ELAN Insurance USVI, Inc.

2 Tenth Street, St. Thomas, Virgin Islands 00802
(herein called ELAN)

ELAN Vital Coverage (EVAC), is a Limited Benefits Insurance Policy underwritten by ELAN Insurance USVI, Inc., (referred to as "ELAN" herein).

This Policy is not a Comprehensive or Major Medical Health Insurance Plan or a Medicare Supplement Policy. This policy/certificate provides coverage only for inpatient and limited after-care medical coverage for the treatment of a sudden serious life-threatening emergency illness or injury requiring Emergency Air Ambulance Transport because appropriate specialized treatment is unavailable.

While the contract is in force, coverage under the Policy will be subject to the terms and conditions established herein. Additionally, benefits will be subject to ELAN's medical and payment policies.

This Policy is issued in consideration of the Application of the Policyholder, a copy of which is attached hereto when issued and made a part hereof, any Individual applications, and the payment of "premiums" by the Policyholder, as provided herein. All these documents constitute the Contract Agreement. The duties and the rights of all persons will be based solely on the Policy terms contained in this document and any amendment attached to this policy.

This Policy is issued as of the first (1st) of the month following ELAN's acceptance of the Application and receipt of Premiums and is valid for twelve (12) months from the effective date and may be renewed for subsequent 12-month periods. All coverage terms begin at 12:01 a.m. and end at 11:59 p.m., Atlantic Standard Time, official time.

You must be a bonafide resident of the U.S. Virgin Islands to purchase this policy.

This policy is signed by the President of ELAN.

Omar Haedo, President

Keep this document – and any riders adhered to it - in a safe place; as it includes important information on your Policy coverage.

IMPORTANT
TELEPHONE NUMBERS AND ADDRESSES

Web: **www.elan.insure**

Customer Service Phones:

Customer Service: **1-844.464.4277**

Call Center Hours: **Monday thru Friday: 8:00 a.m. to 5:00 p.m. Eastern Standard Time.**

Customer Service/Claims Fax: 1- 806-473-3280

Precertification for Emergency Air Ambulance and Policy Benefits: **1-888-201-3437** **24 hrs./ 7days**

Email: precert.evac@elan.insure

- **Billing and Payments:** salessupport.EVAC@elan.insure

INTRODUCTION

ELAN HEREBY INSURES under this limited benefit insurance contract the person named as the insured in the Policy Schedule and the eligible dependents, if any, who are named and approved in the attached application (made a part of the Policy Schedule), all of whom are hereinafter referred to as You, Your, Insured, Insured Person, Covered Person, Eligible Dependent, or Covered Member. A copy of the Application is attached hereto and made a part hereof.

INSURING CLAUSE

Subject to all terms, conditions, provisions, exclusions, exceptions and limitations contained herein, the Company promises to provide the Insured or any eligible dependent under the insurance contract and after a certification of medical necessity made by the Company's Medical Director, inpatient medical coverage of eligible expenses for the treatment of a sudden serious life-threatening emergency illness or injury requiring Emergency Air Ambulance Transport because appropriate specialized treatment is unavailable locally. Such Emergency Air Ambulance Transport will be to the nearest medical facility capable of providing such appropriate specialized treatment. ELAN will provide inpatient medical insurance coverage to treat the condition and the emergency air ambulance transportation after a certification of medical necessity has been made by the Company's Medical Director.

We make this promise in consideration of the information contained in the application for this Policy and the payment of the premiums, prior to the Effective Date.

RENEWAL CONDITION
LIFETIME GUARANTEED RENEWABLE AND BASIS FOR ISSUING THE POLICY

This Policy shall be renewed subject to required premiums being paid on or before the renewal date, subject to Grace Period and all other terms and conditions of the Policy. This Policy is automatically renewable if no notice of cancellation has been given by either party at least one month prior to the renewal date.

ELAN retains the right to adjust premiums per the age of the Policyholder and eligible dependents, require evidence of eligibility for coverage, including dependent status and bona residency if necessary and retains the right to terminate all policies in the same class as defined in the Policy.

RIGHT TO EXAMINE THE POLICY

The Insured has the right to return this Policy to ELAN or its authorized representative within ten (10) days of its receipt for a full refund of the initial amount paid. Should this Policy be returned, it shall be void from the beginning and the parties shall be in the same position as if no Policy had been issued.

IMPORTANT NOTICE

We recommend you read this Policy and the copy of the Application attached thereto. Carefully check the Application and write to ELAN immediately if any information shown is incorrect, incomplete or missing. Any omissions, incorrect or incomplete information could cause an otherwise valid claim to be denied and the Policy to be cancelled as of the original issue date.

Table of Contents

DEFINITIONS

1.	**CHILDREN:**	Natural or adopted unmarried child(ren), or child(ren) placed in the Insured's physical and legal custody under marriage and whom the Insured intends to adopt under marriage under twenty-six (26) years and as long they are financially dependent on the Insured.
2.	**CONTRACT:**	Refers to the duly completed application for insurance, payment of the premiums due and the policy.
3.	**EFFECTIVE DATE:**	Refers to the date the policy becomes active for the first time -meaning the first of the month after the application was approved by the Company and the premiums are received to issue the policy. The policy will remain in force if the premiums are paid in a timely manner.
4.	**EMERGENCY AIR AMBULANCE TRANSPORTATION:**	This is defined as the travel from a local airport to the nearest appropriate medical facility where specialized treatment can be provided, if an insured suffers a sudden and serious life-threatening emergency illness or injury requiring hospitalization and specialized treatment which is not available locally. Travel in this Policy is exclusively provided by "fixed wing" or "rotary blade" medically equipped emergency air ambulance transportation. Transportation to such a facility requires the authorization of the attending physician and certification of medical necessity by the Company's Medical Director taking into consideration that the patient is in a condition sufficiently stable for the flight.
5.	**EVAC BASIC**	Means a limited benefits insurance plan option that provides coverage for the treatment of a sudden and serious life-threatening emergency injury and illness at the most appropriate nearest inpatient facility in the Caribbean when treatment is not available locally and use of emergency air ambulance transport is required to transfer the patient. Services will be subject to the certification of medical necessity for transportation and treatment by ELAN's Medical Director.
6.	**EVAC USA**	Means a limited benefits insurance plan option that provides coverage for the treatment of a sudden and serious life-threatening emergency injury and illness at the most appropriate nearest inpatient facility in the United States when treatment is not available locally and use of emergency air ambulance transport is required to transfer the patient. The Insured's treating physician must provide certification to ELAN's Medical Director that the flight is in the best interest of the Insured and that the Insured is in a medical condition sufficiently stable for the flight to the Continental United States.
7.	**EXCLUSIONS:**	Refers to certain conditions, benefits, services and situations not covered by this Policy.
8.	**FAMILY COVERAGE:**	Means coverage for the Insured and their eligible dependents under the Insurance, as defined by this Policy.
9.	**FIRST POLICY ANNIVERSARY:**	Refers to the completion of the twelve (12) months from the initial Effective Date of the Policy.
10.	**FRAUDULENT DECLARATIONS:**	Refers to false information provided by the Insured, or applicant of the Policy, or claimant for obtaining the approval of the Policy and / or payment of any claim.

11. GRACE PERIOD: Refers to the thirty (30) days that the Company will concede for payment of each premium due after the first of the month, during which the policy will continue in full force, subject to the right of ELAN to cancel in accordance with the termination provision hereof.

12. IN FORCE: Means that the policy is active and the Insured and their eligible dependent(s) are covered subject to the terms and conditions of the Policy.

13. INSURED: Refers to the insured and eligible dependent(s) who are covered by the Company's policy while it remains in force, subject to the payments of the premium agreed to in this contract.

14. INPATIENT CARE: Means care in a hospital that requires an admission as an inpatient and normally requires an overnight stay or at least twenty-four (24) hours admission in a hospital facility. Emergency room and out-patient visits in the hospital are not considered inpatient care or hospitalizations.

