GlobalFusion[SM]

INTERNATIONAL MEDICAL INSURANCE

Policy Wording

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Important Notice for Insured Persons: 30 Day Money Back Guarantee

Please read through the Policy Wording and *Plan Terms* carefully and check the details on the *Certificate of Insurance* to confirm that the cover chosen meets with *Your* requirements.

If *You* are not satisfied, or this cover is not suitable for *You* and *You* want to cancel *Your Plan*, please provide written cancellation instructions (by e-mail, fax or post) and return the Policy Wording with the *Certificate of Insurance* to the *Plan Manager* within 30 days after receipt, to:

IMG Europe Ltd.
Kingsgate
High Street
Redhill, Surrey
RH1 1SH
United Kingdom

Fax: +44 (0) 1737 86 06 00
E-mail: Admin@imgeurope.co.uk

i) If *You* cancel *Your Plan* within 30 days from the date *You* receive this Policy Wording, subject to the *Plan Terms*, and provided no claims have been paid or are in progress. *You* will receive a full refund of the *Premium* paid.

ii) If *You* cancel *Your Plan* after 30 days from the date *You* receive this Policy Wording, subject to the *Plan Terms* and that no claims have been paid or are in progress, *You* will be eligible to receive a pro-rata refund of *Premium* paid, based on the number of days cover remaining from the date *We* receive *Your* written cancellation request, less the applicable administration charge determined by *Us* at that time.

Of course, if *You* cancel *Your Plan You* cannot make a claim under it and neither *You* nor *Us* will have any further rights, liabilities or obligations under the *Plan*.

Your request for cancellation will be dealt with promptly and *Your Plan* will be retroactively cancelled as from the date of *Your* request.

If *You* have any doubts regarding the *Terms of Your Plan*, please contact the *Plan Manager* directly for clarification, otherwise it shall be assumed that all *Terms* are understood and acceptable to *You*.

Statements Made in the *Application*

Your Plan is the contract of insurance between *You* and *Us* and consists of *Your Application, Certificate of Insurance,* this Policy Wording including the *Schedule of Cover and Excesses*, any *Endorsements* and *Our* written acceptance. *Your Plan* is based on the information that *You* provide *Us* with in *Your Application* and is issued on the basis that all the answers given to all the questions is complete and accurate. *We* used this information to assess the cover *We* would provide for *You* and to set the *Terms* of *your Plan*. *You* must take reasonable care to

provide true, accurate, complete and correctly recorded answers to all the questions *We* ask when *You* take out, make changes to, or renew *Your Plan*. If *You* are in doubt as to whether *You* have answered any question truthfully, accurately or completely, *You* should check *your* records rather than guess.

Please read *Your Application,* the *Certificate of Insurance* and fulfilment documentation that accompanies this Policy Wording, and this Policy Wording carefully. If any information shown on it is not true, accurate, correct or complete, or if any of *Your* past medical history has been left out, *You* must write to the *Plan Manager* within 10 days of receiving the Policy Wording.

How to Contact *Us*

Claims should be advised immediately in writing to the *Plan Manager*. *You* can download a claim form from the website www.imgeurope.co.uk, which should be completed in accordance with the instructions contained therein and returned together with the original invoices and all supporting documentation.

Mailing Address:
IMG Europe Ltd.
Kingsgate
High Street
Redhill, Surrey
RH1 1SH
United Kingdom

Telephone Numbers:

Customer Service (UK)	+44(0)1737 306 710
Claims (UK)	+44(0)2920 474 236
Pre-Certification (UK)	+44(0)1444 46 55 88
(Calling from outside the USA) (US)	+1317 655 4500
(Calling from inside the USA) (US)	+1800 628 4664
USA Medical Concierge	+1877 654 6229
(Toll Free Within USA)	

***Emergency* Medical Helpline:**

Emergency calls only to the UK	+44(0)2920 474 235
Emergency calls only to the USA	+1317 655 4500

Useful E-Mail Addresses:

Customer Services	info@imgeurope.co.uk
Claims	claims@imgeurope.co.uk
Pre-Certification	acm@imglobal.com
USA Medical Concierge	mcs@akesocare.com

Fax Numbers:

UK	+44 (0)1737 860 600
USA	+1317 655 4505

Our Agreement

We promise and agree to provide *You* with the cover and benefits described in this *Policy Wording*, subject to all of the *Terms* contained herein. *We* make this promise and agreement and issue *Your Plan* in consideration of *Your Application* and the payment of *Premium*.

Commencement of Cover

Your cover will commence from the 00:01Hrs Greenwich Mean Time (GMT) on the *Effective Date*, as stated on the *Certificate of Insurance*. *We* will not commence *Your* cover unless and until *We* have accepted *Your Application*, received payment of *Your* first full *Premium*, and issued *Your Plan*.

Eligibility and Age Limits

Eligibility is subject to *Our* acceptance of *Your Application*. The minimum age at entry is 14 days attained. If *You* are a *child* under the age of 18 years attained, a parent or guardian is required to sign the *Application* on *Your* behalf. The maximum age at entry is 74 years attained. *Your Plan* will automatically terminate on the date of *Your* 75th birthday.

Refer to General Conditions, Section 7. “Eligibility” for further details.

Definitions

Certain words and phrases used in this Policy Wording have specific meanings and are defined in this section. The defined words and phrases are capitalised and printed in italics wherever they appear in the Policy Wording.

Accident: A sudden, unintentional, unforeseen and *Unexpected* incident caused by external, visible means and resulting in physical *Injury* to *You* occurring whilst *Your Plan* is in effect.

Affidavit of Eligibility: The properly completed form provided to *Us* which certifies that *You* are eligible to be covered under the *Plan* because *You* do not meet the citizenship or residency requirements of other insurance companies in the area where *You* reside.

AIDS: Acquired Immune Deficiency Syndrome.

Alcohol and Substance Abuse: A misuse, illegal use, over use or abuse of, or a dependency on, or an addiction to any Alcohol, *Drug*, medicine, controlled substance, narcotic, toxin or chemical.

Amateur Athletics: An amateur or other non-professional sporting, recreational, or athletic activity that is organised, sponsored and/or sanctioned, and/or involves regular or scheduled practices, games and/or competitions (collectively, “organised athletic activities”). This definition does not include non-organised athletic activities that are non-contact and engaged in by *You* solely for recreational, entertainment or fitness purposes.

Ancillary Charges: The charges made by a *Hospital* for particular services provided during the course of *In-Patient* or *Day-Patient Treatment*, such as charges for operating theatre, surgical appliances used by a *Specialist* during *Surgery* and special nursing requirements.

Annual Excess: The first amount payable by *You* (or on *Your b*ehalf) per 12 month *Period of Insurance* in respect of *Eligible Charges* and covers, before any benefits are paid under *Your Plan*, and exclusive of *Co-Insurance*.

Application: The fully answered and signed form entitled "*Application Form*" and all amendments and supplements to that form submitted by *You* or on *Your* behalf for acceptance into, renewal of cover under, or reinstatement in the *Plan*. Any insurance agent, broker or other intermediary assigned to or assisting with the *Application* is *Your* agent and representative, and is not an agent or representative for or on behalf of *Us* or *Our Plan Administrator* or the *Plan Manager*.

ARC: *AIDS* related complex.

Certificate of Insurance: A document issued by *Us* to *You* in conjunction with the *Plan* evidencing *Your* cover under the *Plan* including the benefits, *Period of Insurance*, the level and *Geographic Area of Cover*, *Your Annual Excess* and any *Endorsements* that may apply.

Child; Children: An *Insured Person* who is less than eighteen (18) years of age.

Chronic Condition: A Medical Condition which has at least one of the following characteristics:

- It continues indefinitely and has no known cure.
- It comes back or is likely to come back.
- It is persistent or permanent.
- *You* need to be rehabilitated or specially trained to cope with it.
- It needs long term monitoring, consultations, checkups, examinations or tests.

Co-Insurance: The payment by *You* (or *Your* obligations for payment) of *Eligible Charges* at the percentage specified in the *Schedule of Cover and Excesses* contained herein and exclusive of the applicable Annual *Excess* chosen by *You.*

Congenital Disorder: Physical abnormality that is present at birth.

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

Country of Residence: the country of which *You* are a citizen or national; including any country where *You* maintain *Your* primary residence or usual place of abode and any country of which *You* pay income taxes or are the possessor of a validly issued passport.

Covered Transplant: The *Pre-Certified transplant* of a heart, heart/lung, lung, kidney, kidney/pancreas, liver and allogenic or autologous bone marrow into *Your* body from a human donor while *Your Plan* is in effect.

Custodial Care: Those types of *Treatment*, care or services, wherever furnished and by whatever name called, that are designed primarily to assist an individual in activities of daily life.

Day-Patient: An *Insured Person* who is admitted to a *Hospital* solely to receive *Medically Necessary Treatment* for an *Eligible Medical Condition*, occupies a bed and stays for a period of clinically-supervised recovery or *Treatment*, but does not stay in *Hospital* overnight.

Dental Practitioner: A person who is licensed by the relevant authority to practice dentistry in the state or country where the *Dental Treatment* is given.

Dental Treatment: *Treatment* and supplies relating to the care, maintenance or repair of teeth, gums or bones supporting the teeth, including dentures and preparation for dentures.

Dependent Child: *Your* or *Your* Spouse's, natural, adopted or fostered *child*, who is unmarried and living with *You* and/or such Spouse, who is under the age of 18 years old but older than 14 days and otherwise eligible for this insurance pursuant to the Eligibility section, and who has been properly listed and identified on the *Application* and for whom the proper *Premium* has been timely paid.

Direct Settlement: (Only available in certain countries): Where *You* are able to obtain *Treatment* for an *Eligible Medical Condition* at a medical provider and where the charges will be settled directly by *Us*.

Please Note: *You* are still responsible for any *Co-Insurance* and *Excess* applicable to *Your Plan* which must be settled directly with the medical provider at time of *Treatment*. Where *You* receive *Treatment* for a *Medical Condition* that is not covered under the *Terms* of *Your Plan*, *You* remain liable for the cost of such *Treatment*, which must be settled in full upon request. Failure to act accordingly will result in the suspension or cancellation of *Your Plan*, without refund of *Premium*.

Drugs: *Medically Necessary drugs* or medicines prescribed by a *Medical Practitioner* or *Specialist*, which are not available without prescription and which are not *Experimental*.

