UWC COSTA RICA
Fundación UWC Costa Rica

Brochure: Collective Health Policy – UWC Costa Rica 2026

Provider: BMI (Best Meridian Insurance) Costa Rica

Students.

In case of an accident: For the purposes of the plan, any accident is considered an emergency. Preauthorization is required within the first 24 hours.

Disease-related emergency: Will be covered according to the list presented below. If the emergency is not included in the list, the policy holder must pay the entirety of the bill and request reimbursement from the Company.

List of emergency medical conditions

Hemorrhages, convulsions, precordial pain in the first twelve (12) hours or myocardial infarction, acute abdominal pain, severe respiratory failure, shock states, acute neurological episodes, dehydration, hypertensive crisis, cerebrovascular accident, thrombosis, continuous high fever in children under five (5) years, asthma attack, loss of consciousness or confusion, acute intoxication, renoureteral or biliary colic, severe vomiting and diarrhea, acute allergic reaction, acute urinary retention, as well as any other disease defined as a medical emergency or urgency.

Hospitalization: Any hospitalization or optional surgical procedure requires preauthorization. However, the hospital must submit a preauthorization certification approved by the Company, which must include the usual number of days necessary for the type of surgery or treatment that will be carried out. If during hospitalization it is determined that this number of days is not sufficient, the attending physician must request an authorization for an extension of days from the Company. It is convenient that the second opinion or pre-certification be requested at least 48 to 72 hours before the date on which a surgery or treatment is scheduled.

Medicine Expenses: 80% of the expenses incurred for medications will be reimbursed, if they are within the network, and 70% if they are outside the BMI provider network.. The claim form must be submitted with the original bills and doctor's prescription. The bill must include details of each of the medicines with their respective cost. When medicines of prolonged use are required, an annual prescription will be sufficient.

Requirements for submitting a claim: All parts of the claim form for reimbursements must be completed, since it contains the necessary information which allows it to be processed rapidly; this includes the diagnosis, procedure, date on which the original cause of the condition began, signature, seal and legal business number of the doctor. In case of an accident, it is necessary to specify where, when and how the accident occurred.

All bills filed for reimbursement must be original, and must contain the name of the provider, and its identification card or official identification number. In addition, they must specify the complete name of the patient, the date when the services were provided, and the costs of each service. Each receipt must be presented with its corresponding form, duly completed by the doctor, and the medical prescription.

FREQUENTLY ASKED QUESTIONS

What is a pre-existing condition?

This is any condition or symptom, injury, or disease present at the moment of taking out the insurance policy, including pregnancy, regardless of whether the person insured had knowledge or not indicating that these symptoms may have been related to said condition or disease, or a condition that medical experience indicates started before the effective date of the policy. Pre-existing conditions of new insured will not be covered during the first 12 months of coverage after the effective date of the plan.

What is a waiting period?

It is the time that must elapse from the start date of the policy (or from the date on which specific coverage is contracted) until the insured can begin to claim benefits or coverage. During this period, even if the policy is active, the insurer will not cover certain specific risks or benefits.

Some conditions with a waiting period are:

Waiting Period	
Diseases	**30 days**
Anorectal conditions	**12 months**
Arthritis of any type, systemic lupus erythematosus, fibromyalgia, and gout	12 months
Cataract	12 months
Chronic and degenerative osteoarticular conditions, including the spine	12 months
Conditions related to cholesterol and elevated blood lipids and glucose	12 months
Gallbladder and bile ducts	12 months
Hernias of any type (internal and external), whether due to illness or accident	12 months
High blood pressure	12 months
Knee surgery except for those caused by an accident covered by the Policy	12 months
Malignant neoplasm, malignant tumor, or cancer of any type	12 months
Procedures on the tonsils or adenoids, turbinates, paranasal sinuses, nasal cavity, soft palate, pharynx, and asthma	12 months
Prostate conditions	12 months
Thyroid diseases	12 months
Urinary tract stones	12 months
Uterine tumors, pelvic floor disorders and urinary incontinence, mammary gland diseases	12 months
Varicose veins	12 months

What is co-insurance?

This is the percentage of the cost of services received that the insured party assumes according to the benefits established in the policy. If you obtain your medical services from the BMI Providers Network, this is your share of medical costs.

What is a deductible?

This is a fixed amount established in the table of benefits that must be paid by the insured party before the Company starts to reimburse medical expenses covered by the policy.

When do co-insurance or deductibles apply?

In general terms, your deductible applies first, and once the amount of the deductible is consumed, the other benefits apply according to the level of co-insurance specified. However, there are certain benefits for which deductibles do not apply, such as services received in an emergency room. Additionally, certain plans offer benefits without a deductible within the BMI Providers Network.