15. IN WRITING: Refers to a document written by the Insured or Policy Payor, acceptable to the Company and submitted and received at the Company's Main Office:

ELAN Insurance USVI, Inc.
9500 South Dadeland Boulevard, Suite 706
Miami, FL 33156

16. LIFE-THREATENING EMERGENCY ILLNESS OR INJURY For purposes of the policy coverage, it refers a stage of a disease in which there is a reasonable likelihood that death will occur without early or immediate treatment for the following:

- Burns requiring treatment in a burn center
- Conditions requiring treatment in a Hyperbaric Chamber
- Cardiogenic shock
- Multiple severe injuries requiring a trauma center
- Loss of a limb
- Intracranial bleeding, Subdural hematoma, subarachnoid hemorrhage that requires neurosurgical intervention
- Life threatening trauma
- Premature labor that puts endanger the life of the mother and baby
- Neonatal services

Transportation to such a facility requires the authorization of the attending physician and certification of medical necessity by the Company's Medical Director taking into consideration that the patient is in a condition sufficiently stable for the flight. Coverage under this Policy requires also the authorization and certification of the Company's Medical Director Coverage of the medical necessity and immediately life-threatening requirement.

17. MEDICAL FACILITY OR HOSPITAL: Institution legally authorized for the care and treatment of sick or injured persons, with established facilities for diagnosis, treatment and operations, either on its premises or in facilities available to the hospital by prior agreement, which is supervised by one or more physicians with in force license (s) duly issued to practice and includes nursing services twenty-four (24) hours a day. Institutions excluded from this definition are Physical Rehabilitation Centers, Skilled Nursing, and Hospice facilities even though these may be within a hospital. There are also excluded facilities mainly engaged and authorized to operate as a nursing home, rest home, or those who serve primarily as an institution for the care and treatment of addictions, controlled substances, medications, alcohol or mental conditions are also excluded.

18.	**PHYSICIAN:**	Health professional authorized by the Medical Examining Board of the Territory or State and / or competent governmental authorities where services are rendered, to diagnose and treat illnesses, injuries and provide medical services within the limits of their license.
19.	**POLICY LAPSE:**	Means that all the benefits to the Insured or its eligible dependents under this Policy ceased or were terminated due to non-payment of the premium amounts owed to the Company after the Grace Period ended.
20.	**POLICYHOLDER:**	The person that holds an insurance contract with ELAN that entitles him/her to the benefits issued in his/her name and assumes the responsibilities established in the policy.
21.	**POLICY PAYOR:**	Insured person or Individual who makes the agreed premium payments under the Policy.
22.	**POLICY YEAR(S):**	Refers to a period of twelve (12) months following the effective date - as specified on this Policy - and each subsequent similar period.
23.	**PREMIUMS:**	The monthly amounts that must be paid by the Insured or Policy Payor to the Company for this insurance Policy.
24.	**REINSTALLMENT or REINSTATEMENT**	Placing the insurance policy back in force after the policy lapse occurred. Reinstatement must be conducted after the specific time allowed by the Company and accompanied with the full payment of the premium amounts owed to the Company.
25.	**RESIDENCE:**	Means the address provided in the insurance Application. This policy is subject to residence requirements and changes of residence must be sent to the Company by certified mail or return/receipt mail. Changes of residence must be received and approved by the Company prior to any injury, illness or other incident which may activate the provision of services covered under this Policy.
26.	**RESCIND:**	Means to annul, contest, reject or challenge the validity of the Policy.
27.	**RIDER/ ENDORSEMENT:**	Refers to any document adhered as part of this Policy intended to change or modify the benefits, terms and provisions in this Policy or Insurance Contract.
28.	**SINGLE COVERAGE:**	Means coverage for an Individual insured under the Policy.
29.	**SPOUSE OR DOMESTIC PARTNER:**	**Spouse** means a person to whom the insured is legally married. A **Domestic Partner** refer to an affective relationship between two (2) persons, regardless of gender, who live in public under the same roof, both are eighteen (18) years of age or older and between whom there is a legitimate - verifiable - insurable interest.
30.	**SUITABLE AIRPORT:**	Means an airport of such location, construction or facilities where a safe landing/maintenance and a takeoff can be made by a fixed-wing aircraft, as determined by the emergency air ambulance transportation provider.
31.	**WAITING PERIOD:**	Refers to the number of days before the insurance coverage begins or the insured must wait before he/she can receive the covered services under this Policy, after its effective date.
32.	**WE, US, OUR:**	Refers to the Company.

GENERAL CONDITIONS

1. **ACCESS TO BENEFITS**: In order to obtain coverage under this Policy, it is the responsibility of the

Insured, the Insured's Attending Physician, the facility or the Insured's personal representative to call the Plan and communicate occurrence of a life-threatening emergency illness or injury to activate benefits and coordination of the emergency air ambulance transportation. Benefits under this policy are subject to the certification of medical necessity by THE COMPANY's Medical Director. If the plan is not notified or the Plan does not approve such services, the insured member will be solely responsible for all the costs associated with the services without the right of reimbursement.

2. **ACTS OF WAR:** The Company shall not be liable for any loss or reimburse for any fee, cost or charge that results from any treatment or service of a condition caused by an act of war, either declared or undeclared, or acts of terrorism.

3. **AGENT FOR PROCESS:** Legal process may be served on the Company or its legal representative.

4. **ASSIGNMENT:** The Insured person cannot assign or transfer any benefits or interests under this Policy to any person, company or organization. Any assignment by the Insured person other that the monies due to a claim for rendered services under this Policy will be void. However, the insured person can request the Company to make payments for eligible covered expenses or services directly to the provider instead of the insured person.

5. **BENEFIT CERTIFICATE:** Our preferred method of providing the Insured member the Policy/Certificates of Benefits will be electronic or through email, upon insured member's affirmatively consent to such method in the enrollment form and has not withdrawn such consent for the issuance of the Policy/Certificate of Benefits after its initial confirmation. However, the insured member has the right to receive the Policy/Certificate of Benefits on paper.

   If insured member consented THE COMPANY in the enrollment form to provide the Policy/Certificate of Benefits in an electronic format or email and wants to withdraw the initial consent, he/she can call Customer Service at the number in the back of the ID Card to confirm the withdraw of the initial consent for electronic issuance of the Policy/Certificate of Benefits.

6. **CIVIL ACTIONS:** No action at law or in equity may be maintained against the Company prior to the expiration of sixty (60) days after written submission of a claim has been furnished to the Company as required in this Policy/Certificate of Benefits. No action may be taken after three (3) years have elapsed from the date in which it was required that written proof of the service had to be filed.

7. **CHANGES IN THIS POLICY:** The Company may unilaterally change this Policy upon renewal and with at least thirty days (30) days prior written notice to the Insured.

8. **CHANGES OF PREMIUM FEE SCHEDULE:** The Company reserves the right to modify the Premium Fee Schedules at the Policy's Renewal or Anniversary by providing at least thirty (30) days written notice.

9. **CLAIM FORMS**: Upon receipt of a notice of claim, the Company will furnish to the insured member the claim forms that are usually furnished by it for filing proofs of loss. If such forms are not furnished before the expiration of the fifteen (15) days of giving such notice the insured member shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss written proof covering the occurrence, the character and the extent of the loss for which claim is made.

10. **CLAIM PAYMENTS:** The benefits provided under this policy will be paid to the plan provider, the non-plan facility or provider or directly to the insured member if the insured member has used a plan provider, or a nonplan facility or provider and services are paid based on reimbursement. The benefits provided will be paid as long as all reports and evidence required by THE COMPANY is filed.

11. **CLERICAL ERRORS:** A mistake, error or delay made by The Company will not a) invalidate this Policy if indeed this Policy is in force, nor would it keep it in effect if it were not validly in force, b) will not deny coverage which should has been granted, c) will not extend coverage which should otherwise has been terminated, and d) will be subject to the proper adjustments of premiums when an adjustment is needed.

12. **COMMENCEMENT OF BENEFITS**: Benefits begin after the Waiting Period is fulfilled and not on the date of application for insurance or the Effective Date of the Policy.

13. **COMPLIANCE WITH APPLICABLE LAW:** It is agreed that this Policy shall be interpreted in accordance with laws of the Jurisdiction within which the Policy was issued.

14. **CONFIDENTIALITY:** The Company will keep the confidentiality of your medical information and claims. Only the following people will have access to it:

    a. The Company and its contractors when both are the administrators of the contract;
    a. Public officials investigating or filing a judicial or civil action;
    b. Bona fide individuals participating in an educational or medical investigation in which the identity of the insured member is not necessary; or
    c. When according to a federal or state law, a reimbursement related with a National Medical Support Notice and subject to an order or resolution of an authorized administrative agency or court is paid to a different person other than the main policyholder.