Durable Medical Equipment: A standard basic *Hospital* bed and a standard basic wheel chair.

Educational or Rehabilitative Care: Care for restoration (by education or training) of a person's ability to function in a normal or near normal manner following an *Illness* or *Injury*. This type of care includes, but is not limited to, vocational or occupational therapy, and speech therapy.

Effective Date/Original Effective Date: The date shown on the *Certificate of Insurance from which the Period*

of Insurance starts, and Original Effective Date shall mean the date shown on the Certificate of Insurance on which *You* were first covered under *Your Plan*.

Eligible Charges: The *Reasonable and Customary Charges* for those costs, charges, and expenses incurred by *You* during a *Period of Insurance* for *Medically Necessary Treatment* or supplies which are directly related to an *Eligible Medical Condition*, and for which *You* or *Your* beneficiary will make a claim or seek payment under *Your* Plan.

Eligible Medical Condition: Any *Medical Condition* for which there is cover under *Your Plan*.

Emergency: A *Medical Condition* manifesting itself by acute signs or symptoms which could reasonably result in placing *Your* life or limb in danger if medical attention is not provided within twenty-four (24) hours, based upon a reasonable medical certainty.

Emergency Medical Evacuation: Emergency transportation provided by designated, licensed, qualified, professional *emergency* personnel acting within the scope of such license from the *Hospital* or medical facility where *You* are located to a non-local *Hospital* or medical facility, recommended by the attending *Medical Practitioner* who certifies, to a reasonable medical certainty, that *You* have experienced:

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

Endorsement: Any exhibit, schedule, attachment, amendment, *endorsement*, rider or other document which is prepared by *Us* and attached to, issued in connection with, accompanying or otherwise expressly made a part of or applicable to the Policy Wording, *Plan*, *Terms*, the *Certificate of Insurance,* or the *Application*, as the case may be.

Excess: The first amount payable by *You* (or on *Your* *b*ehalf), per *Insured Person* (unless stated otherwise), as selected on the *Application* and specified in the *Certificate of Insurance* that *You* must pay in respect of *Eligible Charges* and covers, before any benefits are paid under *Your Plan*, and exclusive of *Co-Insurance*.

Experimental: Any *Treatment* or supply, including a new, untested *Dru*g, procedure, therapies, or service or the use of that: by nature or composition deviates from, or is used or applied in a way which deviates from, generally accepted standards or current medical practice; or is under investigation to determine its safety and effectiveness; or is only available to individuals who are participating in a research study or clinical trials; or is *investigational* or unproven.

Extended Care Facility: An institution, or a distinct part of an institution, which is licensed as a *Hospital*, *Extended Care Facility* or rehabilitation facility by the state or country in which it operates; and is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *Medical Practitioner* and the direct supervision of a *Registered Nurse*; and maintains a daily record on each patient; and provides each patient with a planned program of observation prescribed by a *Medical Practitioner*; and provides each patient with active *Treatment* of a *Medical Condition*. *Extended Care Facility* does not include a facility primarily for rest, the aged, the *Treatment* of *Alcohol and Substance Abuse*, *Custodial Care*, nursing care, or for care of *Mental or Nervous Disorders* or the mentally incompetent.

Geographic Area of Cover: One of the three geographical areas within which *You* are located, or will be, or travelling within and to which *Your* cover is restricted, as selected by *You* during *Your* original *Application* and for which the appropriate *Premium* has been paid, and as shown on the *Certificate of Insurance*. Any charges incurred by *You* for *Treatment* or supplies whilst outside the selected Geographic Area of Cover will only be met under the cover provided by Section C7 of this *Policy Wording* and only for a period not exceeding the duration in days per *Period of Insurance* as shown in the *Schedule of Cover and Excesses* for *Your* relevant *Sub-Plan*, provided the trip was not specifically made for the purpose of obtaining *Treatment*. The *Geographic* Areas of Cover are defined as follows:

Area 1: Europe including Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Canary Islands, Channel Islands, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Gibraltar, Greece, Greenland, Holland, Hungary, Iceland, Ireland, Italy, Jersey, Kazakhstan, Kosovo, Kyrgyzstan, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Madeira, Malta, Moldova, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Russian Federation, San Marino, Serbia, the Slovak Republic, Slovenia, Spain (including the Balearics and Canary Islands), Sweden, Switzerland, Tajikistan, Turkey, Turkmenistan, Ukraine, United Kingdom, Uzbekistan and the Vatican City.

Area 2: Worldwide excluding USA, Canada, China, Hong Kong, Macau, Japan, Singapore and Taiwan

Area 3: Worldwide

Home Country: The country which is *Your Country of Residence*; or where *You* have multiple residences, dual citizenship, or *You* hold more than one passport, in the absence of other evidence, *Your Home Country* will mean the country declared on the *Application.* For USA Citizens, the *Home Country* is both the United States of America and *Your Country of Residence*.

Home Health Care Agency: A public or private agency or one of its subdivisions, which operates pursuant to law; and is regularly engaged in providing *Home Nursing Care* under the supervision of a *Registered Nurse*; and maintains a daily record on each patient; and provides each patient with a planned program of observation and *Treatment* prescribed by a *Medical Practitioner*.

Home Nursing Care: Services and/or *Treatment*, provided by a *Home Health Care Agency* and supervised by a *Registered Nurse*, which are directed toward the personal care of a patient, provided always that such care is in lieu of *Medically Necessary In-Patient* care.

Hospice: An institution which operates as a *hospice*; and is licensed by the state or country in which it operates; and operates primarily for the reception, care and palliative control of pain for terminally ill persons who have, as certified by a *Medical Practitioner*, a life expectancy of not more than six (6) months.

Hospital: An institution which operates as a *hospital* pursuant to law; and is licensed by the state or country in which it operates; and operates primarily for the reception, care, and *Treatment* of sick or injured persons as *In-Patients*; and provides 24-hour nursing service by *Registered Nurses* on duty or call; and has a staff of one or more *Medical Practitioners* available at all times; and provides organised facilities and equipment for diagnosis and *Treatment* of *Medical Conditions*, or *Mental or Nervous Disorders* on its premises. *Hospital* does not include a place that is primarily a long-term care facility, *Extended Care Facility*, or a nursing, rest, *Custodial Care*, or convalescent home, or a place for the aged, the *Treatment* of *Alcohol and Substance Abuse*, or runaways or similar establishment.

Hospitalisation/Hospitalised: Confined or *Treated* in a *Hospital* as an *In-Patient*.

Host Country: The country or countries other than the *Home Country* that the *Insured Person* is travelling to/in.

Illness: A sickness, disorder, *illness,* pathology, abnormality, malady, morbidity, affliction, disability, defect, handicap, deformity, birth defect, congenital defect, symptomatology, syndrome, malaise, infection, infirmity, ailment, disease of any kind, or any other medical, physical or health condition. Provided, however, that *Illness* does not include learning disabilities, or attitudinal or disciplinary problems. All Illnesses that exist simultaneously or which arise subsequent to a prior *Illness* and which directly or indirectly relate to or result or arise from the same or related causes or as a consequence thereof or from one another are considered to be one *Illness*. Further, if a subsequent *Illness* results or arises from causes or consequences that are the same as or related to the causes or consequences of a prior *Illness*, the subsequent *Illness* will be deemed to be a continuation of the prior *Illness* and not a separate *Illness*.

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

Injury: Bodily *injury* resulting or arising directly from an *Accident*. All *Injuries* resulting or arising from the same *Accident* shall be deemed to be one *Injury*.

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

Insured Person; You; Your: The person in whose name the *Plan* is effected, as indicated on the *Certificate of Insurance*.

Insurer; We; Us; Our: Sirius International Insurance Corporation (publ), headquartered in Stockholm, Sweden is the underwriter of the *Plan* and its risks. *We* are solely obligated and liable for all covers and benefits provided under the *Terms* of this Policy Wording and *Plan*.

Intensive Care Unit: An area of a *Hospital* set up for very ill or seriously injured patients who must be closely, constantly monitored. The unit must have specially trained staff and special equipment and supplies at all times. *Intensive Care Unit* includes a cardiac care unit and special care unit, such as a neonatal care unit and burn unit.

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

Lifetime Limit: The maximum cumulative total amount of benefit payments or reimbursements available to *You* during *Your* lifetime under the *Plan* irrespective of the number of times that *Your Plan* is renewed.

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

Maternity Annual Excess: The first amount payable by *You* (or on *Your* behalf) per *Period of Insurance* in respect of *Eligible Charges* and covers, specifically related to maternity before any benefits are paid under *Your Plan*, and exclusive of *Co-Insurance*.

Medical Condition: Any *Injury*, *Illness* (including *Mental* or *Nervous Disorders*), disease or symptom, and any

related condition in which one is a result of the other or each is the result of the same *Medical Condition*.

<u>Medically Necessary; Medical Necessity</u>*:* A *Treatment, service, medicine,* or supply which is necessary, appropriate and required for the diagnosis or *Treatment* of an *Eligible Medical Condition* and which is provided in accordance with generally accepted medical standards or current medical practice as determined by *Us*. A *Treatment,* service, medicine, or supply will not be considered *Medically Necessary* or of a *Medical Necessity* if it is provided or obtained solely as a convenience to *You* or *Your* provider or *Medical Practitioner*; or if it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or *Treatment*.

<u>Medical Practitioner</u>*:* A qualified practitioner of the medical arts who is duly educated, trained and is currently and appropriately licensed by the state or country in which the *Treatment* is provided and who is acting within the scope of that license, training, experience, competence, and health professions standards of practise, other than *You* or a *Relative* or a person who resides or has resided in *Your* home.

<u>Mental or Nervous Disorder</u>*:* Any mental, nervous, or emotional *Illness* which generally denotes an *Illness* of the brain with predominant behavioral symptoms; or an *Illness* of the mind or personality, evidenced by abnormal behavior; or an *Illness* or disorder of conduct evidenced by socially deviant behavior. *Mental or Nervous Disorders* include without limitation: psychosis; depression; schizophrenia; bipolar affective disorder; learning disabilities and attitudinal or disciplinary problems; any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Statistical Classification of Diseases and Related Health Problems (ICD) as produced by the World Health Organisation; For purposes of this insurance, *Mental or Nervous Disorder* does not include learning disabilities, or attitudinal or disciplinary problems or *Alcohol* and *Substance Abuse*.

