment of nasal deformities or of the nasal septum caused by trauma due to an accident. This surgery must be previously approved by the Insurance Company. Evidence of trauma resulting in a fracture must be confirmed by radiological testing (X-rays, scans, magnetic imaging, etc.).

6.8 Covered expenses: As stated in this policy and subject to the stipulations within the conditions of coverage and all remaining dispositions and conditions, covered expenses shall be defined as the usual, reasonable and customary charges incurred by the Insured during the period that this policy is in force. These expenses include treatments, medical services or supplies that are incurred as a result of, or in relation to, the treatment of illnesses or covered medical conditions that are deemed medically necessary.

Covered expenses are incurred charges for:

- a) Medical, Surgical and Hospital Services.
- b) Outpatient Services as defined in this policy (see article 11.38).
- c) Diagnostic Tests.
- d) Prescribed Medications, Medical Equipment, and Surgical Implants.

The Insured has a right to these benefits as described in this section, subject to the limitations and exclusions as described in other sections of the conditions of coverage.

6.9 Durable medical equipment or special devices: External prosthesis, orthotic devices, durable medical equipment (for rent or sale) and implants will be covered after the corresponding deductible has been met. This benefit must be coordinated and approved in advance by the Insurance Company. In the event that it is approved and acquired by the Insured, reimbursement will be made in accordance with the usual, customary and reasonable cost within the geographical area.

6.10 Emergency transportation: Emergency transportation (by ground and air ambulance) is only covered if related to a covered condition for which treatment cannot be provided locally and transportation by any other method would result in loss of life or limb. Emergency transportation must be provided to the nearest medical facility by a licensed and authorized transportation company. The vehicle or aircraft used must be staffed by medically trained personnel and must be equipped to handle medical emergencies.

Air ambulance transportation:

- a) All air ambulance transportation must be pre-approved and coordinated by the Insurance Company.
- b) The amount payable for this benefit is fifty thousand dollars (\$50,000) per Insured, per policy year.
- c) The Insured agrees to hold the Insurance Company and any company affiliated with the Insurance Company, harmless from any negligence resulting from such services, or for delays or restrictions on flights caused by mechanical problems, by governmental restrictions, or by the pilot, or due to operational conditions or bad weather.

Ground ambulance transportation: The maximum amount payable for this benefit is unlimited.

6.11 Temporary emergency coverage: From the time the Insurance Company receives the application and the total premium for this policy, through the cover start date of the policy, or sixty (60) days later, whichever date comes first. The Insurance Company

agrees to insure all the proposed Insured members for covered medical expenses resulting from accidental bodily injury incurred while this Temporary Emergency Coverage is in force, up to a maximum benefit of twenty-five thousand (\$25,000) dollars per policy. This temporary accidental coverage is subject to and governed by the respective policy terms, provisions, and exclusions which would have been applicable had the policy been in effect on the date of the accident of the proposed Insured. This benefit is subject to the deductible chosen by the Insured and does not apply if the request for coverage is denied for any reason. The injuries sustained in an accident occurring while the application is being evaluated cannot be a reason to decline an application.

- 6.12 **Illness or injury in a private aircraft:** Any illness or injury sustained as a passenger, pilot and/or member of the crew in a private aircraft is covered in accordance with the stipulations of this policy.
- 6.13 **Maternity care:** (Benefit available only for options I, II and III)
- a) The maximum benefit for maternity care is five thousand dollars (\$5,000) per pregnancy with no deductible.
 - b) Maternity coverage always has a ten (10) month waiting period, whether or not the thirty day (30) grace period for coverage of this policy has been waived.
 - c) There is no maternity coverage for dependent daughters.
 - d) Those Insured members that were previously dependent daughters under another policy with the

Insurance Company must have maintained their own individual policy for a minimum of ten (10) months to be eligible for this maternity care benefit.

- e) Pre and post-natal treatment, childbirth, complications of pregnancy or delivery, and well baby care are included in the maximum maternity benefit listed in this policy.

There is an optional rider available to cover maternity complications.

6.14 **Newborn coverage:**

If born within a covered maternity: Policy limits for complications of birth relating to a newborn are limited to the maximum benefits described in article 11.10. The inclusion for the newborn must be received within the first thirty (30) days of birth. If such notification is not received within the first thirty (30) days of birth, then an application requesting additional dependent coverage is required for the newborn and will be subject to underwriting. The payment of the corresponding premium must be received within thirty (30) days from the date on which the inclusion for the newborn was made.

Routine medical care for a healthy newborn will be covered as specified in the conditions described within the provision for “Maternity Care” of this policy.

If born within a non-covered maternity: Children born from a non-covered maternity will not have automatic coverage as a newborn.

In order to add a newborn to the policy, submission of completed application for insurance which is subject to underwriting by the Insurance Company is required.