15. **CONTRACTING OF SERVICES:** The Insured shall not contract, authorize or engage any service or expense in the name of or on behalf of The Company for the provision of services under this Policy. The Company shall not be under any obligation to reimburse the Insured should the insured independently authorize, contract or make payment for any services failing to follow the procedures established in this Policy for coverage determination and preauthorization.

16. **CURRENCY:** All payments shall be in the currency of the United States of America (U.S. Dollars ($)).

17. **ELIGIBILITY FOR COVERAGE FOR ADOPTED CHILDREN:** Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

    If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

18. **ENTIRE CONTRACT AND DECLARATIONS IN THE APPLICATION:** The Application to this Insurance, the Policy, including endorsements or riders as applicable, attached hereto, constitute the entire contract between the parties. All statements made by the Policyholder or by the individuals insured, shall be deemed to be factual and no statement shall void the insurance, or be used in defense of a claim under it, unless it is deemed to be fraudulent.

    False representations, omissions, concealment of facts and incorrect declarations shall not impede the collection of premiums in respect to this Policy, unless:

    a) They are fraudulent; or
    b) Are material to the acceptance of risk; or
    c) The company, in good faith, would not have approved coverage in respect to the risk resulting from the loss incurred, if it would have had complete knowledge of the facts as required in the application.

    When the Applicant or any eligible dependent incur in any of these (a), (b) and/or (c), the collection of premium will be impeded only if the act or omission at stake would have contributed to the incurred loss for which a claim is being presented.

The rights of the policyholder or of any insured shall not be affected by any provision other than the ones contained in the Policy or in the copy of the application attached hereto.

No agent is authorized to alter or amend this Policy, to accept premium in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted. No change in this section of the Policy shall be valid unless approved by the Company and evidenced by endorsement hereon, or by amendment hereto signed by the Policyholder and by the Company.

19. **GRACE PERIOD:** thirty (30) days will be conceded for payment of each premium due after the first of the month, during which the policy will continue in full force, subject to the right of ELAN to cancel in accordance with the termination provision hereof.

20. **IDENTIFICATION:** The Company agrees to provide the Insured with an identification card bearing the Insured's Identification Number. Such card and other forms of identification should always be carried by the Insured to provide proof of the right to benefits under this Policy.

21. **INCONTESTABILITY.** No statement made by the Policy holder/ Insured Member in an application for coverage under this Policy shall avoid the Policy or be used in any legal proceeding unless the application or an exact copy is attached to this Policy.

22. **INDIVIDUAL CANCELLATION:** The Company may cancel the insurance of any insured member or any dependent at any time through written notice delivered to the insured member delivered or mailed by certified mail to the last known address as is appears in the Company files, indicating when the cancellation will be effective, which will not be less than thirty (30) days after notice, when the insured member or any of his/her dependents has presented or made to be presented a false or fraudulent claim or any proof to support it, for the payment of a claim under any Company policy regardless of the date in which said act was committed nor the date and the manner in which such act was discovered or when such persons present patterns of fraud in the use of benefits provided by the policy.

    THE COMPANY will provide the insured member a certification of coverage. If the insured member does not receive a certification of coverage he/she may obtain one by calling our Member Services at the number on the back of your ID card.

23. **INDIVIDUAL TERMINATION:** If the insured member terminates the insurance policy, he/she is responsible of returning the insured identification cards to the Company.

    The Company will not cover services used after termination of coverage. The insured member will be responsible for payment of these services.

24. **LEGAL ACTIONS:** No action at law or in equity shall be brought to recover in this section of the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

25. **MISSTATEMENT OF AGE:** If the age of an Insured has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

26. **NOTICE OF CLAIM:** Claims for services must be submitted to the Company within twenty (20) days the insured member receives the services for which payment is being requested. If it's not reasonably possible to submit a claim twenty (20) day period, the insured member or service provider must submit it as soon as reasonably possible. Please refer to the IMPORTANT TELEPHONE NUMBERS AND ADDRESSES at the beginning of the policy for the address where you can fax such notice.

27. **NOTICE OF PROVIDER DIRECTORY/ NETWORKS -** Our preferred method of providing the insured

member the Provider's Network Directory will be electronic by email or by visiting myhealth.elan.insure, upon insured member's affirmatively consent to such method in the enrollment form and has not withdrawn such consent after its initial confirmation.

The insured member has the right to receive the Provider's Network Directory on paper, upon request by calling Customer Service at the number in the back of the ID Card.

If insured member consented the Company in the enrollment form to provide the Provider's Network Directory in an electronic format or email and wants to withdraw the initial consent, he/she can call Customer Service at the number in the back of the ID Card. Insured member will need to send a confirmation in writing to withdraw the initial consent for electronic issuance of the Provider's Network Directory.

28. **PERSONAL RIGHTS:** The insured may not yield, transfer or waive in favor of third party any of the rights and benefits that he/she may claim by virtue of this policy. The Company reserves the right to recover all expenses incurred in case the insured members, with express or implicit consent, permits non-insured member to use the card issued by the Company in his/her favor. It is also provided that recovery of such expenses will not prevent the Company from canceling the insurance contract when illegal use of the card is discovered nor from filing suit against the insured or uninsured user of the card to recover the amount corresponding to claims improperly paid.

29. **POLICY YEAR**: Period of twelve (12) consecutive months for which the Policy holder/ Insured Member acquires or renews the insurance.

30. **PHYSICAL EXAMINATION AND AUTOPSY:** The Company, at its own expense, shall have the right and opportunity to examine the Insured Person when and as often as it may reasonably require during the claim review process hereunder and to conduct an autopsy, unless forbidden by law.

31. **PREMIUM PAYMENTS:** The Insured Member will be liable for the payment of the premium covering the policy; and it is provided that such liability will cover the entire premium outstanding up to the date of termination of the policy, according with the TERMINATION clause.

    The Company will have the right to collect the premium due from the Insured member after the cancellation of the insurance. In such event, the insured member will be liable for payment of the premium claimed by the Company. The Company may use the services of collection agencies to collect payment for any debt extant with the Company. It is provided, additionally, that the debtor is obligated to pay legal costs, expenses and fees as well as any other additional amount or expense the Company incurs to collect the debt.

    The Company reserves the right to notify any agency, institution or organism dedicated to credit investigation detailed information regarding lack of payment by an insured member.

32. **PROOF OF LOSS/SERVICE:** Any claim for services/loss incurred by the insured member, should be submitted in writing to THE COMPANY within ninety (90) days of said services/losses. Not submitting the proof within the required time will not invalidate or reduce any claim if it was not reasonably possible to submit proof within that time, if such proof is submitted as soon as reasonably possible and, in no case, except under legal incapacity, later than one (1) year from the date in which the proof is otherwise required. The Insured agrees and authorizes any professional or service provider to submit to the Company reports, to be kept confidentially, regarding the diagnostic and services rendered to him or her or any insured dependent, to be utilized only and exclusively to determine rights and obligations contracted in the policy.

33. **PROTECTION AGAINST CREDITORS:** To the extent allowable legally and subject to the terms and conditions of this Policy, all benefits and amounts payable under this Policy will be exempt and free from claims of creditors and from judicial process to levy upon or attach the same.

34. **RECOVERY OF PAYMENTS MADE IN EXCESS OR BY MISTAKE:** If the Company issues a payment for a claim to the insured member that should have been paid by the primary plan or pays in excess of those for which we were obligated to provide under the policy, The Company will have the discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company or organization. THE COMPANY may recover the amount paid in excess to the insured member.

35. **REINSTATEMENT:** If payment of any renewal premium is not made within the time allowed to the Insured member for its payment, subsequent acceptance of a premium by the insurer or any duly authorized agent of the insurer to accept such premium without requiring with it an application for restoration will serve to renew the policy; however, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium paid, the policy will be reinstated upon approval of said application by the insurer or, if such approval is not forthcoming, on the forty-fifth day after the date of said conditional receipt, unless the insurer has notified the Insured Member in writing that said application has not been approved. The reinstated policy will only cover losses resulting from any accidental injury that may have been suffered after the date of reinstatement and losses due to any illness that may begin more than ten days after such date.

    In any other case, insured member and the insurer will have the same rights under the policy as they had immediately before due date of the unpaid premium, subject to any provisions endorsed or attached to this document regarding the reinstatement. Any premium accepted with regards to a reinstatement should be applied to a period for which no premium was previously paid and that do not exceed more than sixty (60) days prior to the date of reinstatement.