<u>Mortal Remains</u>: The bodily remains or ashes of an *Insured Person*.

<u>Newborn</u>*:* An infant born from *You* or *Your* spouse from the moment of birth through the first 31 days of life.

<u>Non-Disclosed Condition</u>*:* An *Illness* or *Injury* diagnosed, *Treated*, or known to *You* prior to completing the *Application* for coverage under this *Plan,* but not disclosed, revealed, listed or otherwise made known on the *Application* or any subsequent Claim Form.

<u>Out-Patient</u>*:* An *Insured Person* who receives *Medically Necessary Treatment* by a *Medical Practitioner* or other healthcare provider that does not require an overnight stay in a *Hospital*, nor is admitted as an *In-Patient* or *Day-Patient*, regardless of the hour that the person arrived at the *Hospital*, whether a bed was used, or whether the person remained in the *Hospital* past midnight.

<u>Palliative Care</u>: Any *Treatment* given to offer temporary relief of symptoms, rather than to cure the *Medical Condition* causing the symptoms.

<u>Partner</u>: A person who is residing with *You* in a conjugal relationship.

<u>Period of Insurance</u>: The period starting on the *Effective Date* and ending on the earliest of the following dates: (a) the expiry date specified in the *Certificate of Insurance*, or (b) the termination date as determined in accordance with the Termination of Cover.

<u>Plan</u>*:* The contract of insurance between *You and Us*. *Your Plan* consists of *Your Application*, the *Certificate of Insurance*, this Policy Wording including the *Schedule of Cover and Excesses* relevant to *Your* chosen *Sub-Plan*, and any *Endorsements*. *We* are solely liable and responsible for the cover and benefits provided under the *Plan*.

<u>Plan Administrator</u>: The person appointed by *Us* to administer the *Plan*. The appointed *Plan Administrator* is International Medical Group, Inc., and it acts solely as the disclosed and authorised agent and representative for *Us* and on *Our* behalf, and has and shall have no direct, indirect, joint, several, separate, individual, or independent responsibility, liability or obligation of any kind whatsoever under the *Plan, Policy Wordings, or Certificate of Insurance*.

<u>Plan Manager</u>*:* The person appointed to act as coordinator between the *Plan Administrator* and *Us*. The *Plan Manager* is also an authorised agent for *Us* and on *Our* behalf for the purposes of: receiving *Premiums* from or on behalf of *Insured Persons*; receiving and holding claims money prior to transmission to the *Insured Person* making the claim in question; and receiving and holding *Premium* refunds prior to transmission to the *Insured Person* entitled to the *Premium* refund in question. The appointed *Plan Manager* is IMG Europe Limited, Kingsgate, High Street, Redhill, Surrey, RH1 1SH, United Kingdom, and it has and shall have no direct, indirect, joint, several, separate, individual, responsibility, or independent liability or obligation of any kind under the *Plan, Policy Wordings, or Certificate of Insurance*.

<u>Pre-Certification; Pre-Certified</u>*:* A process through which *You* are responsible for providing notification to *Us* prior to incurring costs or undertaking *Treatment* for many of the benefits under *Your Plan*. It involves a general determination of *Medical Necessity*, made by *Us* in reliance and based upon the completeness and accuracy of the information provided to *Us* at the time thereof. *Pre-Certification* does not assure, authorise, verify, or guarantee that *We* will pay charges incurred by *You*. Cover under *Your Plan* remains subject to the *Terms* of *Your Plan.* See Section labelled '*Pre-Certification*' for further details, *Terms* and conditions.

Pre-Existing Condition: Any *Medical Condition* or any chronic, subsequent or recurring complication or consequence associated with or arising from a *Medical Condition* where, at any time prior to the original *Effective Date*:

1. Medication (including *drugs*, medicines, special diets, injections or other forms of medication), advice or *Treatment* was sought by, recommended for or received by *You*; and *You* were aware or should reasonably have been aware *You* had the *Medical Condition*; or

2. *You* have experienced or displayed symptoms, where *You* were aware or should reasonably have been aware *You* had the *Medical Condition*; or

3. *You* were aware or should reasonably have been aware *You* had the *Medical Condition*; whether or not:
   a) the *Medical Condition* has been investigated or diagnosed on or at any time prior to the Original *Effective Date; or*
   b) the *Medical Condition* was known or unknown to be connected to or related to the medication, advice or *Treatment* referred to at paragraph 1 above, or to the symptoms referred to at paragraph 2 above; or
   c) the *Medical Condition* was historical or dormant or cured or resolved; or
   d) the *Medical Condition* was disclosed on the *Application* or any claim form or otherwise.

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

Premium: The payments required to activate and maintain *Your* cover and benefits under *Your Plan*, in the amounts and at the times established by *Us* in *Our* sole discretion from time to time.

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

Qualified Facility: A *Hospital* or other medical facility that can successfully perform the needed procedure or *Treatment*.

Reasonable and Customary Charges: A typical and reasonable amount of reimbursement for similar services, medicines, or supplies within the area in which the charge is incurred. In determining the typical and reasonable amount of reimbursement, *We* may, in *Our* reasonable discretion, consider one or more of the following factors, without limitation: the amount charged by the provider; the amount charged by similar providers or providers in the same or similar locality; the amount reimbursed by other payors for the same or comparable services, medicines or supplies in the same or similar locality; the amount reimbursed by other payors for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or service as compared to the length of time required to perform other similar services; the length of time required to perform the procedure or service as compared to national standards and/or benchmarks; the severity or nature of the *Illness* or *Injury* being *Treated*; and such other factors as *We*, in the reasonable exercise of *Our* discretion, determine are appropriate.

Registered Nurse: A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other government authority, and who is legally entitled to place the letters "R.N." after his or her name, or whose name is currently on any register or roll of nurses, maintained by any statutory nursing registration body within the country in which he or she is a resident.

Relative: Your spouse, *Partner*, husband- or wife-to- be, *child*, son- or daughter-in-law, parent, step-parent, parent-in-law, legal guardian, grandparent, grandchild, sibling, brother-in-law or *sister-in-law* or immediate family member.

Renewal Date: An anniversary that is twelve (12) months following the *Effective Date.*

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

Schedule of Cover and Excesses: The summarised schedule of benefits, coverage, limits, *Sub-Limits* and *Excesses* as set forth for ease of reference in this Policy Wording, all of which are subject to the full *Terms* of this *Plan and* the *Certificate of Insurance*.

Self-inflicted: Action or inaction by *You* that *You* consciously understand will or may cause or contribute, directly or indirectly, to *Your Injury* or *Illness*. *Self-inflicted* specifically includes failure of *You t*o follow *Your Medical Practitioner's* orders, complete prescriptions as directed, or follow any health care protocol or procedures designed to return or maintain *Your* health.

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

Sports Diving: Recreational underwater diving activities requiring the use of underwater or artificial breathing apparatus, and carried out in strict accordance with the guidelines, codes of good practice, and recommendations for safe diving practices as laid down by an Authoritative Diving Body.

Sub-Limit: The maximum amount of benefit payments or reimbursements available to *You* per *Period of Insurance* for *Eligible Charges* with respect to an *Eligible Medical Condition* or section of cover under *Your* chosen *Sub-Plan*. The *Sub-Limit* is subject to the overall m*aximum limit* sum insured per *Period of Insurance* for *Your* chosen *Sub-Plan* as selected by *You* at time of *Application*.

Sub-Plan: One of the pre-set levels of cover chosen by *You* under the *Plan*, as indicated on the *Certificate of Insurance*. The *Sub-Plans* are Bronze, Silver, Gold, Gold Plus and Platinum.

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

Surgery: A generally accepted invasive diagnostic or operative procedure or *Treatment* of a *Medical Condition* by manual or instrumental operations performed by a *Medical Practitioner* while *You* are under general or local anaesthesia.

Telemedicine: The use of medical information (beyond a verbal history) exchanged from one healthcare provider site to another via electronic communications to improve patients' health status. Videoconferencing, transmission of still images, and remote monitoring of vital signs are all considered part of *Telemedicine*. *Telemedicine* services that would be considered for *Medical Necessity* and appropriateness by *Us* under the *Plan* would include without limit:

- *Specialist* referral services which typically involves of a specialist assisting a general practitioner in rendering a diagnosis to guide *Treatment*.
- Patient consultations using telecommunications to provide medical data, which may include audio, still or live images, between a patient and a *Medical Practitioner* or other healthcare provider for use in rendering a diagnosis and *Treatment* plan. This might originate from a remote clinic to a *Medical Practitioner's* office using a direct transmission link or may include communicating electronically.
- Remote patient monitoring uses devices to remotely collect and send data from a medical facility to a monitoring station for interpretation. Such applications might include a specific vital sign, such as blood glucose or heart ECG.

Terms: Terminology, provisions, conditions, definitions, limits, *Sub-Limits*, limitations, wordings, restrictions, qualifications and/or exclusions.

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

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

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

Unexpected: Sudden, unintentional, not expected, and unforeseen.

Your Cover

We will provide cover for benefits within *Your Geographic Area of Cover*, as shown under the *Schedule of Cover and Excesses* applicable to *Your* chosen *Sub-Plan*, subject to the *Terms* of *Your Plan*. *Your Plan* does not cover any and all benefits which do not appear in the *Schedule of Cover and Excesses* relevant to *Your* chosen *Sub-Plan,* nor any cover that *You* have selected upon initial *Application* in respect of which *You* have not paid the appropriate *Premium*. *We* will be liable for only those benefits relating to *Reasonable and Customary Charges* for *Medically Necessary Treatment* and supplies which are directly related to *Eligible Medical Conditions* and for which such charges are incurred by *You* whilst *Your Plan* is in effect, subject always to the *Terms* of *Your Plan*. Please note that any *Pre-Certification* or verification of benefits is only a general determination of *Medically Necessary Treatment* and supplies and not a confirmation of cover. The availability of cover remains subject to the *Terms* of *Your Plan*.

Schedule of Cover and Excesses

Subject to the *Terms* of *Your Plan* and if no other limitations apply, after deduction of any *Excesses* and *Co-Insurance*, *We* will pay *Eligible Charges* up to the *Lifetime Limit* sum insured per *Insured Person* as relevant to *Your* chosen *Sub-Plan as* shown in the *Schedule of Cover and Excesses*. Please note: *Eligible Charges* for certain benefits under *Your Plan* are payable only up to a *Sub-Limit* per *Insured Person* per *Period of Insurance* and/or only up to a *Lifetime Limit* per *Insured Person*, as shown in the *Schedule of Cover and Excesses* as relevant to *Your* chosen *Sub-Plan*.