6.15 **Outpatient physical therapy and home health care:** Coverage for this care or treatment must be approved in advance by the Insurance Company, including any and all extensions. In all cases, the Insurance Company must receive the treatment plan and evidence of medical need.

6.16 **Pre-existing conditions:** Pre-existing conditions are classified in two (2) categories:

Disclosed upon application for coverage:

- a) Conditions free of symptoms and/or treatment during the five (5) year period prior to the cover start date of the policy. The conditions are covered upon expiration of the thirty (30) day waiting period, unless specifically excluded.
- b) Conditions with symptoms and/or treatment any time during the five (5) year period prior to the cover start date of the policy. These conditions will be covered after two (2) years from the cover start date of the policy, unless specifically excluded.

Not disclosed upon application for coverage:

- a) Pre-existing conditions not disclosed at the time of the application will not be covered during the lifetime of the policy. Furthermore, the Insurance Company retains the right to rescind, cancel or modify the policy based on the omission of such conditions.

6.17 **Prescription medications/drugs:** The maximum benefit for prescription drugs is subject to a per Insured per policy year deductible. The covered expenses are limited to medications that:

- a) Require a medical prescription for use and are not sold over-the-counter.
- b) Are provided by a physician or authorized pharmacist.
- c) Are approved by the Food and Drug Administration of the United States of America (FDA) and according to the specified regulations that apply to the country in which treatment is being received.

In all cases, a copy of the prescription must accompany the claim.

6.18 **Repatriation of mortal remains:** In the event an Insured dies outside of his/her country of residence, the Insurance Company will pay up to five thousand dollars (\$5,000) for the repatriation of the deceased's remains to the country of residence. This benefit will always be offered provided that the death resulted from a hospitalization which would have been covered and is included under the Air Ambulance benefit. Coverage is limited to only those services and supplies necessary to prepare the deceased's body and to transport the deceased to his/her country of residence (this benefit will apply after any applicable benefit the Insured has used independent of this policy).

6.19 **Surgeon fees:** Coverage for surgeon fees are limited to the lesser benefit of the following:

- a) One hundred percent (100%) of the usual, customary and reasonable fees for the actual surgical procedure; or
- b) One hundred percent (100%) of the approved surgeon's fee for the procedure; or

- c) Special rates established or contracted by the Insurance Company for an area, country or determined provider.
- d) In the event a surgical procedure is performed and another one is incidentally necessary, the principal, most important procedure will be paid in accordance with the lesser benefit of points A, B, C, described in this section. The secondary procedure will be paid at fifty percent (50%) in relation to the principal procedure, and the third and subsequent ones will be paid at twenty-five percent (25%) in relation to the principal procedure.

6.20 **Transplant coverage:** It is a requirement for this benefit that the Insured obtains approval from the Insurance Company prior to receiving service. This benefit must be coordinated by the Insurance Company. Notification is required.

No payments will be made for any treatment, procedure, service, or surgery when:

- a) It is not medically necessary.
- b) It is considered elective, experimental or investigative.
- c) It is performed when the patient had access to alternative procedures and/or treatments, with the same level of results and care, to treat the medical condition or illness that caused the need for a transplant.
- d) It is originated by or as a result of a transplant from the use of a mechanic artifact or artificial equipment aim to replacing a human organ or where the donor is an animal.
- e) It is performed because of an initial failed transplant carried out prior to the start cover date of this policy.

6.21 **Waiver of the waiting period:** The waiting period can be waived if:

- a) The Insured was previously covered by a policy for medical expense insurance that was in force for at least one (1) continuous year; and
- b) The cover start date of this policy commences within thirty (30) days following the termination of the previous coverage; and
- c) The prior coverage is disclosed in the application for insurance, and a copy of the prior policy and receipt for the last year's premium payment is received with the application.

If the waiting period is waived, benefits payable for any condition incurred during the first thirty (30) days of coverage are permanently limited to the lesser benefit provided either by this policy or the prior policy.

ART. 7 EXCLUSIONS AND LIMITATIONS

Coverage or benefits will not be provided for any of the following:

- 7.1 Any treatment, injury, illness or charges arising from any service or supply which is:
 - a) Not medically necessary; or
 - b) For an Insured who is not under the care of a physician, doctor or legally skilled professional; or