What is the maximum co-insurance limit?

This is the maximum amount that the insured party will have to pay for co-insurance during a calendar year.

What cases require prior authorization or reimbursement?

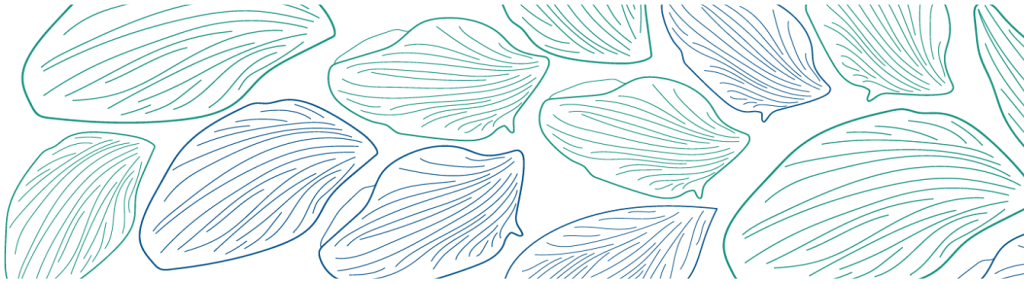
Any medical expense due to an accident or illness covered by the policy can be submitted either by pre-authorization or by reimbursement, pre-authorization is carried out only within BMI network providers. Reimbursement can be applied whether within or outside the provider network.

What are the requirements for using the Providers Network?

The insured must present a current identification of the Principal insured of the Insurance. The policyholder must present an identification document to the Provider. The Provider will verify that the person requesting the service is registered under that identification number. The policy number may be requested.

How does coverage apply outside of Central America?

Expenses incurred outside of Central America will be reimbursed, and the amount reimbursed will be equal to the amount that the Company would have paid if you had received the services



of one of the providers in the Providers Network; this benefit will only apply in cases of demonstrated emergencies occurring while the insured party is traveling.

BMI Telephone number for emergencies: 0800-200-2020 or email asistencia@bmicos.com

Conditions Health Policy:

The benefits and coverages to which you have a right when you are insured are the following:

MEDICAL EXPENSES PLAN (US$)

Coverage limits

Maximum lifetime per person	$25,000
Deductible per year of coverage per person	$100
Local coinsurance limit* per person hospitalized	$2,500

*Local includes Costa Rica, the rest of Central America and Latin America. 70% of the expenses incurred within the BMI Providers Network in each country will be covered, according to the reasonable and usual expenses previously negotiated.

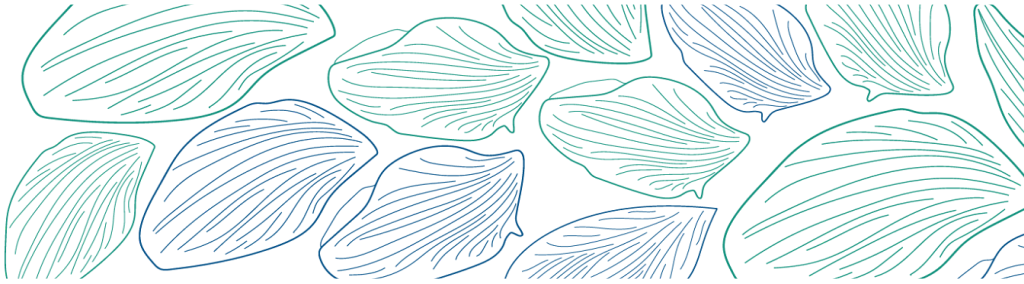
Expenses for outpatient services

Outpatient consultation (Maximum $80)

- X-Ray and laboratory exams: 80% - 20% in network or 70%- 30% outside the provider network.
- Prescribed medicines – applies to deductible: 80% - 20% in network or 70%-30% outside the provider network.
- Use of emergency room due to accident (shock room): 80% - 20% in network or 70%-30% outside the provider network.
- Use of emergency room due to disease: 80% - 20% in network or 70%-30% outside the provider network.

(According to list of diseases)*

Specialist consultation in emergency room due to accident or disease: $165 to 80% or 70%.



*All expenses incurred outside of the BMI Providers Network must be claimed through reimbursement; the corresponding, co-insurance and deductibles apply.

*** List of emergency medical conditions**

Hemorrhages, convulsions, pre-cordial pain in its first twelve (12) hours or myocardial infarction, acute abdominal pain, severe respiratory failure, shock states, acute neurological episodes, dehydration, hypertensive crisis, cerebrovascular accident, thrombosis, continuous high fever in children under five (5) years, asthma attack, loss of consciousness or confusion, acute intoxication, renoureteral or biliary colic, severe vomiting and diarrhea, acute allergic reaction, acute urinary retention, as well as any other disease defined as a medical emergency or urgency.