All benefit limits and *Excesses* in this table are set in $US Dollar, £Sterling and €Euros. The currency in which *You* pay *Your Premium* being either $US Dollar, £Sterling and €Euros, is the currency that applies to *Your Plan* for the purposes of the benefit limits and *Excesses*.

	Benefit *All sub-limit sums insured are the maximum per Insured Person, per Period of Insurance unless otherwise stated*	**Bronze**	**Silver**	**Gold** **(1st 36 months of continuous coverage)**	**Gold** **(Beginning the 1st day of the 37th month)**	**Gold Plus**	**Platinum**
	Lifetime Maximum Limit Per Individual *Insured Person*	$2,500,000 £1,375,000 €1,675,000	$5,000,000 £2,750,000 €3,350,000	$5,000,000 £2,750,000 €3,350,000	$5,000,000 £2,750,000 €3,350,000	$5,000,000 £2,750,000 €3,350,000	$8,000,000 £4,400,000 €5,360,000
	"Full Cover" means up to the applicable Lifetime Limit per Individual insured Person shown above and is based upon Usual, Reasonable and Customary Eligible Charges.						
A	***In-Patient & Day-Patient Treatment***						
1	***Surgery*, Surgeons, *Consultants*, Second Surgical Opinion, *Medical Practitioners*, Nurses, *Treatment*, Services and Supplies routinely provided and *Ancillary Charges***		Full Cover		Full Cover		
2	***Hospitalisation /* Room & Board**		Up to $600 / £350 /€400 per day 240 day Maximum		Up to $2,250 / £1,250 / €1,500 per day		
3	***Intensive Care Unit***		Up to $1,500 / £850 / €1,000 per day – 180 day per event		Up to $4,500 / £2,500 / €3,000 per day		
4	**Anaesthetist's Charges** associated with *Surgery*		20% of *Surgery* Benefit		20% of *Surgery* Benefit		
5	**Diagnostic Tests and Procedures, X-Rays, Pathology & MRI/CT Scans**						
6	**Prescribed *Drugs*, Dressings and *Durable Medical Equipment***	Full Cover		Full Cover	Full Cover	Full Cover	Full Cover
7	**Reconstructive *Surgery*-** following an accident or following *surgery* for an eligible condition						
8	**Cancer Tests, *Drugs*, *Treatment* and *Consultants*,** including cover for Chemotherapy and Radiotherapy		Full Cover		Full Cover Except: Radiation & Chemotherapy *Treatments* (In and *Out-patient*) limited to $10,000 / £5,500 / €6,700 with a $50,000 / £27,500 / €33,500 *Lifetime Limit*		
9	**Physiotherapy**						
10	**Parental Hospital Accommodation**				Full Cover		
11	**Prosthetic Devices**						

	Benefit *All sub-limit sums insured are the maximum per Insured Person, per Period of Insurance unless otherwise stated*	**Bronze**	**Silver**	**Gold** **(1st 36 months of continuous coverage)**	**Gold** **(Beginning the 1st day of the 37th month)**	**Gold Plus**	**Platinum**
12	**Transplants**	$250,000 / £137,500 / €167,500 Per Transplant	$250,000 / £137,500 / €167,500 Per Transplant	$1,000,000 / £550,000 / €670,000 *Lifetime Limit*	$500,000 / £275,000 / €335,000 *Lifetime Limit*	$1,000,000 / £550,000 / €670,000 *Lifetime Limit*	$2,000,000 / £1,100,000 / €1,340,000 *Lifetime Limit*
13	**State Hospital Cash Benefit**	$300 /£165 / €200 Per Night; Up to 60 Nights	$300 /£165 / €200 Per Night; Up to 60 Nights	$300 /£165 / €200 Per Night; Up to 60 Nights	$300 /£165 / €200 Per Night; Up to 60 Nights	$300 /£165 / €200 Per Night; Up to 60 Nights	$300 /£165 / €200 Per Night; Up to 60 Nights
14	***Terrorism* Coverage**	£5,500 / $10,000 / €6,700 *Lifetime Limit*	£5,500 / $10,000 / €6,700 *Lifetime Limit*	£5,500 / $10,000 / €6,700 *Lifetime Limit*	£5,500 / $10,000 / €6,700 *Lifetime Limit*	£5,500 / $10,000 / €6,700 *Lifetime Limit*	£5,500 / $10,000 / €6,700 *Lifetime Limit*
B	***Out-Patient Treatment*, Wellness Benefits and Other Coverages**						
1	***Out-Patient* including: Family Doctor, *Treatment* and Referrals, Specialists and *Consultants*, X-Rays, Pathology, Diagnostic Tests and Procedures** *not dependent upon admission	**No Family Doctor Cover** *Specialists* & *Consultants*: Up to $500 / £275 / €335 Prior to admission*, then up to $500 / £275 / €335 following related *Out-Patient Surgery* or *In-Patient/Day-Patient treatment*: for 90 days after leaving *hospital* Including Pre* & Post *Hospital*: $250 / £140 / €170 X-Ray per Examination Maximum Limit; $300 / £165 / €200 Lab Tests per Examination Maximum Limit	25 Visit Maximum Maximums Per Visit/ Examination: $70/ £40 / €50 Doctor/ *Specialist*; $60 / £35 / €40 Psychiatrist; $50 / £30 / €35 Chiropractor; $250 / £140 / €170 X-Ray per Examination Maximum Limit; $500 / £275 / €335 *Surgery* Intervention Consultation; $300 / £165 / €200 Lab Tests per Examination Maximum Limit	Full Cover	Full Cover Except: $150 / £85 / €100 *Medical Practitioner* Charges Maximum per Visit; *Hospital* Charge $100 / £55 / €67 Co-Pay unless admitted; Urgent Care Facility - $25 / £15 / €20 Co-Pay; Diagnostic Lab and X-Rays limited to $5,000 / £2,750 / €3,350 per *Period of Insurance*	Full Cover	Full cover
2	***Emergency* Room *Illness***, Waived if admitted as an *In-Patient* or *Day-Patient* (Additional $250/£138/€168 Excess if not admitted)	No Cover	Full Cover		Full Cover		
3	***Emergency* Room Accident**						
4	**Supplemental Accident Benefit**		No Cover	$300 / £165 / €200 per covered accident	$300 / £165 / €200 per covered accident	$300 / £165 / €200 per covered accident	$500 / £275 / €335 per covered accident

	Benefit *All sub-limit sums insured are the maximum per Insured Person, per Period of Insurance unless otherwise stated*	**Bronze**	**Silver**	**Gold** **(1st 36 months of continuous coverage)**	**Gold** **(Beginning the 1st day of the 37th month)**	**Gold Plus**	**Platinum**
5	***Out-Patient Surgery***	Full Cover	Full Cover	Full Cover	Full Cover	Full Cover	Full Cover
6	**MRI, CAT Scan, Echocardiography, Endoscopy, Gastroscopy Colonoscopy, Cystoscopy**	$600 / £330 / €400 Maximum Per Examination	$600 / £330 / €400 Maximum Per Examination				
7	**Cancer Tests, *Drugs*, *Treatment* and *Consultants*, including cover for Chemotherapy and Radiotherapy**	Full Cover	Full Cover		Full Cover Except: Radiation & Chemotherapy *Treatments* (In and *Out-patient*) limited to $10,000 / £5,500 / €6,700 with a $50,000 / £27,500 / €33,500 *Lifetime Limit*		
8	**Prescribed *Out-Patient Drugs*, Medicines, Dressings and *Durable Medical Equipment***	Up to $600 / £330 / €400 Following and in relation to *In-Patient/Day-Patient Treatment* or *Out-Patient Surgery*: for 90 days after leaving *hospital*	Full Cover	Full Cover	Up to $5,000 / £2,750 / €3,350	Full Cover	Outside USA: Full Cover Inside USA: Full Cover and must use the *Out-Patient* Prescription Drug Card. A Co-Pay: $20 for generic, $40 for brand name where generic is not available and not Subject to *Annual Excess* or *Co-Insurance* when using the *Out-Patient* Prescription Drug Card. No coverage if the *Out-Patient* Prescription Drug Card is not used
9	**Physiotherapy, Homeopathic, Chiropractic Therapy and Osteopathic Therapy**	Physiotherapy Only: Relating to *In-Patient/Day-Patient Treatment* or *Out-Patient Surgery* Up to $40 / £25 / €30 per visit 10 visit maximum for 90 days after leaving *hospital*	Up to $40 / £25 / €30 per visit 30 visit maximum	Maximum of 1 visit per day 45 visit maximum Up to $4,000/ £2,500 / €3,000 per *Period of Insurance*	Maximum of 1 visit per day 30 visit maximum Up to $1,000 / £550 / €670 per *Period of Insurance* $10,000 / £5,500 / €6,700 *Lifetime Limit*	Maximum of 1 visit per day 45 visit maximum Up to $4,000 / £2,500 / €3,000 per *Period of Insurance*	Maximum of 1 visit per day 60 visit maximum Up to $5,600 / £3,500 / €4,200 per *Period of Insurance*
10	**Complementary Medicine Therapies**: **Acupuncture, Aroma , Herbal, Magnetic, Massage, Vitamin, Traditional Chinese Medicine**	No Cover	No Cover	Up to $200 / £110 / €135	Up to $200 / £110 / €135	Up to $200 / £110 / €135	Up to $200 / £110 / €135