- c) Not authorized or prescribed by a physician or doctor or legally skilled professional; or
- d) Custodial or hospice care.
- 7.2 Any care or treatment for illnesses or self inflicted injuries, while the Insured is sane or insane, suicide, failed suicide, alcohol abuse, drug use or abuse, or the use of illegal substances or illegal use of controlled substances. This includes any accidents resulting from any of the aforementioned criteria.
- 7.3 Routine eye and ear examinations, hearing aids, eye glasses, contact lenses, radial keratotomy and/or other procedures to correct eye refraction disorders.
- 7.4 Any medical examination or diagnostic study which is part of a routine physical examination, prophylactic treatments, including vaccinations and the issuance of medical certificates and examinations as to the suitability of the Insured for employment or travel.
- 7.5 Any chiropractic care, homeopathic treatment, acupuncture or any type of alternative medicine.
- 7.6 Any illness or injury not caused by an accident or illness of infectious origin which is manifested within the first thirty (30) days of the cover start date of the policy.
- 7.7 Elective or cosmetic surgery or medical treatment whose main purpose is for beautification, unless necessitated by injury, deformity or illness which first occurs while the Insured is covered under this policy. Also excluded is any surgical treatment for nasal or nasal septum deformity that was not induced by trauma, except as provided for in this policy.
- 7.8 Any expense related to pre-existing conditions as defined within this policy.
- 7.9 Any treatment, service or supply that is not scientifically or medically recognized for the prescribed treatment, or which is considered experimental and/or not approved for general use by the Food and Drug Administration of the United States.
- 7.10 Any treatment or expense in a government or private facility in which the Insured would be entitled to free care, services or treatment for which payment would not have been made had no insurance coverage existed. This includes costs for procedures in institutions that receive government or private funding related to an investigative project for the procedure in question.
- 7.11 Diagnostic procedures or treatment of mental or psychiatric illnesses, behavioral or developmental disorders, Chronic Fatigue Syndrome, sleep apnea and any other sleep disorder.
- 7.12 Any portion of any charge that is in excess of the usual, customary and reasonable charge for the particular service or supply for that geographical area.
- 7.13 Any expense for male or female sterilization, reversal of sterilization, sex change, sexual transformation, birth control, infertility treatment, artificial insemination or prosthesis to improve or restore sexual dysfunction or inadequacies, disorders related to Human Papillomavirus (HPV) and/or sexually transmitted diseases (excluding HIV infection/AIDS regardless of how it was contracted).

- 7.14 Any expense, service or treatment for obesity, weight control or any form of food supplement, including bariatric surgery and gastric “by-pass” surgery, its complications and treatments. Also excluded is any type of surgical procedure for weight loss (unless necessary to sustain life in a critically ill person).
- 7.15 Podiatric care to treat functional disorders of the structures of the feet, including but not limited to, corns, calluses, bunions, hallux valgus, hammer toe, Morton’s Neuroma, flat feet, weak arches, weak feet or other symptomatic complaints of the feet, including pedicures, special shoes and inserts of any type or form.
- 7.16 Any treatment relating to growth hormone, regardless of the reason for prescription, and treatment by bone growth stimulator, or bone growth stimulation.
- 7.17 All treatment to a mother or a newborn related to a non-covered maternity.
- 7.18 Any voluntarily induced termination of pregnancy, unless imminent maternal danger is apparent.
- 7.19 Any congenital or hereditary disorder or illness, except as provided for under the provisions of this policy (see provision 6.5).
- 7.20 Any dental treatment or orthodontics, related or not to a mandible problem, not related to a covered accident or not reported within ninety (90) days of the date of such accident.
- Treatment of the upper maxilla, the jaw or jaw joint disorders, including but not limited to jaw anomalies, malformations, Temporomandibular Joint Syndrome, craniomandibular disorders or other conditions of the jaw or the jaw joint linking the jawbone and the skull and all muscles, nerves and other tissues linked to this joint.
- 7.21 Treatment of injuries resulting while the Insured is in service as a member of a police or military unit or from participation in war, riot, civil commotion or any illegal activity, including resulting imprisonment.
- 7.22 Any hospital admission more than twenty-four (24) hours before a planned surgery, or any additional day of hospitalization for a mother remaining in the hospital due to a newborn hospitalization, except if approved by the Insurance Company.
- 7.23 Any treatment rendered by a family member, including but not limited to the spouse, father, mother, children or by another person who regularly resides in the Insured’s home, or any treatment provided in any entity or facility owned by, or under the operation, of the Insured or a family member.
- 7.24 Any over the counter medicine or non-prescription drug.
- 7.25 Any dietary supplement, appetite suppressant, vitamins, anti-aging medicine, medications or treatment for hair regeneration.
- 7.26 Personal artificial kidney equipment for home use and all related expenses.
- 7.27 Any cost relating to the acquisition and implantation of an artificial heart, mono or bi-ventricular devices, other artificial or animal organs and all expenses related with cryopreservation lasting more than twenty-four (24) hours.