36. **RESIDENCY REQUIREMENT:** Coverage under this Policy is available exclusively to bona fide residents of the jurisdiction where the Policy is issued, except eligible dependents that study full time off island in a duly accredited college or university. Insured individuals must be physically present in that jurisdiction for at least one hundred eighty-one (181) days of each calendar year. For those insured persons, not physically resident at least one hundred eighty-one (181) days of each calendar year in the jurisdiction where this policy is issued, the Company's liability is limited to refunding all premiums paid on behalf of the individuals who do not qualify for coverage under this residency requirement. The premium refund will be from the Policy's inception or its last renewal date, whichever is most recent.

    The individual who does not qualify for coverage under the residency requirement is liable to the Company for any claim paid while the individual did not qualify for coverage under the residency requirement.

    The Insured must notify the Company of any change in country and/or residence that exceeds one hundred eighty-one (181) days by sending written notice to the Company within forty-five (45) days of the change.

    Residence in a country or territory other than shown in the application, for one hundred eighty-one (181) days a year or more, will result in policy cancellation and retroactive termination of benefits to the change in resident status.

    In the case of eligible dependents studying full time off island in a duly accredited college or university, they are eligible to enroll in this plan, where the Company will provide state to state coverage when a life-threatening illness or injury occurs if treatment is not offered locally at the location where they are studying. Certificate of enrollment from an accredited college or university must be provided as evidence at the time of enrollment to the plan.

37. **RESCISSION:** The Company will rescind your coverage if you or someone seeking coverage on your behalf has:

    - performed an act, practice, or omission that constitutes fraud, or

- made an intentional misrepresentation of material fact to the Company or another party, which results in you or a dependent obtaining or retaining coverage with the Company or the payment of claims under this certificate.

NOTE: Your coverage may be rescinded back to the effective date of your contract after we have provided you with prior notice, if required under the law. You will be required to repay the Company for its payment for any services you received during this period.

38. **RIGHT TO AUDIT:** Once enrolled in this limited benefit insurance policy, the insured member and his/her dependents accept, acknowledge and understand that the Company, as payer of the health services incurred by the main policyholder and his/her dependents, has the authority to access his/her medical information to audit all or any health service claims that health plan has paid.

39. **RIGHT TO DEVELOP GUIDELINES AND ADMINISTRATIVE RULES.** The Company may develop or adopt standards that describe in more detail when we will or will not make payments under this Certificate. Those standards will not be contrary to the descriptions in this Certificate or limit the benefits provided in this policy or certificate, unless a rider has been duly approved by the Division of Banking, Insurance and Financial Regulations of the U.S. Virgin Islands and implemented at renewal of the policy. For additional information about the standards that apply to a particular benefit, please contact Customer Services. If necessary, we may send a copy of the standards.

40. **SUBROGATION:** The Insured hereby assigns to The Company, all rights, entitlements and interests in all insurance policy benefits to which the Insured may be entitled to receive monies for any of the same services provided in this Policy by the Company. Said assignment is irrevocable and Insured further warrants that The Company may pursue any claims for payment of any insurance benefits directly to itself from the Insured's insurance carrier or from any insurance carrier from which Insured is entitled to payment of monies for any of the same services provided in this Policy.

41. **TERMINATION:** This policy will terminate when:

    A. The Applicant dies and there is no other insured covered by the same Policy, or
    B. The insured requests the cancellation of the Policy in writing, or
    C. The insured's failure to pay plan premiums, subject to at least fifteen (15) days written notice before the effective date of termination.
    D. The Grace Period expires without receipt of premium by The Company, subject to at least fifteen (15) days written notice before the effective date of termination, or
    E. The Company rescinds the contract, if it finds that the insured omitted information, does not meet the terms and conditions of the Policy, or made misrepresentations in the Application,
    F. The company decided to discontinue the issuance of such policies in the jurisdiction, upon written notice to insured persons of at least 90 days prior the discontinuation of the policies.
    G. The occurrence of any other event permitting termination or cancellation, subject to at least thirty (30) days written notice before the effective date of termination.

    ELAN shall issue a written notice of such termination, delivered or mailed by certified mail, to the insured or to his representative in charge of the subject of the insurance.

    The mailing of such notice shall be effected by certified mail by depositing it in a sealed envelope, directed to the addressee at his last address as known to the insurer or as shown by the insurer's records, with proper prepaid postage affixed, in a letter depository of the United States post office. ELAN shall retain in its records any such item so mailed together with its envelope, which was returned by the post office upon failure to find, or deliver the mailing, to the addressee.

42. **TIMELY CLAIMS PAYMENT:** Claims payable under this Policy will be paid immediately upon receipt of complete and accurate written proof of such loss.

43. **THIRD PARTY ACTIONS**: If because of fault or negligence of a third party the insured member or any of the dependents suffers an illness or an injury covered under the policy, the Company will have the right to subrogate in the rights of the insured member in order to claim and receive from that third party a compensation equivalent to the expenses incurred in treating the insured as a result of such negligent acts.

    The insured member is obligated to acknowledge the Company right of subrogation and will be responsible for notifying the Company of all actions initiated against the third party; provided that if the insured member acts in otherwise, the insured member will be responsible to pay for such expenses to the Company.

    The insured member acknowledges the Company right to transact in his/her behalf actions necessary to recovery of the expenses incurred as a consequence of the blame or negligence of the third party.

44. **TIME LIMITS FOR CERTAIN DEFENSES:** After two (2) years of having issued this policy, no false declaration (except fraudulent declarations) made by any insured person under the policy may be used to cancel insurance coverage for that person or to deny a claim for services that began after said period of two (2) years.

45. **UNHONORED PAYMENTS**: Any premium payment made not honored by the bank shall be considered as an unpaid premium hereunder unless and until valid restitution is made to the Company within the grace period provided herein for making such premium payment.

46. **UNIQUE CONTRACT/CHANGES**: This contract, riders, and any attached documents, if there are any, constitute the insurance contract. All statements made by the policyholder or by the individuals insured shall, in the absence of fraud, be deemed representations and not warranties, and no statement made by any individual insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such individual or to his beneficiary, if any.

    No change in this policy will be valid until it has been approved by the executive official of the Company, and unless said approval is endorsed in the present document or is attached to it. No agent has authority to change this policy or waive any of its provisions.

47. **WAITING PERIODS:** A ninety (90) day Benefit Waiting Period will apply as of the Effective Date of the Policy. The Effective Date of the Policy begins at 12:01 A.M Atlantic Standard Time on the first (1st) of the month following (a) the Company's approval of this application and, (b) the issuance of a Policy and, (c) the receipt and acceptance of the applicable premium payment by the Company.

48. **PRE-EXISTING CONDITIONS:** There are no medical pre-existing condition exclusions in this Policy.

49. **WORKER'S COMPENSATION:** This policy is not in lieu of and does not affect any requirements for coverage under a Worker's Compensation or similar law of the jurisdiction or the domicile of the policyholder.

ELIGIBILITY PROVISIONS

1. **ELIGIBILITY**: You and your Eligible Dependents will be eligible under this Policy if:

    a. Proof of Insurability is received and approved by the Company, and
    b. Policyholder and eligible dependents are insured continuously for ninety (90) days prior to commencement of benefits.

2. **ELIGIBLE DEPENDENTS:** Means a covered member of the Applicant's family including the spouse, domestic partner and direct or legally adopted children, or other dependents where the Applicant has legal custody, if they remain unmarried and are under 26 years of age.

3. **EFFECTIVE DATE NEWBORN DEPENDENT**: While the policy is in force, the Policyholder on the date he or she has a newborn child, the Policyholder must enroll such child on a form satisfactory to The Company within thirty-one (31) days of the birth date. Dependent coverage will then become effective from the date of birth. If not enrolled, Policyholder must wait until the next renewal date of the Policy to enroll the newborn.

4. **DOMESTIC PARTNERS**: This policy/certificate of benefits will cover domestic partners of Policyholder as spouses. Only in such instances, proof of the domestic partnership and financial interdependence must be submitted in the form of:

    A. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or for partners residing where registration does not exist, by an alternative affidavit of domestic partnership.

    B. For the cancellation of the domestic partner as an eligible dependent, an affidavit must be provided to proceed with the cancellation process due to ending of cohabitation.

CHANGES TO THE CONTRACT

After a person enrolls in the plan, he or she may not be able to make changes to the insurance until the next contract renewal date, unless such changes are necessary for any of the following reasons:

1. Death of any of the insured: If any of the insured members die while the policy is in force, the request to terminate the coverage should be submitted within thirty (30) days following the date of death accompanied with the Death Certificate. The Change shall be effective on the first day of the following month in which the event occurred.