	Benefit *All sub-limit sums insured are the maximum per Insured Person, per Period of Insurance unless otherwise stated*	Bronze	Silver	Gold (1st 36 months of continuous coverage)	Gold (Beginning the 1st day of the 37th month)	Gold Plus	Platinum
11	**AIDS/HIV *Treatment***			Up to $5,000 / £2,750 / €3,350 per *Period of Insurance* $50,000 / £27,500 / €33,500 *Lifetime Limit*	Up to $5,000 / £2,750 / €3,350 per *Period of Insurance* $50,000 / £27,500 / €33,500 *Lifetime Limit*	Up to $5,000 / £2,750 / €3,350 per *Period of Insurance* $50,000 / £27,500 / €33,500 *Lifetime Limit*	Up to $5,000 / £2,750 / €3,350 per *Period of Insurance* $50,000 / £27,500 / €33,500 *Lifetime Limit*
12	***Home Nursing Care***	30 Days Limit: Up to $150 / £85/ €100 per visit	30 Days Limit: Up to $150 / £85/ €100 per visit	45 Days Limit: Up to $150 / £85 / €100 per visit	30 Days Limit: Up to $150 / £85/ €100 per visit	45 Days Limit: Up to $150 / £85/ €100 per visit	60 Days Limit: Up to $150 / £85/ €100 per visit
13	**Rehabilitation**	No Cover	No Cover	Full Cover Up to 90 Days	Full Cover Up to 45 Days	Full Cover Up to 90 Days	Full Cover Up to 180 Days
14	***Extended Care Facility***		Full Cover Up to 30 Days	Full Cover Up to 90 Days	Full Cover Up to 90 Days	Full Cover Up to 90 Days	Full Cover Up to 180 Days
15	***Hospice* Care**		No Cover	Full Cover Up to 180 Days	Full Cover Up to 90 Days	Full Cover Up to 180 Days	Full Cover Up to 180 Days
16	**Adult Wellness and Health Check** - includes Hearing Test, Sight Test and Vaccinations/Inoculations (Not subject to *Annual Excess* or *Co-Insurance*) - After 12 months continuous coverage (6 months on Platinum)			Up to $250 / £140 / €170	Up to $250 / £140 / €170	Up to $250 / £140 / €170	Up to $500 / £275 / €335
17	**Child Wellness and Health Check** (**Under 18 years of age)** - includes Hearing Test, Sight Test and Vaccinations/Inoculations (Not subject to *Annual Excess* or *Co-Insurance*) - After 12 months continuous coverage (6 months on Platinum)		3 visits per *Period of Insurance* Up to $70 / £40 / €50 per visit	Up to $200 /£110 / €135	Up to $200 /£110 / €135	Up to $200 /£110 / €135	Up to $400 / £220 / €270
18a or	***Pre-Existing Conditions*** **-Underwriting/Coverage Options** **Full Medical Underwriting Option*:** - After 24 months continuous cover - Declared and Accepted conditions (unless otherwise excluded or terms applied as indicated otherwise in writing) **- Flexible Underwriting Option available -** *Endorsement* issued if applicable.	No Cover	Up to $5,000 / £2,750 / €3,350 $50,000 / £27,500 / €33,500 *Lifetime Limit*	Up to $5,000 / £2,750 / €3,350 $50,000 / £27,500 / €33,500 *Lifetime Limit*	Up to $5,000 / £2,750 / €3,350 $50,000 / £27,500 / €33,500 *Lifetime Limit*	Up to $5,000 / £2,750 / €3,350 $50,000 / £27,500 / €33,500 *Lifetime Limit*	Full Cover No requirement for 24 months continuous cover

	Benefit *All sub-limit sums insured are the maximum per Insured Person, per Period of Insurance unless otherwise stated*	**Bronze**	**Silver**	**Gold** **(1st 36 months of continuous coverage)**	**Gold** **(Beginning the 1st day of the 37th month)**	**Gold Plus**	**Platinum**
18b	**Moratorium Enrolment & Underwriting Option*** - After 24 months continuous coverage: subject to 24 months without *treatment*, symptoms, medication or consultation (refer to *Endorsement* for further details)* - Available to insureds up to age 64	No Cover	Full Cover	Full Cover	Full Cover	Full Cover	Full Cover
*Coverage in respect of *Pre-Existing Conditions* is as selected at time of application and identified on *Your Certificate of Insurance*. Refer to Section B for further details and *Endorsements* issued for full Policy definitions, terms, conditions and restrictions.							
19	**Newly Diagnosed Chronic Conditions**	Covered	Covered	Covered	Covered	Covered	Covered
20	**Mental/Nervous** - After 12 months continuous coverage	No Cover	*Out-Patient* Only - See Section B1	Up to $10,000 / £5,500 / €6,700 $50,000 / £27,500 / €33,500 *Lifetime Limit*	Up to $2,500 / £1,375 / €1,675 25 days *In-Patient* Limit 20 visit *Out-Patient* Limit at 70% eligible expenses, up to $75 / £42 / €51 per visit; $30,000 / £16,500 / €20,100 *Lifetime Limit*	Up to $10,000 / £5,500 / €6,700 $50,000 / £27,500 / €33,500 *Lifetime Limit*	Up to $50,000 / £27,500 / €33,500 *Lifetime Limit*
C	**Travel, Transportation and Out of Area Benefits**						
1	***Emergency* Local Ambulance**	Up to $1,500 /£825 / €1,000 per event Not subject to *Annual Excess* or *Co-Insurance*	Up to $1,500 /£825 / €1,000 per event Not subject to *Annual Excess* or *Co-Insurance*	Full Cover	Up to $100 / £55 / €70 per event Not subject to *Annual Excess* or *Co-Insurance*	Full Cover	Full Cover
2	***Emergency* Evacuation and Transportation To the Nearest Suitable Hospital Facility**	Up to $50,000 / £27,500 / €33,500 Not subject to *Annual Excess* or *Co-Insurance*	Up to $50,000 / £27,500 / €33,500 Not subject to *Annual Excess* or *Co-Insurance*	Full Cover Not subject to *Annual Excess* or *Co-Insurance*	Up to $250,000 / £137,500 / €167,500	Full Cover Not subject to *Annual Excess* or *Co-Insurance*	Full Cover Not subject to *Annual Excess* or *Co-Insurance*
3	**Accompanying *Relative*, Travel and Accommodation**	No Cover	No Cover	$10,000 / £5,500 / €6,700 *Lifetime Limit*	$10,000 / £5,500 / €6,700 *Lifetime Limit*	$10,000 / £5,500 / €6,700 *Lifetime Limit*	$10,000 / £5,500 / €6,700 *Lifetime Limit*
4	**Cremation/Burial or Return of Mortal Remains**	$10,000 / £5,500 / €6,700 *Lifetime Limit* -Not subject to *Annual Excess* or *Co-Insurance*	$25,000 / £13,750 / €16,750 *Lifetime Limit* -Not subject to *Annual Excess* or *Co-Insurance*	$25,000 / £13,750 / €16,750 *Lifetime Limit* -Not subject to *Annual Excess* or *Co-Insurance*	$15,000 / £8,250 / €10,050 *Lifetime Limit* -Not subject to *Annual Excess* or *Co-Insurance*	$25,000 / £13,750 / €16,750 *Lifetime Limit* -Not subject to *Annual Excess* or *Co-Insurance*	$50,000 / £27,500 / €33,500 *Lifetime Limit* -Not subject to Annual Excess or Co-Insurance

	Benefit *All sub-limit sums insured are the maximum per Insured Person, per Period of Insurance unless otherwise stated*	**Bronze**	**Silver**	**Gold** **(1st 36 months of continuous coverage)**	**Gold** **(Beginning the 1st day of the 37th month)**	**Gold Plus**	**Platinum**
5	**Remote Transportation** - for additional transport for on-going *Treatment* once stabilised	No Cover	No Cover	No Cover	No Cover	No Cover	Up to $5,000 / £2,750 / €3,350 $20,000 / £11,000 / €13,400 *Lifetime Limit*
6	**Security & Political Evacuation & Repatriation**	No Cover	No Cover	No Cover	No Cover	No Cover	$10,000 / £5,500 / €6,700 *Lifetime Limit*
7	**Worldwide Accident & *Emergency* Out of Area Coverage** (USA *Treatment* Must Be within PPO Network)	15 Days Maximum	30 Days Maximum	30 Days Maximum	30 Days Maximum	30 Days Maximum	30 Days Maximum
D	***Dental Treatment* & Vision Care Benefits**						
1a	***Emergency* Dental Due to Accident**	Up to $1,000 / £550 / €670	Up to $1,000 / £550 / €670	Full Cover	Up to $500 / £275 / €345	Full Cover	Full Cover
2a	***Emergency* Dental due to Sudden *Unexpected* Pain To Sound Natural Teeth**	No Cover	No Cover	Up to $100 / £55 / €70	Up to $100 / £55 / €70	Up to $100 / £55 / €70	Up to $100 / £55 / €70
	Dental and Vision Optional Add-On Coverage Additional *Premium* Applies Coverage is issued via a Dental & Vision Care Coverage *Endorsement* Sections D1a & D2a above are replaced with: Refer To Policy Wording/*Endorsement* for Full Details & Listing						**Dental Coverage Included** – See Below
1b	***Emergency* Dental Due to Accident**	Full Cover	Full Cover	Full Cover	Full Cover	Full Cover	As D1a Above
2b	***Emergency* Dental due to Sudden *Unexpected* Pain To Sound Natural Teeth**	Up to $100 / £55 / €70	Up to $100 / £55 / €70	Up to $100 / £55 / €70	Up to $100 / £55 / €70	Up to $100 / £55 / €70	As D2a Above
3	**Non-*Emergency* Dental Sections D4, D5 & D6 Combined:** i) Calendar Year Maximum Sum Insured *ii)* Dental Annual *Excess* *iii)* Maximum Annual *Excesses* per Family per Calendar Year - After 6 months continuous cover	i) $750 /£425 /€500 ii) $50 / £30 / €35 iii) 2	i) $750 /£425 /€500 ii) $50 / £30 / €35 iii) 2	i) $750 /£425 /€500 ii) $50 / £30 / €35 iii) 2	i) $750 /£425 /€500 ii) $50 / £30 / €35 iii) 2	i) $750 /£425 /€500 ii) $50 / £30 / €35 iii) 2	i) $750 /£425 /€500 ii) $50 / £30 / €35 iii) 2
4	**Class I *Treatment**:** - Preventative & Diagnostic - *Emergency* Palliative *Treatment* - includes up to two dental check-ups per calendar year to include scraping, cleaning and polishing - After 6 months continuous cover * Refer To Policy Wording for Full Details & Listing	90% Coverage, Dental Annual *Excess* Waived	90% Coverage, Dental Annual *Excess* Waived	90% Coverage, Dental Annual *Excess* Waived	90% Coverage, Dental Annual *Excess* Waived	90% Coverage, Dental Annual *Excess* Waived	90% Coverage, Dental Annual *Excess* Waived
5	**Class II *Treatment**:** - Radiographs & X-Rays - Oral *Surgery* & Extractions - Routine Compound Fillings, Restorations, Re-cementing crowns, inlays and bridges & Prosthetic Repairs - Endodontics & Root Canals - Periodontics & Gum Disease - Minor Restorative Services - After 6 months continuous cover * Refer To Policy Wording for Full Details & Listing	70% Coverage, after Dental Annual *Excess*	70% Coverage, after Dental Annual *Excess*	70% Coverage, after Dental Annual *Excess*	70% Coverage, after Dental Annual *Excess*	70% Coverage, after Dental Annual *Excess*	70% Coverage, after Dental Annual *Excess*