- 7.28 Injuries or illness caused by, or related to ionized radiation, pollution or contamination, radioactivity from any nuclear material, nuclear waste, or the combustion of nuclear fuel or nuclear devices.
- 7.29 Any expense related to extraction, repair or replacement of damaged medical equipment (unless the product lifecycle has expired).
- 7.30 Any expense related to the duplication of functions of medical equipment that produce the same result.
- 7.31 Treatment rendered by more than one surgical assistant, unless approved by the Insurance Company.
- 7.32 Any expense related to recreational or educational therapy.
- 7.33 Any expense related to custodial charges in case of senility or loss of mental faculties.
- 7.34 Any custodial assistance, home health aides including but not limited to maintenance care or therapy for chronic conditions. Treatment, services, and supplies provided by facilities that are mental institutions, nursing homes, assisted living facilities, long term care facilities, health spas, and water therapy spas.
- 7.35 Any injury, accident or illness caused as a result of direct professional practice or participation in competitive sports or dangerous activities.

ART. 8 HOW AND WHEN TO NOTIFY AND PRE-CERTIFY

Benefits related to the treatment of an illness or medical condition, covered by this policy, are subject to advance notice (Notification). Any major medical procedure requires a Pre-Certification allowing the Insurance Company to confirm the Insured's eligibility and coverage level. The Insured must notify the Insurance Company, by calling the telephone number that appears on the reverse of the identification card, at least seventy-two **(72) hours** prior to receiving any medical treatment that is not an emergency. All medical emergencies must be notified within forty-eight **(48) hours** after the event.

The benefits of this contract may be reduced if the Insured does not contact the Insurance Company as previously established above. *The Insured will be responsible for thirty percent (30%) of all covered costs, including, but not limited to medical costs, hospitalization, and diagnostic testing, in addition to the deductible (if applicable).*

ART. 9 HOW TO REPORT A CLAIM

The Insured must present a bill for reimbursement to the Insurance Company for all expenses of the covered costs within the conditions stated in this policy, not including those cases for which the provider has agreed to receive payment directly from the Insurance Company.

In order to comply fully with this claim procedure, the Insured must:

- 9.1 Present a properly completed and signed claim form accompanied by the patient medical report.
- 9.2 Submit original bills and/or receipts itemized by hospital charge, pharmacy, treating physicians, diagnostic tests, lab exams, etc. Photocopies shall not be regarded as acceptable documentation.
- 9.3 Each receipt shall present the following information:
 - a) Patient's name and date of birth
 - b) Diagnosis and type of service received (consultations, procedure, diagnostic or other tests, hospitalization, etc)
 - c) Date, itemized amount of the service received, and proof of payment by the Insured
 - d) In the case of a pharmacy expense, both the itemized paid pharmacy invoice and the medical prescription must be submitted, as well as a clear indication of the medicines on the invoice or items that do not pertain to the doctor's prescription or condition treated.
 - e) In the event that two (2) claims are filed for reimbursement simultaneously from different Insured members, separate itemized expenses per covered person, by illness and provider must be detailed and submitted.

If the information that is provided is inadequate or incomplete, it may delay the reimbursement process or temporarily close the claim until the required information is received.

Claims must be received within the first one hundred eighty (180) days following the treatment service date. If the information is not received within the established period of time, the claim will be denied.

ART. 10 ADMINISTRATION

- 10.1 **Delivery of medical information to agent of record:** The Insured and covered dependents specifically understand and agree that they have elected to allow the Agent of record (Agent) to have access to all of the health and medical information (past, present and future) that is ever delivered to the Insurance Company or any one of its affiliates or subcontractors. You have requested the Insurance Company to make this information available to the Agent in order to facilitate the transfer of information, on the Insured's behalf, between the Insured and the Insurance Company in the processing of the Insured's and covered dependents claims and/or the provision of medical treatment. The Insured has requested this access to the Agent from the Insurance Company, and it is not an obligation that the Insurance Company required the Insured to consent to. Instead, the Insured has knowingly and voluntarily requested such provision of access and information to the Agent. The Insured hereby agrees that the Insurance Company may provide and/or deliver this information to the Agent in any manner that the Insurance Company so elects, in its sole discretion.
- 10.2 **Authority:** No agent has the authority to change the policy or to waive any of its provisions. After issuance, no change in the policy shall be valid unless

approved in writing by an officer approved by the Insurance Company and such approval is endorsed by an amendment to the policy.