Hospitalization (preauthorization required)

Room and food (local)	$600
Intensive care room (local)	$1.200

Benefit for surgical procedures (preauthorization required)

Surgeon's fees 80% - 20% or 70%-30% outside network

Anesthesiologist's fees

Maximum of 30% of surgeon's fees: 80% - 20% or 70%-30% outside network

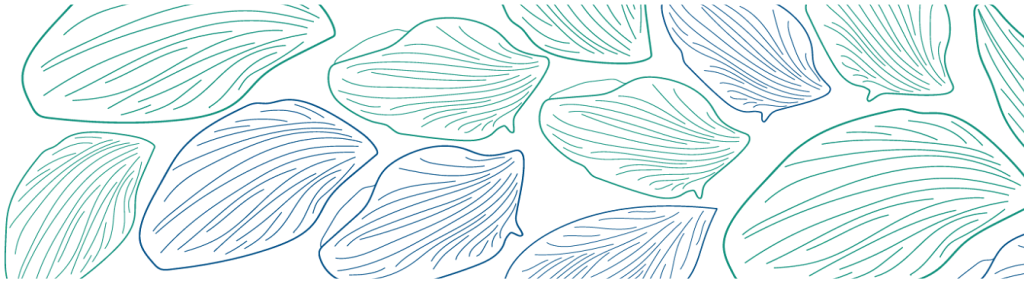
Assistant's fee

Maximum of 20% of surgeon's fees: 80% - 20% or 70%-30% outside network

Hospital services 80% - 20% or 70%-30% outside network

SPECIAL BENEFITS

- Air ambulance – Maximum $1500:80% - 20% or 70%-30% pre-authorized only
- Local ground ambulance – Maximum $300: 80% - 20% pre-authorized only.
- Allergy treatment maximum $300: 80% - 20% or 70%-30%
- Extraction of impacted wisdom teeth (third molars) : $175.00 amount each, RXs are covered
- Coverage for psychiatric treatment – $2 500 per year.



- Psychology therapies. The maximum amount for each appointment is $60: 80% - 20% or 70%-30% outside network.

Exclusions (not covered by health insurance company)

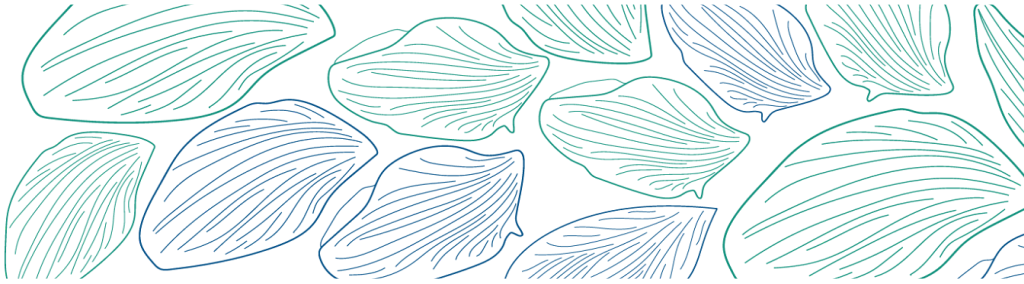
The following treatments, items, and their related expenses are excluded from this Policy:

- Any treatment related to undeclared Pre-existing Conditions and those specifically excluded, as stated in the Insured's Certificate of Insurance, if any, unless amended or otherwise stipulated in the Specific Conditions.
- Any treatment during the first thirty (30) calendar days after the Original Policy Start Date, with the exception of Accidents and Infectious Diseases.
- Any treatment that requires certification or pre-authorization, but that has not been certified or pre-authorized by the Insurance Company, unless otherwise indicated in Section 1.56. Pre-authorization of Clause 1. Definitions.
- Any treatment that exceeds the coverage limits.
- Any expense where it is proven that the Policyholder and/or Insured intentionally omitted information or made false or incorrect statements.
- Any portion of a charge that exceeds what constitutes a necessary, reasonable, and customary charge for that service in that area.
- Medical checkups or preventive exams, except when the Specific Coverages and the Insurance Certificate indicate that the Medical Checkup Coverage, the Additional Annual Preventive Medical Checkup Coverage, or the Additional Cuida tu Salud Coverage defined in Clause 3. Scope of Coverage, has been purchased.
- Vaccinations, except as defined in this Policy.
- Issuance of medical certificates and medical attestation for travel or employment purposes.