Benefit *All sub-limit sums insured are the maximum per Insured Person, per Period of Insurance unless otherwise stated*		Bronze	Silver	Gold (1st 36 months of continuous coverage)	Gold (Beginning the 1st day of the 37th month)	Gold Plus	Platinum
6	**Class III *Treatment**:** - Prosthodontic Services including: appliances, bridges, full and partial dentures that replace missing natural teeth that were extracted while the person is covered with this Plan. - Major Restorative *Treatment* including: Crowns, Jackets, gold-related services required when teeth cannot be restored using other filling material. - After 6 months continuous cover * Refer To Policy Wording for Full Details & Listing	50% Coverage, after Dental Annual *Excess*	50% Coverage, after Dental Annual *Excess*	50% Coverage, after Dental Annual *Excess*	50% Coverage, after Dental Annual *Excess*	50% Coverage, after Dental Annual *Excess*	50% Coverage, after Dental Annual *Excess*
7	**Vision Care** Not subject to *Annual Excess* or *Co-Insurance*. (Benefit payable per 24 months)	Exams – up to $100 / £55 / €70 Materials – up to $150 / £85 / €100	Exams – up to $100 / £55 / €70 Materials – up to $150 / £85 / €100	Exams – up to $100 / £55 / €70 Materials – up to $150 / £85 / €100	Exams – up to $100 / £55 / €70 Materials – up to $150 / £85 / €100	Exams – up to $100 / £55 / €70 Materials – up to $150 / £85 / €100	Exams – up to $100 / £55 / €70 Materials – up to $150 / £85 / €100
E	**Additional Benefits & Services**						
1	**High School Sports *Injury***	No Cover	No Cover	No Cover	No Cover	No Cover	Up to $20,000 / £11,000 / €13,400
2	**Recreational Scuba**	No Cover	No Cover	Full Cover	Full Cover	Full Cover	Full Cover
3	**Medical Information Service**	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Included
4	**Global Concierge & Assistance Services**	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Included
5	**24 Hour *Emergency* Helpline**	Included	Included	Included	Included	Included	Included
F	**Maternity**						
	Maternity - Only available to Female Insureds - After 10 months of continuous cover *All benefits reduced by 50% for births occurring in the 11th or 12th month of continuous coverage	**Optional Add-On Coverage** Additional *Premium* Applies	**Optional Add-On Coverage** Additional *Premium* Applies	**Optional Add-On Coverage** Additional *Premium* Applies	**Optional Add-On Coverage** Additional *Premium* Applies	**Optional Add-On Coverage** Additional *Premium* Applies	**Maternity Coverage Included –** See Below
	Maternity Annual Excess	Section F1 & F2: Not subject to *Annual Excess* or *Co-Insurance*	Section F1 & F2: Not subject to *Annual Excess* or *Co-Insurance*	Section F1 & F2: Not subject to *Annual Excess* or *Co-Insurance*	Section F1 & F2: Not subject to *Annual Excess* or *Co-Insurance*	Section F1 & F2: Not subject to *Annual Excess* or *Co-Insurance*	$1,000 / £550 / €670 *Maternity Annual Excess* (*Annual Excess* Does Not Apply)
	Lifetime Limit	*$50,000 / £27,500 / €33,500 *Lifetime Limit*	*$50,000 / £27,500 / €33,500 *Lifetime Limit*	*$50,000 / £27,500 / €33,500 *Lifetime Limit*	*$50,000 / £27,500 / €33,500 *Lifetime Limit*	*$50,000 / £27,500 / €33,500 *Lifetime Limit*	*$50,000 / £27,500 / €33,500 *Lifetime Limit*
1	**Normal Delivery** - Including Premature Birth *Treatment*, Pre, Post and Routine Natal Care	*Up to $5,000 / £2,750 / €3,350	*Up to $5,000 / £2,750 / €3,350	*Up to $5,000 / £2,750 / €3,350	*Up to $5,000 / £2,750 / €3,350	*Up to $5,000 / £2,750 / €3,350	Included within and up to *Lifetime Limit*
2	**C-Section**	*Up to $7,500 / £4,125 / €5,025	*Up to $7,500 / £4,125 / €5,025	*Up to $7,500 / £4,125 / €5,025	*Up to $7,500 / £4,125 / €5,025	*Up to $7,500 / £4,125 / €5,025	Included within and up to *Lifetime Limit*

	Benefit *All sub-limit sums insured are the maximum per Insured Person, per Period of Insurance unless otherwise stated*	Bronze	Silver	Gold (1st 36 months of continuous coverage)	Gold (Beginning the 1st day of the 37th month)	Gold Plus	Platinum
3	***Newborn* Baby Wellness** - Not subject to Annual or Annual Maternity *Excess* or *Co-Insurance* - for the first 12 months of life	$200 /£110 / €134	$200 /£110 / €134	$200 /£110 / €134	$200 /£110 / €134	$200 /£110 / €134	$200 /£110 / €134
4	**Cover for *Newborns* including non-hereditary birth defects and congenital abnormalities**	*Up to $250,000 / £137,500 / €167,500 for the first 31 days	*Up to $250,000 / £137,500 / €167,500 for the first 31 days	*Up to $250,000 / £137,500 / €167,500 for the first 31 days	*Up to $250,000 / £137,500 / €167,500 for the first 31 days	*Up to $250,000 / £137,500 / €167,500 for the first 31 days	*Up to $250,000 / £137,500 / €167,500 for the first 31 days
Additional Optional Add-On Coverages (Upon selection at initial *Application* and subject to additional *Premium*)							
	***Terrorism* Coverage Add-On** **(Platinum Plans Only)**	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	$50,000 / £27,500 / €33,500 *Lifetime Limit*
	Sports* Coverage Add-On i) Listed Extreme Sports\ ii) Amateur Sports *Non-Professional **(Gold Plus and Platinum Plans Only)**	Not Applicable	Not Applicable	Not Applicable	Not Applicable	i) $25,000 / £13,750 / €16,750 Lifetime Limits ii) $10,000 / £5,500 / €6,700 *Lifetime Limit*	i) $25,000 / £13,750 / €16,750 *Lifetime Limits* ii) $10,000 / £5,500 / €6,700 *Lifetime Limit*
Annual Excess* and *Co-Insurance							
	Annual Excess* Options** **- Per *Insured Person*, Per *Period of Insurance	NIL $250 to $10,000 £138 to £5,500 €168 to €6,700	NIL $250 to $10,000 £138 to £5,500 €168 to €6,700	NIL $250 to $10,000 £138 to £5,500 €168 to €6,700	NIL $250 to $10,000 £138 to £5,500 €168 to €6,700	NIL $250 to $10,000 £138 to £5,500 €168 to €6,700	NIL $100 to $10,000 £55 to £5,500 €67 to €6,700
		50% waived (up to a maximum reduction of $2,500 / £1,375 / €1,675) for: US PPO *Out-Patient* & *Emergency In-Patient Treatment* & Non-*Emergency In-Patient* US Medical Concierge Provider *Treatment*					
	Family Maximum Annual *Excesses*	3 x Individual *Annual Excess*	3 x Individual *Annual Excess*	3 x Individual *Annual Excess*	3 x Individual *Annual Excess*	3 x Individual *Annual Excess*	2 x Individual *Annual Excess*
	***Annual Excess* Carry Forward** - If prior *Annual Excess* not met, then last 30 days Expenses from the previous *Period of Insurance* are carried forward and applied towards satisfying the *Annual Excess* for the next *Period of Insurance*	YES	YES	YES	YES	YES	YES
	***Co-Insurance* within the USA & Canada PPO Network**	No *Co-Insurance*	No *Co-Insurance*	No *Co-Insurance*	No *Co-Insurance*	No *Co-Insurance*	No *Co-Insurance*
	Co-Insurance outside the USA & Canada	No *Co-Insurance*	No *Co-Insurance*	No *Co-Insurance*	No *Co-Insurance*	No *Co-Insurance*	No *Co-Insurance*
	***Co-Insurance* Payable by Insured inside the USA & Canada** **– When *treatment* is taken outside the USA & Canada PPO Network (No *Co-Insurance* for Non-*Emergency In-Patient treatment* when utilising a USA Medical Concierge Provider)**	20% of the next $5,000 / £2,750 / €3,350 eligible expenses after the *Annual Excess*, then No *Co-Insurance* to the overall maximum per *Period of Insurance*	20% of the next $5,000 / £2,750 / €3,350 eligible expenses after the *Annual Excess*, then No *Co-Insurance* to the overall maximum per *Period of Insurance*	20% of the next $5,000 / £2,750 / €3,350 eligible expenses after the *Annual Excess*, then No *Co-Insurance* to the overall maximum per *Period of Insurance*	20% of the next $5,000 / £2,750 / €3,350 eligible expenses after the *Annual Excess*, then No *Co-Insurance* to the overall maximum per *Period of Insurance*	20% of the next $5,000 / £2,750 / €3,350 eligible expenses after the *Annual Excess*, then No *Co-Insurance* to the overall maximum per *Period of Insurance*	10% of the next $5,000 / £2,750 / €3,350 eligible expenses after the *Annual Excess*, then No *Co-Insurance* to the overall maximum per *Period of Insurance*

SECTION A: *In-Patient* & *Day-Patient Treatment*

Subject to the *Terms* of this Policy Wording, including without limitation the *Excess*, *Co-Insurance,* and limits and *Sub-Limits* set forth in the *Schedule of Cover and Excesses* applicable for *Your* chosen *sub-plan, We* will pay *In-Patient* and *Day-Patient* charges *You* incur during the *Period of Insurance* with respect to an *Illness* or *Injury* suffered or sustained by the *Insured Person* during the *Period of Insurance* and while *Your Certificate of Insurance* is in effect, as follows, as long as the costs, charges or expenses are *Reasonable and Customary* ("*Eligible Charges*"):

A1. *Surgery*, Surgeons, *Consultants*, *Medical Practitioners*, Nurses, *Treatment*, Services and Supplies and *Ancillary Charges*

We will pay *Eligible Charges* for *Surgery; Pre-Certified* second surgical opinion; use of operating theatre, *Treatment* room or recovery room; and services and supplies which are routinely provided by the *Hospital* to *You* in the course of *In-Patient* or *Day-Patient Treatment*, as well as professional services (including *Ancillary Charges*) rendered by surgeons, *Consultants*, and nurses; provided however, that *Eligible Charges* for an assistant surgeon will be limited and covered at the rate of 20% of the eligible charge of the primary surgeon; and provided further that standby availability of a surgeon will not be deemed to be a professional service and is not eligible for cover.