- 10.3 **Changes of country of residence:** The Insured must notify the Insurance Company in writing of any changes to the Insured's country of residence within the first thirty (30) days of its occurrence. Change of residence could result in an adjustment to the premium for an amount in relation to the geographical area. Failure to notify the Insurance Company of any change of the Insured's country of residence may result in cancellation of the policy or modification of coverage on the next renewal anniversary date.
- 10.4 **Commencement of insurance:** Benefits begin on the cover start date of the policy, subject to the provisions of this policy.
- 10.5 **Other insurance coverage:** Should there be other health insurance, including government sponsored programs, it must be declared at the time it is acquired or upon completing the original application. Upon filing a claim document, proof of coverage and a copy of the claim details, along with proof of payment of expenses by the other health insurance (EOB) must be submitted. The Insurance Company will begin the process of coordination of benefits by which the amounts paid by the other insurance will be applied to the deductible, according to the benefits and limitations of this policy.
- 10.6 **Entire contract:** The policy, the application, the certificate of coverage and any riders or amendments shall constitute the entire contract between the parties.
- 10.7 **Payment of claims:** The Insurance Company will make payments directly to physicians and hospitals worldwide. When this is not possible, the Insurance Company will reimburse the Insured in accordance with the usual, customary, and reasonable fees for that geographical area. In the event of death of the primary Insured, the Insurance Company will pay any unpaid benefits to the legal estate of the deceased primary Insured, or to the provider of medical services.
- 10.8 **Proof of claim:** Reimbursement requests or claims related to medical services must be submitted to *Best Doctors Claims Center, 5301 Blue Lagoon Drive, Suite 620, Miami, Florida 33126 USA*. This information must be received within the first one hundred and eighty (180) days after the treatment or service date. Failure to do so will result in denial of the claim. Claims must be original itemized bills detailing each service included. It must also be accompanied by the properly completed and signed Best Doctors Insurance Limited claim form. The medical files or records are also required, following instructions indicated at the end of this document.
- 10.9 **Refunds:** If the Insured or the Insurance Company cancels the policy after it has been issued, reinstated or renewed, the Insurance Company will refund the unearned portion of the premium, less administrative charges and policy issuance fees, up to a maximum of sixty-five percent (65%) of the premium. The policy fee and thirty-five percent (35%) of the base premium are nonrefundable. The unearned portion of the premium is based on the number of days corresponding to the payment mode, minus the number of days the policy was in force.

- 10.10 **Currency:** All currency values stated in this policy are in American Dollars (USD). The exchange rate used to pay claims generated in a currency other than American Dollars (USD), will be calculated at the current official Wall Street rate for that date of service.
- 10.11 **Physical examinations:** The Insurance Company, at its own expense, reserves the right to request a medical examination or second opinion to any Insured member whose illness or injury is the basis of a claim, when and as often as considered necessary by the Insurance Company while the claim is in process.
- 10.12 **Medical reports:** The Insurance Company will request all medical files and/or reports necessary directly from the provider in those cases that a direct payment was made, or to the Insured in the case of reimbursement. The Insured will be the ultimate responsible person for obtaining these medical records and reports. In order to obtain such records, the Insurance Company needs the signed authorization of the Insured on all forms that the provider of medical services requires. Failure to obtain such authorization and the necessary medical records and reports, could result in the delay or denial of a claim.
- 10.13 **Policy cancellation or non-renewal:** The Insurance Company retains the right to cancel, modify or rescind the policy if the full annual premium is not paid, by which the Insured and/or dependents will only have coverage for the period covered by the premium paid, or if statements on the application are found to be misrepresentations, incomplete or if fraud has been committed. No individual Insured shall be penalized by cancellation of the policy or the increase in the premium based on the Insured's claim record.
- 10.14 **Fraud:** If an Insured attempts or succeeds, by misrepresentation or deceit, in obtaining benefits for himself/herself, or for another person, to which he/she would not have been entitled or would not have been payable otherwise, his/her insurance coverage may be terminated automatically by the Insurance Company.
- 10.15 **Policy issuance:** This policy cannot be issued or delivered in the United States, except as may be specifically permitted under the laws of the State of Massachusetts. The policy is deemed issued or delivered upon receipt of the policy by the Insured in his/her country of residence.
- 10.16 **Policy mode:** All policies are considered annual policies. Premiums can be paid annually, semi-annually or quarterly.
- 10.17 **Grace period:** A thirty (30) day grace period is allowed for the payment of the premium. If the premium is not paid within the grace period, the Insurance Company will terminate coverage at 11:59 PM on the last day that the premium was paid. Benefits are not provided under the policy during the grace period unless the policy is renewed.
- 10.18 **Premium payment:** On time payment of the premium is the responsibility of the Insured. The premium is payable on the renewal date of the policy or other due dates if authorized by the Insurance Company. Premium notices are provided as a courtesy to the Insured, and the Insurance Company provides no guarantee of delivering such notices. If an Insured

does not receive a premium notice thirty (30) days prior to the due date and the Insured does not know the amount of the premium payment, the Insured should contact his/her Agent or the Insurance Company representative.