2. Divorce of the main insured: If the insured divorces while the policy is in force, the request to terminate insurance must be submitted within thirty (30) days following the date of the divorce, accompanied with the Divorce Decree. The change will be effective on the first day of the month following the month in which the divorce occurred.

3. A child, under the definition of direct dependent of this policy, ceases to be eligible as a direct dependent of the insured, when:

    a. The child reaches the age of twenty-six (26). The birth date will be taken as the date of the request for change to end insurance coverage. Termination will be effective the first day of the following month the month in which the event occurred. The child may continue as a direct dependent as long as he/she meets all the requirements established in this policy.

    b. The child joins the Armed Forces of the United States of America; the date he/she joins will be taken as the date of request for change. The change will be effective on the first day of the following month in which the event occurred.

It will be understood that a person enrolls in the insurance when the person fills out the enrollment and submitted to the Company Offices or Customer Services via email or fax. This rule will apply to any change request, except those related to age. Changes due to age will be applies automatically. The Company hast the right to confirm the eligibility of the insured person to assure that the insured person meets the requirements to obtain the benefits this policy provides.

SPECIAL ENROLLMENT PERIODS

A person may enroll himself/herself or his/her eligible dependents at any moment when any of these conditions occurs and under the following terms and conditions:

1. Marriage: If the insured gets married while the policy is active, he/she may include his/her spouse and any eligible dependents under his/her insurance within thirty (30) days following the date of the marriage. Insured must present the Marriage Certificate and evidence that accredits the new eligible dependents with the request for change. In this case, insurance will be effective on the first day of the month following the month in which the application is received at the Company.

2. Birth, adoption, placement for adoption or custody adjudication: If a natural child is born to the Insured, he/she legally adopts a child, a child is placed in his home for adoption or the court adjudicates him/her the custody of a minor, the Insured may include the eligible dependent under his/her policy. This insurance will not cover those services rendered to the dependents, if the birth, adoption, placement for adoption or awarding of custody was not evidenced and the request for enrollment was not submitted within the thirty (30) days following the event; being it understood, that the payment of the cost for those services will be sole responsibility of the insured. The event will have to be evidenced with the original Birth Certificate, Court Decree or Resolution, or the official document issued by the corresponding government agency with authority, as may be the case. In these cases, insurance will be effective on the day of the birth, placement for adoption or custody adjudication.

EVAC PLAN COVERAGE

MAXIMUM BENEFIT: Eligible medical charges in this policy will be covered up to $2,000,000 (USD) Lifetime Benefit per covered person.

COVERED BENEFITS: The benefits listed in this Section are the only charges for which ELAN will pay under the ELAN Vital Coverage Policy.

Covered services will be provided under this Policy when a sudden and serious life-threatening emergency illness or injury occurs requiring hospitalization and specialized treatment which is not available locally, except otherwise specified for conditions such as the following:

- Burns requiring treatment in a burn center
- Conditions requiring treatment in a Hyperbaric Chamber
- Cardiogenic shock
- Multiple severe injuries requiring a trauma center
- Loss of a limb
- Intracranial bleeding, Subdural hematoma, subarachnoid hemorrhage that requires neurosurgical intervention
- Life threatening trauma
- Premature labor that puts endanger the life of the mother and baby
- Neonatal services

Upon plan selected, covered services include:

COVERED SERVICES	EVAC BASIC (transportation and coverage in the nearest facility in the Caribbean)	EVAC USA (transportation and coverage in the nearest facility in the United States)
In-patient care	ELAN hereby agrees to provide - subject to medical necessity as determined by ELAN's Medical Director - Medical Coverage described in the Policy should the Insured suffer a sudden and serious life-threatening emergency illness or injury that requires emergency air ambulance transportation of that insured to the nearest medical facility in the Caribbean capable of providing such specialized treatment. The Insured's treating physician must provide ELAN the required documentation to evaluate medical necessity and certify to ELAN that the Insured is in sufficiently stable medical condition to be transferred. Notice must be made to the Plan when the sudden and serious life-threatening emergency illness or injury has arisen. Determining medical necessity is the exclusive responsibility of ELAN's Medical Director. All benefits and services under this Policy are subject to pre-authorization by ELAN's Medical Director. Failure to pre-authorize Medical Coverage will result in total forfeiture of the benefits provided by this policy. Services include semi-private room, Intensive Care or Specialized Unit if they are considered medically necessary as well as other medically necessary inpatient services contracted by the hospital and required for the treatment of the specific sudden and serious life-threatening emergency illness or injury while the insured is inpatient.	ELAN hereby agrees to provide - subject to medical necessity as determined by ELAN's Medical Director - Medical Coverage described in the Policy should the Insured suffer a sudden and serious life-threatening emergency illness or injury that requires emergency air ambulance transportation of that insured to the nearest medical facility in the continental Unites States capable of providing such specialized treatment. The Insured's treating physician must provide certification to ELAN's Medical Director that the flight is in the best interest of the Insured and that the Insured is in a medical condition sufficiently stable for the flight to the Continental United States. The Insured's treating physician must provide ELAN the required documentation to evaluate medical necessity and certify to ELAN that the Insured is in sufficiently stable medical condition to be transferred. Notice must be made to the Plan when the sudden and serious life-threatening emergency illness or injury has arisen. Determining medical necessity is the exclusive responsibility of ELAN's Medical Director. All benefits and services under this Policy are subject to pre-authorization by ELAN's Medical Director. Failure to pre-authorize Medical Coverage will result in total forfeiture of the benefits provided by this policy. Services include semi-private room, Intensive Care or Specialized Unit if they are considered medically necessary as well as other medically necessary inpatient services contracted by the hospital and required for the treatment of the specific sudden and serious life-threatening emergency illness or injury while the insured is inpatient.

COVERED SERVICES	EVAC BASIC (transportation and coverage in the nearest facility in the Caribbean)	EVAC USA (transportation and coverage in the nearest facility in the United States)
Other Inpatient Services	Operating room, general nursing care, diagnostic tests, pre-admission testing, medicines, oxygen, inhalation therapy and any other medically necessary hospital services and supplies while the insured is inpatient.	Operating room, general nursing care, diagnostic tests, pre-admission testing, medicines, oxygen, inhalation therapy and any other medically necessary hospital services and supplies while the insured is inpatient.
Physician Services - Inpatient	Hospital visits limited to the medically necessary number of visits per day, per physician, and per specialist. Surgery performed when confined in the hospital facility and limited to coverage for the specific condition which was the basis for the air ambulance transport. Assistant surgeon when confined in the hospital facility and limited to coverage for the specific condition which was the basis for the air ambulance transport. Anesthesiology and its administration by an Anesthesiologist when confined in the hospital facility and limited to coverage for the specific condition which was the basis for the air ambulance transport and the hospital admission.	Hospital visits limited to the medically necessary number of visits per day, per physician, and per specialist. Surgery performed when confined in the hospital facility and limited to coverage for the specific condition which was the basis for the air ambulance transport. Assistant surgeon when confined in the hospital facility and limited to coverage for the specific condition which was the basis for the air ambulance transport. Anesthesiology and its administration by an Anesthesiologist when confined in the hospital facility and limited to coverage for the specific condition which was the basis for the air ambulance transport and the hospital admission.
Travel outside U.S. Virgin Islands	Should a member suffer a sudden and serious life-threatening emergency illness or injury requiring hospitalization and if the member needs specialized treatment not available locally, it is defined to mean travel from a suitable airport to the nearest appropriate medical facility in the Caribbean capable of providing such specialized treatment. Travel in this Policy is exclusively provided by “fixed wing” or “rotary blade” medically equipped emergency air ambulance transport. The Insured’s treating physician must provide certification to the medical air transportation provider that the flight is in the best interest of the Insured and that the Insured is in a medical condition sufficiently stable for the flight to the nearest appropriate medical facility.	Should a member suffer a sudden and serious life-threatening emergency illness or injury requiring hospitalization and if the member needs specialized treatment not available locally, it is defined to mean travel from a suitable airport to the nearest appropriate medical facility in the Continental United States capable of providing such specialized treatment. Travel in this Policy is exclusively provided by “fixed wing” or “rotary blade” medically equipped emergency air ambulance transport. The Insured’s treating physician must provide certification to the medical air transportation provider that the flight is in the best interest of the Insured and that the Insured is in a medical condition sufficiently stable for the flight to the nearest appropriate medical facility in the Continental United States.