A2. *Hospital* Accommodation

We will pay *Eligible Charges* for *Hospital* accommodation, food and nursing services, limited to a standard private room (except for *Treatment* in the USA where cover is limited to a semi-private room); Unbundled services or personal items such as telephone calls, newspapers and guest meals are excluded from cover.

A3. Intensive Care Unit

We will pay *Eligible Charges* for *Hospital* accommodation, food, *Medical Practitioner* services; services and supplies routinely provided in *Intensive Care Unit*.

A4. Anaesthetist's Charges

We will pay *Eligible Charges* for processing and administration of blood or blood components (including haemodialysis), but not the cost of the actual blood or blood components; and for anaesthetics and their administration by *Medical Practitioner*; and for oxygen and other gasses and their administration.

A5. Diagnostic Tests and Procedures, X-rays, Pathology & MRI/CT Scans

We will pay Eligible Charges for diagnostic procedures and testing using radiology, ultrasonographic or laboratory *services* (psychometric, behavioural and educational testing are not included).

A6. Prescribed *Drugs*, Dressings and *Durable Medical Equipment*

We will pay *Eligible Charges* for *Drugs*, but not to exceed a maximum supply of 90 days and not for the replacement of lost, stolen, damaged, expired or otherwise compromised *Drugs*. *We* will also pay *Eligible Charges* for dressings, sutures, casts or other supplies, including *Pre-Certified* and *Medically Necessary* rental of *Durable Medical Equipment*, up to the purchase price.

A7. Reconstructive *Surgery*

We will pay *Eligible Charges* for reconstructive *Surgery* or *Surgery* that is required to restore natural function or appearance that was lost as a result of an *Accident* or *Illness* and is undertaken within 12 months after the date of occurrence of the *Accident* or the date of onset of the *Illness*, as long as the *Accident* or *Illness* and the reconstructive *Surgery* occur whilst *Your Plan* is in effect.

A8. Cancer Tests, *Drugs*, *Treatment* and Consultants

We will pay *Eligible Charges* for chemotherapy, radiation therapy, radiotherapy, oncology tests, *Drugs* and *Consultants* directly relating to cancer *Treatment*.

A9. Physiotherapy

We will pay *Eligible Charges* for physiotherapy prescribed by a *Medical Practitioner* and performed by a professional physiotherapist, and necessarily incurred to continue recovery from an *Eligible Medical Condition*. Such Physiotherapy is initially restricted to 10 visits per *Eligible Medical Condition*, after which it must be further reviewed by a *Specialist* and subsequently *Pre-Certified*.

A10. Parental *Hospital* Accommodation

We will pay *Eligible Charges* for standard private *Hospital* accommodation in respect of one of *Your* parents or *Your* legal guardian staying with *You* in *Hospital* whilst *You* are under 18 years of age and admitted as an *In-Patient*.

A11. Prosthetic Devices

We will pay *Eligible Charges* for *Pre-Certified* basic functional artificial limbs, eyes, larynx or breast prostheses, but not the replacement or repair thereof. *We* will pay *Eligible Charges* for *Implant* devices that are *Medically Necessary,* however any *Implants* provided by a non-PPO provider are limited to payment of no more than 150% of the established invoice price and/or list price for that item.

A12. Organ Transplant

We will pay *Eligible Charges* for *Pre-Certified Covered Transplants* that *You* obtain or receive from an independent transplant network provider approved by *Us*, up to the total *Lifetime Limit* indicated on the *Schedule of Cover and Excesses* and limited to the following benefits:

1. *Reasonable and customary* medical expenses incurred by a live donor in the course of or as a result of donating an organ or tissue to *You* for a *Covered Transplant*; and

2. *Eligible Charges* for the procurement and harvesting, excluding acquisition, purchase or cryopreservation of the actual organ or tissue to be used for the *Covered Transplant*, up to the *Lifetime Limit* of $10,000/£5,500/€6,700

(Silver, Gold or Gold Plus *Sub-Plans)* or $20,000/£11,000/€13,400 (Platinum *Sub-Plan*); and

3. *Eligible Charges* for pre-transplant evaluation, the *Covered Transplant* procedure, re-transplantation if performed while in *Hospital* during the initial *Covered Transplant*, and post-transplant care; and

4. *Your* reasonable travel and lodging expenses if *You* must travel more than 50 miles/85 kilometres to the nearest independent transplant network provider approved by *Us* to receive *Covered Transplant Treatment* or supplies, up to a *Sub-Limit* of £2,750/$5,000 /€3.350 (Bronze, Silver, Gold or Gold Plus *Sub-Plans)* or $10,000/£5,500/€6,700 (Platinum *Sub-Plan*) per *Your* lifetime.

The *Covered Transplant* must be *Pre-Certified*. If *You* receive *Covered Transplant Treatment* or supplies from a provider that is not approved by *Us*, or if the transplant is not a *Covered Transplant* or is not properly *Pre-Certified*, no transplant benefits shall be available under *Your Plan.*

A13. State *Hospital* Cash Benefit
When *You* are admitted to a state, government or charitable *Hospital* as an *In-Patient* and *You* receive *Treatment* for an *Eligible Medical Condition* which is not an admission to, or overnight stay in, an *Accident* and *Emergency* Department, and no costs are incurred by *You* or *Us* for accommodation and *Treatment*, *We* will pay a cash benefit up to the *Sub-Limit* and up to a maximum number of nights in *Hospital* per *Period of Insurance*, as shown in the *Schedule of Cover*. No *Excess* or *Co-Insurance* applies to this benefit. To claim this benefit, please ask the *Hospital* to sign and stamp *Your* claim form.

A14. *Terrorism*
We will pay Eligible Charges for any claim or charges, *Illness*, Injury or other consequence as a result of being a victim of an act of *Terrorism*, as long as the act occurred whilst *Your Plan* is in effect and *You* sustained injury whilst an innocent bystander.

SECTION B: *Out-Patient Treatment*, Wellness Benefits and Other Coverages

IMPORTANT NOTE: The Bronze *Sub-Plan* contains the following special cover restrictions relating to Sections B1, B8 and B9 of this Policy Wording.

A) With respect to Section B1 of the Bronze *Sub-Plan*:

1. No cover is provided under Section B1 with respect to Family Doctor Charges, Family Doctor *Treatment*, Visits, Appointments and Family Doctor Referral Fees.

2. Cover for *Eligible Charges* for professional services rendered by *Specialists* and *Consultants* is limited up to the *Sub-Limit* shown in the *Schedule of Cover and Excesses*, per *Period of Insurance* and further limited to being soley in respectto:

   a) *Consultant* or *Specialist* fees prior to (although not dependent upon) *Hospital* admission;

   b) additional *Consultant* or *Specialist* Fees incurred in relation to and within 90 days after being discharged from *Hospital,* following: *Out-Patient Surgery*, *In-Patient* or *Day-Patient Treatment*;

3. Cover is provided prior to *Hospital* admission (although not dependent upon) and after being discharged from *Hospital* following *Out-Patient Surgery*, *In-Patient* or *Day-Patient Treatment* for: X-Rays, Pathology, Lab Tests including Diagnostic Tests and Procedures, undertaken by a recognised medical facility, up to the maximum limit per Examination, as shown in the *Schedule of Cover and Excesses* applicable to the Bronze *Sub-Plan*.

B) With respect to Section B8 of the Bronze *Sub-Plan*:
Cover is provided for *Eligible Charges* for *Out-Patient Drugs*, Medicines, Dressings and *Durable Medical Equipment* and appliances prescribed by a *Medical Practitioner* or *Specialist*, incurred within 90 days after being discharged from *Hospital,* following *Out-Patient Surgery*, *In-Patient* or *Day-Patient Treatment*. Any benefit for *Durable Medical Equipment* is conditioned upon *Pre-Certification*.

C) With respect to Section B9 of the Bronze *Sub-Plan*:
Subject to the *Terms* of Section B9, cover is further restricted solely to Physiotherapy. There is no cover for Homeopathic, Chiropractic or Osteopathic Therapy. Physiotherapy cover is further limited to Physiotherapy incurred in relation to and within 90 days after being discharged from *Hospital,* following: *Out-Patient Surgery*, *In-Patient* or *Day-Patient Treatment*.

Subject to the *Terms* of this Policy Wording, including without limitation the *Excess*, *Co-insurance,* and limits and *Sub-Limits* set forth in the *Schedule of Cover and Excesses* applicable for *Your* chosen *sub-plan, We* will pay *Out-Patient* charges, Wellness Benefits and other *Eligible Charges You* incur as follows, as long as the costs, charges or expenses are *Reasonable and Customary* ("*Eligible Charges*"):

B1. Family Doctor, *Treatment* & Referrals, *Specialists* and Consultants, Diagnostic Tests and Procedures, X-rays and Pathology
We will pay *Eligible Charges* for professional services and for referrals rendered by family doctors and general practitioners who are also *Medical Practitioners*; provided however, that standby availability of a *Medical Practitioner* will not be deemed to be a professional service and is not eligible for cover. In addition, *We* will pay *Eligible Charges* for

professional services rendered by *Specialists* and *Consultants*. *We* will pay *Eligible Charges* for x-rays, pathology, diagnostic tests and procedures undertaken by a recognised *Out-Patient* medical facility.

Note regarding Bronze *Sub-Plan*: Please refer to the Important Notes above relating to special cover restrictions.