- Routine hearing and vision examinations, as well as all types of hearing aids (surgically implanted or non-surgically implanted), the costs of eyeglasses, contact lenses, refractive disorders, strabismus, radial keratotomy, and other vision correction procedures, unless otherwise indicated in the Table of Benefits for Particular Conditions and the Policy Certificate.
- Routine eye examinations, the costs of eyeglasses, contact lenses, refractive disorders, strabismus, radial keratotomy, and other vision correction procedures. Likewise, treatments and/or corrective methods generated by visual refraction defects (optometry), except that in the Particular Coverages and in the Insurance Certificate it is indicated that the Coverage has been contracted.
- All dental examinations or treatments, including dentures, crowns, fillings, and bridges, orthodontic, endodontic, and periodontal dental care, unless required as a result of an accident during the policy term. Unless one of the optional Dental Services Coverages detailed in clause 3. Scope of Coverage has been purchased.
- Any injury to teeth occurring during the act of chewing.
- Durable Medical Equipment such as wheelchairs, hospital beds, equipment required for physical or occupational therapy, costs for vehicle adaptations, bathrooms, nursing homes, and any other Durable Medical Equipment, except as defined in this policy.
- Prosthetics and corrective devices that are not surgically necessary, except as defined in this policy.
- Costs for abortions and their consequences, performed for psychological or social reasons.
- Treatment for mental illnesses or psychological or psychiatric disorders, conditions on the autism spectrum; and treatment by a psychologist, psychiatrist, or other mental health specialist; after-effects or side effects of treatment for mental, psychological, or psychiatric illnesses, except when the Particular Coverages and the Insurance Certificate

indicate that Psychiatric Consultation Coverage has been purchased, as defined in Clause 3. Scope of Coverage of this Policy.

- Plastic or cosmetic surgery, as well as medical treatment whose primary purpose is beautification, unless necessary.
- Any type of surgical treatment for nasal or septal deformities not caused by an accident or trauma. Evidence of trauma must be confirmed radiographically (X-rays, CT scans, etc.).
- Costs resulting from self-inflicted physical injuries, suicide attempts, alcohol abuse, smoking, drug and/or narcotic abuse or addiction, as well as those resulting from crimes or misdemeanors, even if the person was not of sound mind. Accidents in which the Insured is driving a land, sea, or air vehicle and does not hold a license to do so.
- Accident or illness due to the use or consumption of alcohol, drugs, and/or narcotics, as well as those resulting from crimes or misdemeanors.
- Unnecessary diagnostic tests and expenses for medical services or equipment unrelated to or inherent to the accident or illness.
- Treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex Syndrome (SCRS), and all diseases caused by or related to the HIV-positive person.
- Treatments by a Family Member and any self-therapy, including self-prescription of medicines
- Cost and acquisition of Organ Transplants, including expenses incurred by the donor, except for covered Transplants as defined in this Policy.
- Cost of acquisition and implantation of an artificial heart and mono- or biventricular devices.
- Expenses for any cryopreservation and the implantation or re-implantation of living cells.
- Treatment of bodily injuries or illnesses resulting from: catastrophes, natural disasters, war.



- Any expense, service, surgery, or treatment related to short stature, thinness, overweight, obesity, or weight control in general, unless the Nutritional Consultation coverage indicated in Clause 3. Scope of Coverage has been purchased, and is shown in the Table of Benefits of the Specific Conditions and in the Insurance Certificate.
- All forms of nutritional supplements, vitamins, immunostimulants, and treatments for disease prevention.
- Podiatric care, including, but not limited to, foot care in connection with corns, bunions, hallux valgus, Morton's neuroma, flat feet,
- Treatment with a bone growth stimulator, bone growth stimulation, or growth hormone-related treatment, regardless of the reason for the prescription.
- Elective hospitalization more than twenty-three (23) hours before surgery.
- Medical Prescriptions or Over-the-Counter Medicines, that is, those sold without a prescription, or Non-Prescribed Medical Prescriptions; Medical Prescriptions except as defined under this Policy. In Costa Rica, "over-the-counter" means those medications described in the current decree regarding the Declaration of Over-the-Counter Medicines for Consumers issued by the Ministry of Health.
- Claims and costs for medical treatment that occur after the Policy Expiration Date, as a result of Illness, Accident, or Maternity during the Policy Year period, except in cases where the Policy has been renewed.
- Treatment for injuries resulting from participation in professional sports competitions, demonstrations, or training, for which the insured receives monetary compensation or financial benefit; and/or amateur motorsports competitions that expose the participant to danger or risk
- Diseases declared as epidemics or pandemics by the Ministry of Public Health, a competent authority, or a recognized international organization.
- Expenses incurred for sleep disorders and alopecia.