- 10.19 **Rate changes:** The Insurance Company retains the right to change the premium rates as a whole for this policy and not individually at the time of each renewal date.
- 10.20 **Reinstatement of the policy:** All policies reinstated after the thirty (30) day grace period are deemed new policies with no antiquity or credit being afforded to the Insured. All medical conditions existing prior to the date of reinstatement of the policy shall be considered and treated as pre-existing conditions under this policy. No reinstatement will be authorized ninety (90) days after the date of termination of the policy.
- 10.21 **Prior approval for some external medical services or home health care:** Prior to receiving home health assistance or terminally ill assistance, these services must be approved by the Insurance Company in order to be covered under this contract.
- 10.22 **Individual case management:** A program for managing benefits of the Insured in certain situations. Through this program, the Insurance Company works with providers to ensure that the Insured receives medically necessary services within the least intensive context that is adapted to the Insured's needs. Individual Case Management is a service offered to members whose medical condition would otherwise require hospitalization.

- 10.23 **Claims appeals:** In the event of any disagreement between the Insured and the Insurance Company regarding the policy and/or its provisions, the Insured can request a review of the case by the Insurance Company. In order to begin such a review, the Insured must submit a written request that must include copies of all relevant information. Upon the submission of a request for review, the Insurance Company will determine whether any additional information and/or documentation is needed, and act in a timely manner to obtain such information. The Insurance Company will notify the Insured of its decision and the underlying rationale on which it is based within thirty (30) days thereafter.
- 10.24 **Arbitration, legal actions, and jurywaiver:** Any disagreement that may persist upon completion of the claims appeal as determined herein must first be submitted to arbitration. In such cases, the Insured and the Insurance Company will submit their differences to three (3) arbiters: Each party selecting an arbiter, and the third arbiter to be selected by the arbiters named by the parties herein. In the event of any disagreement between the arbiters, the decision will rest with the majority. Either the Insured or The Insurance Company may initiate arbitration upon written notice to the other party demanding arbitration and naming its arbiter. The other party shall have twenty (20) days after receipt of said notice within which to designate its arbiter. The two (2) arbiters named by the parties, within ten (10) days thereafter, shall choose the third arbiter and the arbitration shall be held at the place hereinafter set forth ten (10) days after the appointment of the third arbiter. If the other party does not name its arbiter

within twenty (20) days, the complaining party may designate the second arbiter and the other party shall not be aggrieved thereby. Arbitration shall take place in *New York, New York, United States*.

The expenses of the arbitration shall be shared equally between the parties. The Insured confers exclusive jurisdiction in New York, New York for determination of any rights and legal action arising directly from this policy. The Insured and the Insurance Company further agree to pay their respective costs and legal fees. The Insured and the Insurance Company waive any and all rights to a jury trial.

- 10.25 **Subrogation and indemnity:** The Insurance Company has a right of subrogation or reimbursement from an Insured to whom it has paid any claims to or on behalf of, if such Insured has recovered all or part of such payments from a third party. Furthermore, the Insurance Company has the right to proceed at its own expense in the name of the Insured, against third parties who may be responsible for causing a claim under this policy or who may be responsible for providing indemnity of benefits for any claims under this policy. This is true even if the Insured does not receive the total amount of the claim against the other person(s) as well as if the payment that the Insured receives is described as payment for other than health care expenses. The amount the Insured must reimburse the Insurance Company will not be reduced by any attorney's fees or expenses the Insured incurs.

The Insured must cooperate with the Insurance Company, providing the necessary information, completing and signing all required documents to help

the Insurance Company obtain reimbursement. This also means that the Insured must give the Insurance Company notice before settling any claim arising out of injuries the Insured sustained by an act or omission of another person for which the Insurance Company paid benefits. The Insured must not do anything that might limit the Insurance Company's right to full reimbursement.

- 10.26 **Notification:** The Insurance Company must be contacted for any medical service inquiry following the stipulations defined within this policy.
- 10.27 **Termination of coverage after the policy termination date:** There is no coverage for any treatment that occurs after the effective date of termination of this policy, regardless of when the condition first occurred or how much additional treatment may be required.
- 10.28 **Change of plan or deductible:** Upon the anniversary date, the Insured can request to change to a plan with a different deductible. The Insurance Company reserves the right to accept any change of deductible in the annual renewal (if the change is for a lower deductible than the current one). Such requests are subject to underwriting evaluation, and require approval. During the first ninety (90) days from the effective date of the change, benefits payable for any illness or injury not caused by accident or disease of infectious origin will be limited to the lesser of benefits provided by the new plan or the prior plan. In the event that the Insured is under medical treatment or has been diagnosed with a medical condition, he/she may not change options.