COVERED SERVICES	EVAC BASIC (transportation and coverage in the nearest facility in the Caribbean)	EVAC USA (transportation and coverage in the nearest facility in the United States)
Air Ambulance Transportation	Travel from a local airport to the nearest appropriate medical facility where specialized treatment can be provided, if an insured suffers a serious illness or injury requiring hospitalization and specialized treatment which is not available locally. Travel in this Policy is exclusively provided by "fixed wing" or "rotary blade" medically equipped emergency air ambulance transportation. Emergency air ambulance transportation services will be covered in full, with no cost to the member. It is the Insured's responsibility to notify the Plan when the life-threatening and serious emergency illness or injury arose for the need for emergency air ambulance transportation and to obtain a certification of such services.	Travel from a local airport to the nearest appropriate medical facility in the Continental United States, where specialized treatment can be provided, if an insured suffers a serious illness or injury requiring hospitalization and specialized treatment which is not available locally. Travel in this Policy is exclusively provided by "fixed wing" or "rotary blade" medically equipped emergency air ambulance transportation. The Insured's treating physician must provide certification to ELAN's Medical Director that the flight is in the best interest of the Insured and that the Insured is in a medical condition sufficiently stable for the flight to the Continental United States Emergency air ambulance transportation services will be covered in full, with no cost to the member. It is the Insured's responsibility to notify the Plan when the life-threatening and serious emergency illness or injury arose for the need for emergency air ambulance transportation and to obtain a certification of such services.
Immediate off-island aftercare treatment-Extended Care after the serious illness or injury *Precertification is required from plan. The plan must be notified at least 48 hours before the service or procedure. If the plan is not notified, the insured member will be solely responsible for all the costs associated for the procedure or testing without the right of reimbursement.* Immediate off-island aftercare treatment-Extended Care after the serious illness or injury – cont.	Covered medical expenses will include confinement and treatment in a Skilled Nursing Facility and treatment provided by a dully authorized Home Health Care Agency. Services will be covered if they begin within seven (7) days from the date the insured person is discharged from a hospital and if they are rendered for the same condition or in relation to the condition for which the person was hospitalized for treat the emergency illness or injury. These services must be supervised full-time by a licensed physician or a registered nurse and their medical necessity must be certified in writing. • Skilled Nursing Facility - covered up to a maximum of sixty (60) days per year. • Home Health Care - The following services and supplies provided in the home of the patient by a duly licensed Home Health Care Agency	Covered medical expenses will include confinement and treatment in a Skilled Nursing Facility and treatment provided by a dully authorized Home Health Care Agency. Services will be covered if they begin within seven (7) days from the date the insured person is discharged from a hospital and if they are rendered for the same condition or in relation to the condition for which the person was hospitalized for treat the emergency illness or injury. These services must be supervised full-time by a licensed physician or a registered nurse and their medical necessity must be certified in writing. • Skilled Nursing Facility - covered up to a maximum of sixty (60) days per year. • Home Health Care - The following services and supplies provided in the home of the patient by a duly licensed Home Health Care Agency up to 60 days per year:

COVERED SERVICES	EVAC BASIC (transportation and coverage in the nearest facility in the Caribbean)	EVAC USA (transportation and coverage in the nearest facility in the United States)
	up to 60 days per year: o Nursing Care – partial or intermittent o Home Health Care Assistant or o Professional – partial or intermittent o Physical, occupational and speech therapy up to 25 sessions within the covered benefit period. • Outpatient Rehabilitation center – up to 25 days per year for physical, occupational and speech therapy.	o Nursing Care – partial or intermittent o Home Health Care Assistant or o Professional – partial or intermittent o Physical, occupational and speech therapy up to 25 sessions within the covered benefit period. • Outpatient Rehabilitation center – up to 25 days per year for physical, occupational and speech therapy.
Immediate off-island aftercare treatment - External Prosthesis and Implants *Precertification is required from plan. The plan must be notified at least 48 hours before the service or procedure. If the plan is not notified, the insured member will be solely responsible for all the costs associated for the procedure or testing without the right of reimbursement*	Covers prosthesis devices and implants ordered by a physician to replace physical organs or to aid in their functioning if they are rendered for the same condition or in relation to the condition for which the person was hospitalized for treat the emergency illness or injury. • Rent or purchase according to medical criteria up $35,000 USD lifetime. • Appliances and devices include prosthesis, prosthetic appliances and devices, orthoses and orthotic devices, pacemakers, valves, braces, and splints. • Coverage for replacement is excluded. Insured member is responsible to provide physician's certification of medical necessity for the above indicated appliances and devices.	Covers prosthesis devices and implants ordered by a physician to replace physical organs or to aid in their functioning if they are rendered for the same condition or in relation to the condition for which the person was hospitalized for treat the emergency illness or injury. • Rent or purchase according to medical criteria up $35,000 USD lifetime. • Appliances and devices include prosthesis, prosthetic appliances and devices, orthoses and orthotic devices, pacemakers, valves, braces, and splints. • Coverage for replacement is excluded. Insured member is responsible to provide physician's certification of medical necessity for the above indicated appliances and devices.

COVERED SERVICES	EVAC BASIC (transportation and coverage in the nearest facility in the Caribbean)	EVAC USA (transportation and coverage in the nearest facility in the United States)
Immediate off-island aftercare treatment - Durable Medical Equipment *Precertification is required from plan. The plan must be notified at least 48 hours before the service or procedure. If the plan is not notified, the insured member will be solely responsible for all the costs associated for the procedure or testing without the right of reimbursement* Insured member is responsible to provide physician's certification of medical necessity for the above indicated medical equipment.	Covers equipment that is ordered or prescribed by a physician for after care treatment, provided by duly licensed Durable Medical Equipment provider if it's rendered for the same condition or in relation to the condition for which the person was hospitalized for treat the emergency illness or injury. Rental or purchase according to medical criteria up $10,000 USD lifetime. Services include: • Oxygen and necessary equipment for its administration; Wheel chair and hospital type bed; Respirators, ventilators and other equipment needed in the case of respiratory paralysis; Crutches; and Dialysis machine. • Coverage for replacement is excluded.	Covers equipment that is ordered or prescribed by a physician for after care treatment, provided by duly licensed Durable Medical Equipment provider if it's rendered for the same condition or in relation to the condition for which the person was hospitalized for treat the emergency illness or injury. Rental or purchase according to medical criteria up $10,000 USD lifetime. Services include: • Oxygen and necessary equipment for its administration; Wheel chair and hospital type bed; Respirators, ventilators and other equipment needed in the case of respiratory paralysis; Crutches; and Dialysis machine. • Coverage for replacement is excluded.
Immediate off-island aftercare treatment - Necessary medicines prescribed for aftercare by the treating physician for the treatment of the emergency illness or injury	Covered by reimbursement to the Insured. Member pays the full cost and EVAC will pay the Insured up to a maximum of $1,000 USD per year and within ninety (90) days from the date the insured person is discharged from a hospital and if they are rendered for the same condition or in relation to the condition for which the person was hospitalized for treat the emergency illness or injury.	Covered by reimbursement to the Insured. Member pays the full cost and EVAC will pay the Insured up to a maximum of $1,000 USD per year and within ninety (90) days from the date the insured person is discharged from a hospital and if they are rendered for the same condition or in relation to the condition for which the person was hospitalized for treat the emergency illness or injury.
Immediate off-island aftercare treatment - Necessary outpatient physician office visits for aftercare treatment of the emergency illness or injury	Covered by reimbursement to the Insured. Member pays the full cost and EVAC will pay the Insured up to a maximum of $1,000 USD per year and within ninety (90) days from the date the insured person is discharged from a hospital and if they are rendered for the same condition or in relation to the condition for which the person was hospitalized for treat the emergency illness or injury. .	Covered by reimbursement to the Insured. Member pays the full cost and EVAC will pay the Insured up to a maximum of $1,000 USD per year and within ninety (90) days from the date the insured person is discharged from a hospital and if they are rendered for the same condition or in relation to the condition for which the person was hospitalized for treat the emergency illness or injury. .