ART. 11 DEFINITIONS

- 11.1 **Accident:** Any sudden, unforeseen, or unintentional event produced exclusively by an external cause resulting directly from and independently of other causes in bodily injury to the Insured.
- 11.2 **Air ambulance:** Emergency air transportation and medical personnel trained in the transfer of the Insured from the hospital where the Insured is admitted to the nearest suitable hospital where adequate treatment can be provided.
- 11.3 **Amendment:** A document added to the policy by the Insurance Company that clarifies, explains or modifies the policy.
- 11.4 **Anesthesiologist fees:** Incurred charges by an anesthesiologist for the administration of anesthesia during a surgical procedure or services that are medically necessary for pain control.
- 11.5 **Anniversary date:** Date and time that a complete year occurs from the cover start date of the policy or from the last anniversary.
- 11.6 **Applicant:** The individual who signed the application for coverage.
- 11.7 **Application:** A written request on an application form by a proposed Insured with information of himself/herself and/or their dependents used by the Insurance Company to determine coverage. The application includes any medical history, questionnaire, and other documents provided to or requested by the Insurance Company prior to the issuance of the policy.
- 11.8 **Assisting physician/surgeon fees:** Incurred charges by a physician or physicians who assist the principal surgeon during a surgical procedure.
- 11.9 **Certificate of coverage:** Document of the policy that specifies the commencement, conditions, extent and any limitations of the coverage, and lists all insured people.
- 11.10 **Complication of birth:** Any disorder related to the birth of a newborn (not caused by genetic factors), manifested during the first thirty (30) days of life, including, but not limited to, hyperbilirubinemia (jaundice), cerebral hypoxia, hypoglycemia, premature birth, respiratory distress, and birth trauma.
- 11.11 **Congenital and hereditary disorders or illnesses:** Any disorder or illness existing before birth, regardless of its cause, whether or not manifested or diagnosed at birth, after birth, or years later.
- 11.12 **Country of residence:** The country in which the Insured resides the majority of any calendar or policy year, or where the Insured has resided for more than one hundred and eighty (180) continuous days during any three hundred and sixty-five (365) day period while the policy is in effect. This policy does not cover a person residing in the United States.
- 11.13 **Covered expenses:** Covered expenses are defined in the "Policy Provisions" section of this policy.
- 11.14 **Cover start date:** The date on which coverage under this policy begins as is stated in the "Certificate of Coverage." This date will only be effective after delivery of the insurance policy to the Insured and the

expiration of the Ten (10) Day Right to Examine the Policy, during which the Insured reserves the right to examine and return the policy.

- 11.15 **Covered maternity:** A covered maternity is one whose actual date of delivery is at least ten (10) months after the start cover date of the policy for the respective Insured mother (benefits available only with options I, II and III).
- 11.16 **Custodial care:** Services rendered that include but are not limited to personal assistance that does not require the skills of a professional.
- 11.17 **Deductible:** The portion of covered charges that must be paid by the Insured (see article 5).
- 11.18 **Due date:** The date on which the premium is due and payable for the corresponding period. On the due date, all benefits and coverage ends according to the conditions outlined in this document.
- 11.19 **Durable medical equipment:** Any medical equipment designed for continuous use. This includes, but is not limited to, wheelchairs, hospital beds, respirators, crutches, etc.
- 11.20 **Emergency:** A sudden and unforeseen medical condition or event manifested by acute signs or symptoms which could result in immediate danger to the Insured's life or physical integrity.
- 11.21 **Emergency dental treatment:** Treatment necessary to restore or replace sound natural teeth, damaged or lost in a covered accident.
- 11.22 **Emergency treatment:** Medically necessary treatment due to an emergency.
- 11.23 **Experimental or investigative:** Any treatment, procedure, equipment, drugs, device or supply that does not comply with one or more of the following criteria:
- a) Controlled clinical research published in medical literature reviewed by other professionals of the same category who show that this service or device has a clear, beneficial result for one's health for a specific diagnosis.
 - b) Such service or device complies with the norms generally accepted within the medical scope of practice in the United States.
 - c) At the time that the service or device is provided to the Insured, it has been approved for the specific indication or application in question by the United States Food and Drug Administration (FDA) or other federal agency of the government, whose approval is required in the United States, regardless of the location where the medical charges are incurred.
- 11.24 **Grace period:** The period of time of thirty (30) days after the policy due date during which the policy may be renewed.
- 11.25 **Ground ambulance:** Ground transportation with equipment and medical personnel trained in the transfer of the Insured.
- 11.26 **Home health care:** Health care which is prescribed and recommended in writing by the Insured's treating physician, as necessary for the proper treatment of the illness or injury at home in place of hospitalization.