COVERED SERVICES	EVAC BASIC (transportation and coverage in the nearest facility in the Caribbean)	EVAC USA (transportation and coverage in the nearest facility in the United States)
Additional out-patient emergency room services in the Caribbean and the Continental Unites States as a result of a complication of the life-treatment illness that required treatment off-island and irrespective the required care does not require additional emergency air transportation	Up to the maximum amount per person, of $1,500.00 USD per year.	Up to the maximum amount per person, of $1,500.00 USD per year.

EXCLUSIONS

The Policy does not provide medical coverage or transport for illness or injury arising out of or caused by:

1. A medical event within ninety (90) days of the Policy effective date. All Benefits under the Policy are subject to an initial ninety (90) days waiting period.

2. Complications or consequences related to a treatment, emergency illness or injury excluded from this coverage.

3. Experimental or investigative treatments.

4. Elective or elective cosmetic surgery independently of its medical necessity.

5. Treatment for any condition that is not directly related to the emergency injury and illness condition that activated benefits, including the emergency air ambulance flight.

6. Services rendered due to or in connection with an Injury or Sickness arising out of, or during:

   (a) Any employment for wage or profit.
   (b) Services that may be received in accordance with laws for Compensation for Accidents on the Job.
   (c) Employer's liability insurance.
   (d) Private plans for compensation for accidents on the job.
   (e) Automobile or road accidents payable under the terms of any automobile medical, personal injury protection, automobile no-fault, automobile uninsured or underinsured motorist, or other contract of insurance providing benefits without a determination of liability for the injury; Automobile or road accidents caused due to negligent or illegal acts of the insured member, insured member's influence of alcohol or medications or as a direct result of insured member's reckless driving, except to those injuries of an insured victim.
   (f) Items and services for which payment has been made or can reasonably be expected to be made for governmental automobile insurance program in the U.S. Virgin Islands or any state in the United Stated and Puerto Rico.
   (g) Services available through state or federal legislation which the insured members are not legally obligated to pay. Such services will also be excluded when they are denied by the government agencies concerned because of noncompliance or violation of requirements

or provisions of above indicated laws, even when the noncompliance or violation does not constitute a crime.

7. Occurrences related to military personnel during active duty or while on active duty service in a police unit.
8. Expenses while the coverage is not in force;
9. Expenses for Inpatient, Inpatient Physician and Professional Services not eligible under EVAC Plan Benefit options for a sudden and serious life-threatening emergency illness or injury requiring hospitalization and specialized treatment which is not available locally in the U.S. Virgin Islands.
10. Outpatient aftercare in excess of the established amounts in the Policy Specifications, independently of its medical necessity.
11. Outpatient Surgical Facility services including outpatient surgical procedures independently of its medical necessity.
12. Treatment of mental health conditions, substance and/or drug abuse independently of its medical necessity. Intentional self-inflicted injury, suicide, or any attempt at suicide while sane or insane; injuries because of flagrant self-abuse such as continued behavior contrary to a doctor's recommendation, alcohol abuse, drug addiction or abuse. This limitation includes any accident where drug ingestion by the Insured was a contributory factor to the injury or sickness.
13. Routine, vaginal delivery of a child or children or delivery of a child or children by non-emergency Cesarean section.
14. Organ Transplants and hospital services related to or any complications arising from - or associated to - the procedure, independent of the medical necessity of such services.
15. While participating in a riot, civil commotion, war or insurrection or while participating in the commission of a felony, criminal activity, or while engaged in an illegal occupation or activity.
16. Charges which are compensated for or furnished without charge from a government or any of its government agency; charges that in the absence of insurance would not be made or charges for which there is no legal obligation to pay.
17. Comfort items while admitted to the hospital not essential to medical treatment such as telephone, television, additional bed for visitors; custodial care.
18. Hazardous sports including, but not limited to mountaineering, rock climbing, parachuting, scuba diving, racing of any type, other than on foot, and all professional sports commonly considered to be hazardous. This exclusion does not include recreational activities such as skiing, golf, tennis, sailing, or swimming in enclosed pools.
19. Plastic surgery, reconstructive surgery, cosmetic surgery and/or other services and supplies which improve, alter or enhance the appearance, whether for psychological or emotional reasons; except to the extent needed to repair an injury or covered illness which manifests for the first (1st) time while the person is covered under this Policy.
20. Any Hospital confinement not eligible under EVAC Plan Benefit options for the treatment of a sudden and serious life-threatening emergency illness or injury requiring hospitalization and specialized treatment which is not available locally in the U.S. Virgin Islands. This policy also excludes hospitalizations for purposes of receiving medical care, long term custodial care, or chronic maintenance care and when the procedure could have been done as an outpatient or ambulatory setting.
21. Services not preauthorized or approved by the Plan.
22. Epidemics or pandemics which are under the direction of competent authorities.
23. Any service listed as not covered or excluded in this policy in the Covered Benefits Section.
24. Any service not listed as covered in the Covered Benefits Section.

CLAIM PROCEDURES

Filing a Claim

1. Claims for reimbursement must be faxed to **1- 806-473-3280**

   a. Must include the following:

   - Name and contract number of the insured member who received the service.
   - Date of service
   - Diagnosis code (ICD-10)
   - CPT code
   - National Provider Identifier (NPI)
   - Stamp or letterhead with provider's name, address, and specialty
   - Number and description of services received
   - Amount paid
   - Provider or participant signature and licensee
   - Reason for requesting reimbursement
   - In the case of ambulance services, you must include information about the distance traveled, as well as evidence of medical necessity.
   - For services that require a Precertification, include a copy of the Precertification.
   - In cases where surgical assistance was needed, please send a copy of the surgery report indicating the participation of the surgical assistant. If the surgery report does not indicate the participation of the surgical assistant, please submit a certification from the surgeon.

   For pharmacy services include:

   - Official receipt from the pharmacy
   - Name and number of the contract of the insured member receiving the services
   - Name of the drug
   - Daily doses
   - Number of the prescription
   - Amount dispensed
   - National code of the drug (NDC)
   - National Provider Identifier (NPI) of the pharmacy and the doctor who prescribes
   - If you paid a participating pharmacy: indicate the reason
   - Indicate cost per drug.

2. ELAN has a 30-day period from the receipt of the claim for the following:

   (a) Notify you its determination; or
   (b) Request additional information. You will have up to 45 days to provide the requested information.

Method of Appeal/Review of a Denied Claim

The insured member may request a review of the determination as explained below.

If you disagree with a determination made by ELAN regarding a denial of benefits as described in this policy, you may appeal ELAN's determination following this procedure:

You or your authorized representative (refer to the requirements to appoint a representative described further in this document), must submit your appeal, in writing, within 180 days following the date you received the notification on adverse determination. When you submit your appeal, you may request assistance from a

lawyer of your preference (at your cost). For your appeal to be considered, it must include the following, if applicable:

- Name and contract number of the insured that received the services that are being appealed
- Date of service
- Number of services and description of the services received
- Original receipt for any amount paid by the appellant
- Invoices from the provider
- Name and address of the provider
- Evidence of the precertification granted and/or the medical need certification, if any of these was required to receive the service
- Forms CMS-1500 or UB-92 Forms, duly completed by the provider
- A written statement explaining why you believe ELAN's decision was incorrect under this policy.

You must also submit written evidence or information relating to your appeal. You must send your appeal request to ELAN AT:

ATTN: Appeals Department
PO Box 42095
Oklahoma City
OK 73123-3005

Fax: 806-473-3146
Email: HCM_Appeals@healthsmart.com

COORDINATION OF BENEFITS

This Policy will be secondary to any other health coverage including government plans and plans required by statute that the Insured person has in force when paying benefits.

SUBROGATION

'The Company has the right to proceed, at its own expense, in the name of the Insured Person, against third parties who may be responsible for providing indemnity of benefits similar to this insurance. THE COMPANY has full rights of subrogation. Benefits under this Policy will be always secondary to any other insurance, from a private insurance company and of a government sponsored plan, that the Insured Person has in force at the time the medical expenses are incurred.

DISPUTE RESOLUTION PROCEDURE

First, we encourage you to contact our Customer Service Department. We will make every attempt to solve your complaint at the moment you call. If you are not satisfied with the results, you may submit a complaint to ELAN. If you wish to submit a written complaint, you may mail it to the following address:

ELAN
Customer Service Department
Complaints and Grievances

Customer Service: 1-844.464.4277
Call Center Hours: **Monday thru Friday: 8:00 a.m. to 5:00 p.m.**
Eastern Standard Time.