- Home Health Care includes the services of skilled licensed professionals (nurses, therapists, etc.) outside of the hospital and does not include custodial care.
- 11.27 **Hospital:** Any facility which is legally licensed as a medical or surgical facility in the country in which it is located and is:
- Primarily dedicated to providing clinical and surgical diagnoses for injured and ill persons under the supervision of a medical team.
 - Not a place of rest, nursing or convalescent home or institution, or a facility for long term care.
- 11.28 **Hospital services:** Medical treatment or services ordered by a medical professional for the Insured who is admitted to a hospital.
- 11.29 **Illness:** A condition of the human body manifested by signs, symptoms and/or findings through medical exams and evaluations, which makes this condition different than the normal state of the body.
- 11.30 **Injury:** Damage inflicted to the body.
- 11.31 **InterConsultation™:** The opinion of a medical specialist other than the Insured's treating physician, for confirmation of the diagnosis and recommendation of the best treatment and specialists.
- 11.32 **Insured:** The term "Insured" includes the policy holder and/or covered dependents.
- 11.33 **Laboratory and x-ray services:** X-ray services and laboratory testing to diagnose or treat medical conditions.
- 11.34 **Living donor:** A person capable of donating a bodily organ and able to live without such organ, which is compatible to the recipient of the organ.
- 11.35 **Medically necessary or medical necessity:** A medical service, supply, equipment, medication or hospital admission that:
- Is appropriate and essential for the diagnosis and treatment of the Insured's illness;
 - Does not exceed the reach, duration or intensity of the level of care necessary to provide a safe, adequate and appropriate diagnosis and/or treatment;
 - Has been prescribed by a physician;
 - Is consistent with the professional norms accepted within the medical scope of practice in the United States, or by the medical community of the country where the medical service or treatment is rendered.
- 11.36 **Newborn:** An infant from the moment of birth through the first (1st) month of life.
- 11.37 **Nurse:** An individual legally licensed to provide nursing care to patients.
- 11.38 **Outpatient services:** Treatment or services provided that do not require a hospital admission. The services can be rendered in a hospital or emergency room.
- 11.39 **Personalized services:** The Insurance Company offers the coordination of medical appointments, hospital admission, travel arrangements and accommodations when services are rendered outside of the Insured's country of residence. The Insured is responsible for all travel and accommodation costs.

- 11.40 **Physician or doctor:** A person who is legally licensed to practice medicine in the country where treatment is provided. The term “Physician” or “Doctor” shall also include persons legally licensed to practice Dentistry.
- 11.41 **Policy holder or primary Insured:** The person whose name appears on the “Certificate of Coverage” of this contract and for whom it is issued. This individual is the person entitled to receive reimbursement for covered medical expenses and the refund of any unearned premium.
- 11.42 **Policy year:** The period of twelve (12) consecutive months beginning on the start cover date of the policy.
- 11.43 **Pre-existing condition:**
- a) A condition which was diagnosed by a physician prior to the cover start date of the policy or its reinstatement; or
 - b) A condition for which a doctor was consulted and medical treatment was recommended or received prior to the cover start date of the policy or its reinstatement; or
 - c) A condition for which any symptom or sign, if presented to a physician prior to the start cover date of the policy, would have resulted in the diagnosis of an illness or medical condition.
- 11.44 **Prescription medications/drugs:** Medications whose sale and use are legally restricted to the order of a physician.
- 11.45 **Primary procedure:** The procedure that has been identified as such and for which the majority of the benefits are paid under this policy.
- 11.46 **Private aircraft:** Any aircraft in a flight that is not regularly scheduled or chartered by a commercial airline.
- 11.47 **Provider:** The hospitals, diagnostic centers, physicians, pharmacies and any facility that provides legally authorized medical services.
- 11.48 **Renewal date:** The first day of the next policy year. Renewal takes place only on the anniversary date of the policy and can occur on an annual, semi-annual or quarterly basis.
- 11.49 **Rider:** A document added to the policy by the Insurance Company which provides optional coverage.
- 11.50 **Second surgical opinion:** The medical opinion of a physician other than the current attending physician.
- 11.51 **Secondary procedure:** In the event multiple procedures are performed, this procedure shall be the less complex and/or extensive and for which the lesser amount of benefits shall be paid under this policy.
- 11.52 **Semi-private room:** A standard hospital room equipped to accommodate one or more patients.
- 11.53 **Spouse:** The individual with whom the Insured is legally married, which is valid under the jurisdiction where such marriage took place.
- 11.54 **Transplant:** Medically necessary procedure by which organs, skin or cells are surgically transplanted from the living or deceased donor to the recipient.

- 11.55 **Usual, customary and reasonable:** Charges or fees for any medical service provided in a determined geographical area, regardless of whether or not the payment was made directly or issued as a refund. The Usual and Customary fees are defined by the Insurance Company's medical team.
- 11.56 **Well baby care:** Routine medical care provided to a healthy newborn.

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The insurance policy is issued by Best Doctors Insurance Limited, a Bermuda company. Insurance administration services provided by Best Doctors, Inc. on behalf of Best Doctors Insurance Limited. www.bestdoctors.com

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