You must include the following information in your complaint:

- Name and contract number
- A brief description of the situation that motivated you to file a complaint

We will notify our decision on your complaint no later than 30 days from the date your complaint was submitted. If we need more time to make our decision, we will notify you in writing. In said cases, the term to answer your complaint will not exceed a period of 15 days.

If you are not pleased with our determination on your complaint, you may request reconsideration within 60 days from the date you received the notification of our determination. You can send your reconsideration request at the same address to which you sent your complaint. In your request you must include the reasons why you understand ELAN was mistaken in its initial determination. ELAN must answer your request for reconsideration with a term of 30 days.

Appeal to the Government of the United States Virgin Islands

You have the right to contact the Office of the Lieutenant Governor for assistance at any time at following address and telephone number:

Office of the Lieutenant Governor
Division of Banking, Insurance and Financial Regulation
#5049 Kongens Gade Charlotte Amalie,
St. Thomas VI 00802
(340) 774-7166

NOTICE OF OUR PRIVACY PRACTICES

This notice describes how medical information about you, may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our Legal Duties

ELAN is firmly committed to protect the privacy of your medical information. While we serve you in the course of our operations, ELAN creates records about you and the treatment and services we provide to you. The information we collect is called Protected Health Information ("PHI"). We take our obligation to keep your PHI secure and confidential very seriously. We must comply with these procedures according to the Federal and local laws and regulations.

This notice informs you on our privacy practices and your rights regarding your medical information. We will follow the privacy practices described in this notice while it is in effect.

This notice contains some examples of the types of information we collect and describe the types of uses and disclosures we execute. The examples provided are for illustrative purposes and shall not be construed as a complete listing of such uses and disclosures.

We reserve the right to change our privacy practices and the terms of this notice. Before we make a significant change in our privacy practices, we will change this notice and send an updated notice to our active subscribers.

This privacy notice is effective from December 1, 2018.

Organizations Covered by this Notice
ELAN INSURANCE USVI, INC.

SUMMARY OF PRIVACY PRACTICES

We are committed to limit to the minimum necessary the information we collect in order to administer your insurance plan benefits. As part of our role administering the health plan, we may collect your personal, financial or health information from sources such as:

1. applications and other documents you have provided to obtain a product or insurance service;
2. transactions you make with us;
3. consumer credit reporting agencies; healthcare providers;
4. Government health programs

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

Uses and Disclosures of Information

We may use and disclose your personal information to our business associates, who provide services on our behalf and contribute in the administration or coordination of your services. We only share the minimum necessary information and require from each of our business associates to sign a written agreement in which they provide satisfactory assurances of compliance with the security and privacy of your health information. If the business associate goes out of business, we will maintain your information secure to provide the services you need.

As part of our administrative functions, we may use or disclose your information, without your authorization, for treatment, payment and healthcare operations, and when authorized or permitted by law. For example:

Treatment: To a physician or other health care provider who provides medical services to you.

Payment: To pay your medical claims, to determine your eligibility for benefits, to coordinate your benefits with other payers, or to collect premiums, and the like.

Health Care Operations: For audits, legal services, including fraud and abuse, business planning, general administration, and patient safety activities, credentialing, disease management, training of medical or pharmacy students.

We may disclose your medical information to another health plan or to a health care provider subject to federal or local privacy protection laws, as long as the plan or provider has or had a relationship with you.

Affiliated Covered Entities. These companies are subject to the same statutes that require protection for your protected health information.

Your Employer, union or other employee organization: To your employer on whether you are enrolled or disenrolled in the health plan your employer sponsors, and summary health information (aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan) to be used for the administration of the group health plan.

Disaster relief or emergency situations

Government Sponsored Benefits Programs
Public Health and Safety Activities: We may use and disclose your medical information when required or permitted by law for the following activities:

- public health, including to report disease and vital statistics;
- to report child and/or adult abuse or domestic violence;
- healthcare oversight, fraud prevention and compliance;

- in response to court and administrative orders;
- to law enforcement officials or matters of national security;
- scientific research
- as authorized by state worker's compensation laws; and
- as otherwise required by applicable laws and regulations

Health-Related Products and Services: We may use your medical information to inform you about health products, benefits and services we provide or include in our benefits plan, or treatment alternatives that may be of interest to you.

With Your Authorization: You may give us a written authorization to disclose your medical information to anyone for any purpose. Activities such as marketing of non-health related products or services or the sale of health information must be authorized by you. In these cases, your insurance policy and your benefits will not be affected if you denied the authorization.

The authorization must be signed and dated, mention the entity authorized to provide/receive the information, a brief description of the data to be disclosed and the expiration date, which will not exceed 2 years from the date of signage, except if you signed the authorization for one of the following purposes:

- to substantiate a request for benefits under a life insurance policy, its reinstallation or modifications to such policy, in which case the authorization will be valid for thirty (30) months or until the application is denied, the earlier of the two events; or

- to substantiate or facilitate the communication of an ongoing treatment of a chronic disease or rehabilitation of an injury.

The disclosed information pursuant to your authorization may be redisclosed by the recipient of the information and may not be protected by applicable privacy laws.

You may revoke the authorization in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. We will keep copies of the authorizations and revocations executed by you.

Family and Friends Involved in Your Care or Payment for Care: To a family member or friend you involve in your health care or payment for your health care, unless you request a restriction. We will disclose only the medical information that is relevant to the person's involvement.

Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or disabled or in case of an emergency, we will use our professional judgment to determine whether disclosing your medical information is in your best interest.

Terminated accounts: We will not share the data of persons who are no longer our customers or who do not maintain a service relationship with us, except as required or permitted by law.

Security safeguards: We have implemented physical, technical and administrative safeguards to limit access to your personal information. Our employees and business associates are trained and know their duty to protect and maintain the privacy of your medical information and are committed to comply with the highest security and privacy standards to handle your information in a responsible manner.

Individual Rights

Access: You have the right to examine and receive a copy of your protected health information on enrollment and claims within the limits and exceptions provided by law. You must make a written request. Upon receipt of your request, we will have thirty (30) days to do any of the following activities:

- request for additional time
- provide the requested information or allow you to examine your information during working hours

- inform you that we do not have the requested information, in which case, we will orient you where to find it if we know the source
- deny the request, partially or in its entirety, because the information originates from a confidential source or was compiled in anticipation of a legal proceeding, investigations by law enforcement agencies or the anti-fraud unit or quality assurance programs or which disclosures are prohibited by law. We will notify you in writing the reasons for the denial, except in the event there's an ongoing investigation or in anticipation of a legal proceeding.
- The first report will be free of charge, but we may charge you reasonable, cost-based fees for subsequent reports. If you request the report in a special format, you may have to pay an additional charge.

Disclosure Accounting: You have the right to a list of instances after June 1, 2016, in which we disclose your protected health information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

The report will provide the name of the entity to which we disclosed your information, the date and purpose of the disclosure and a brief description of the data disclosed. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests.

Amendment. You have the right to request that we amend your medical information. Your request must be in writing, and it must explain and justify the amendment requested. Within 60 days we will execute the amendment. If we need additional time, we will request you in writing an additional period of 30 days prior to the termination of the original period.

If we deny your request, we will provide you a written explanation. You have the right to request that we include your statement of disagreement with the determination taken by us in future disclosures of the disputed information. If we accept your request, we will make your amendment part of your record and use reasonable efforts to inform our business associates and others who we know may have and rely on the unamended information.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information, if such disclosure may put your life at risk, as in a case of domestic violence. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to a request for restriction must be in writing signed by an authorized officer.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations if your life may be at risk. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.
We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber.

Business closure. In the event of business closure, we will communicate with you to let you know how to obtain your claims history and any other information.

Notice of security breaches in which your health information may be at risk: You are entitled to be notified by any means if the security breach is the result of not having your information secured by technologies or methodologies approved by the Department of Health and Human Services.

Electronic Notice: If you receive this notice on our web site (www.ELAN.com) or by e-mail, you are entitled to receive this notice in written form.

Questions and complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. All the forms to exercise your rights are available at: www.ELAN.com.

If you are concerned that we or any of our business associates may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services (DHHS) at: Region II, Office of Civil Rights, US Department of Health and Human Services, Jacob Javitz Federal Building, 26 Federal Plaza – Suite 3312, New York, New York, 10278; voice phone: (212) 264-3313; fax (212) 264-3039; TDD (212) 264-2355.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the DHHS.

Contact Office: ELAN Insurance USVI, Inc. - Privacy
E-mail: privacy@elan.insure
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