B2. *Emergency* Room - *Illness*
We will pay for *Your* use of the *Emergency* Room for *Treatment* of an *Illness* that is considered an *Eligible Medical Condition,* however if *You* are not directly admitted to the *Hospital* as an *In-Patient* or *Day- Patient* for further *Treatment* of that *Medical Condition*, an additional *Excess* of $250/£138/€168 will be required. (This benefit is not available on Bronze *Sub- Plan*).

B3. *Emergency* Room - *Injury*
We will pay for *Your* use of the *Emergency* Room for *Treatment* of an *Injury,* no additional *Excess* will be charged, even if *Hospital* confinement is not required. (This benefit is not available on Bronze *Sub-Plan*).

B4. Supplemental Accident Benefit
In the event of an *Accident,* which gives rise to benefits covered under the *Terms* of this *Plan*, as a supplemental benefit, *We* will reimburse *You* the first £165/$300/€200 of *Eligible Charges* related to the *Treatment* of an *Injury* resulting from such *Accident*, before applying any *Excess.* (This benefit is not available on Bronze and Silver *Sub-Plans*).

B5. *Out-Patient Surgery*
We will pay *Eligible Charges* for *Pre-Certified Out-Patient Surgery* undertaken by a recognised medical facility.

B6. MRI and CAT Scans, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cystoscopy
We will pay *Eligible Charges* for *Pre-Certified:* MRI and CAT scans, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cystoscopy and undertaken by a recognised medical facility.

B7. Cancer Tests, *Drugs*, *Treatment* and *Consultants*
We will pay *Eligible Charges* for chemotherapy, radiation therapy, radiotherapy, *Medically Necessary* oncology tests, *Drugs* and *Consultants* directly relating to cancer *Treatment*.

B8. Prescribed *Out-Patient Drugs*, Medicines, Dressings and *Durable Medical Equipment*
We will pay *Eligible Charges* for *Drugs* and dressings, *Durable Medical Equipment* and appliances prescribed by a *Medical Practitioner* or *Specialist*. With regard to *Drugs*, *We* will not pay for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, nor for a supply which exceeds ninety (90) days of any one prescription. Any benefit for *Durable Medical Equipment* is conditioned upon *Pre- Certification*.

Special Note for Platinum *Sub-Plan* only: For prescriptions purchased in the USA, to be considered an *Eligible Charge,* prescriptions must be purchased under the Universal Rx Card Program (*Out-Patient* Prescription Drug Card) with a maximum supply of thirty-four (34) days.

Note regarding Bronze *Sub-Plan*: Please refer to the Important Notes above relating to special cover restrictions.

B9. Physiotherapy, Homeopathic, Chiropractic Therapy and Osteopathic Therapy
We will pay *Eligible Charges* for physiotherapy, homeopathic therapy, chiropractic therapy and osteopathic therapy prescribed in advance by a *Medical Practitioner* and performed by a professional therapist, and necessarily incurred for *You* to continue recovery from an *Eligible Medical Condition*.

Such therapy is initially restricted to 10 visits per *Eligible Medical Condition*, after which it must be further reviewed by a *Specialist* and subsequently *Pre-Certified* in order to apply for any additional visits, up to the maximum number of visits and *Sub-Limits* relevant to *Your* chosen *Sub-Plan*, as shown in the *Schedule of Cover and Excesses*. A referral letter/report must be submitted to the *Plan Manager* with the first claims for such *Treatment*. In addition to the above, a medical report will be required for *Treatment* after 10 visits.

Note regarding Bronze *Sub-Plan*: Please refer to the Important Notes above relating to special cover restrictions.

B10. Complementary Medical *Treatment*
We will pay *Eligible Charges* for acupuncture, aroma therapy, herbal therapy, magnetic therapy, massage therapy, vitamin therapy and traditional Chinese medicine, which are performed by a person properly licensed and registered to provide such *Treatment* and referred by a *Medical Practitioner*. Cover is provided up to the *Sub-Limit* shown per *Period of Insurance* in the *Schedule of Cover and Excesses* relevant to *Your* chosen *Sub-Plan*. (This benefit is not available on Bronze and Silver *Sub-Plans.)*

B11. *AIDS*/HIV *Treatment*
We will pay *Eligible Charges* for pre-diagnosis and post-diagnosis consultations, routine check-ups, *Drugs*, dressings, *Hospital* accommodation and nursing services that directly relate to *You* being first exposed to and infected with Human Immunodeficiency Virus (*HIV*) after the *Effective Date*. Any pre-diagnosis test is covered only if the result of the test is positive. (This benefit is not available on Bronze and Silver *Sub-Plans.)*

B12. *Home Nursing Care*
We will pay *Eligible Charges* for personal care services recommended by a *Specialist*, and provided to *You* while in bed in *Your* home by a *home nursing care* agency which operates pursuant to law, and is regularly engaged in providing such care under the supervision of a *Registered Nurse*. Cover is provided only for such *home nursing care* which is immediately

received subsequent to *In-Patient Treatment* or *Day-Patient Treatment*. This benefit is conditional upon *Pre-Certification*. Cover is provided up to the *Sub-Limit* per visit and up to the total number of visits shown in the *Schedule of Cover and Excesses* relevant to *Your* chosen *Sub-Plan*, per *Period of Insurance*.

B13. Rehabilitation

We will pay *Eligible Charges* for *Pre-Certified* assistance immediately following *In-Patient Treatment* for an *Eligible Medical Condition* which is aimed at restoring *Your* health and mobility to help *You* live a more independent life. Such rehabilitation must have been an integral part of *Your Treatment* as an *In-Patient*; and must be under the control or supervision of a *Specialist* and undertaken in a recognised rehabilitation unit of a *Hospital*. Cover is provided up to the total number of days per *Period of Insurance* indicated on the *Schedule of Cover and Excesses* relevant to *Your* chosen *Sub-Plan*. (This benefit is not available on Bronze and Silver *Sub-Plans.)*

B14. *Extended Care Facility*

We will pay *Eligible Charges* for *Pre-Certified* care in a licensed *Extended Care Facility* upon direct transfer from a *Hospital* in which *You* were an *In-Patient*. Cover is provided up to the total number of days per *Period of Insurance* indicated on the *Schedule of Cover and Excesses* relevant to *Your* chosen *Sub-Plan*. (This benefit is not available on Bronze *Sub-Plan*).

B15. *Hospice* Care

We will pay *Eligible Charges* made by a *hospice* for:

i. *Pre-Certified* room and board and part-time nursing services by a *Registered Nurse* received as an *In-Patient* in a *hospice* or *Your* home when a *Medical Practitioner* certifies that *You* are terminally ill with 6 months or less to live; and

ii. *Pre-Certified* counselling for *You* and *Your* spouse, *Partner*, and *Your* dependent *children* who are under the age of 18, which is received within 180 days of *Your* death and limited to 15 counselling visits in total. Services must be rendered by a licensed social worker or a licensed pastoral counsellor and are limited to the *Lifetime Limit* of $300/£175/€205. (This benefit is not available on the Bronze and Silver *Sub-Plans.)*

B16. Adult Wellness and Health Check

We will pay *Reasonable and Customary Charges* toward the costs incurred by *You* during a *Period of Insurance* for the following expenses up to the *Sub-Limit* shown in the *Schedule of Cover and Excesses* applicable to *Your* chosen *Sub-Plan*, per *Period of Insurance*, provided at least 12 months have elapsed since *Your* most recent *routine physical examination*, eye-test, or hearing test (as applicable), and provided *You* have been continuously insured under *Your Plan* for not less than 12 months (6 months for those covered on the Platinum *Sub-Plan*):

i. **For males:** One routine physical examination for preventative or informative purposes only, including prostate cancer test, cancer screening, cardiovascular examinations, neurological examinations, vital sign tests (e.g. blood pressure, cholesterol checks), one Hearing Test, one Sight Test and medically recommended vaccinations / inoculations; and

ii. **For females:** One routine physical examination for preventative or informative purposes only, including cervical smear, mammogram, cancer screening, cardiovascular examinations, neurological examinations, vital sign tests (e.g. blood pressure, cholesterol checks), one Hearing Test, one Sight Test and medically recommended vaccinations / inoculations.

Wellness expenses are not subject to *Annual Excess* or *Co-Insurance*. In no event will *We* reimburse *You* for more than one routine physical examination, one Hearing Test and one Sight Test during any 12 month period. (This benefit is not available on Bronze and Silver *Sub-Plans.)*

B17. Child Wellness and Health Check

If *You* are under 18 years of age, *We* will pay *Reasonable and Customary Charges* toward the costs incurred by *You* during a *Period of Insurance* for the following expenses up to the *Sub-Limit* shown in the *Schedule of Cover and Excesses* applicable to *Your* chosen *Sub-Plan*, per *Period of Insurance*, provided at least 12 months have elapsed since *Your* most recent routine physical examination, and provided *You* have been continuously insured under *Your Plan* for not less than 12 months (6 months for those covered on the Platinum *Sub-Plan*):

(i) One routine physical examination, Hearing Test and Sight Test; and

(ii) Routine inoculations and vaccinations commonly administered to *children* less than 18 years of age in accordance with standard medical practice.

Wellness expenses are not subject to *Annual Excess* or *Co-Insurance*. In no event will *We* reimburse *You* for more than one routine physical examination during any 12 month period. (This benefit is not available on Bronze *Sub-Plan*).

B18. *Pre-Existing Conditions*

The following provision applies to the Bronze *Sub-Plan*:

All *Pre-Existing Conditions* existing at the time of *Application* are excluded from cover, irrespective of whether *You* disclosed them on *Your Application*, or if *Your Application* was on a Moratorium Enrolment or Full Medical Underwriting basis.

The following provision applies to the Silver, Gold and Gold Plus *Sub-Plans*:

Eligible Charges will be paid for *Medical Conditions*, which *You* fully disclose on *Your Application* and which *We* have accepted and agreed to provide cover in

writing and which are not excluded or restricted through an *Endorsement* attached to *Your Certificate of Insurance* provided that *You* have been continuously covered by this *Plan* for a period of twenty four (24) months. *Eligible Charges* will be limited to a maximum per *Period of Insurance* and, subject to the *Lifetime Limits* (independent of the *Limit* selected by *You*) as indicated in the *Schedule of Cover and Excesses*. Any cover provided after twenty four
(24) months shall not include any charges, fees, costs, expenses and/or claims for any *Non-Disclosed Conditions*. Please see Section G Exclusions.

The following provision applies to the Platinum *Sub-Plan*:
Eligible Charges will be paid for *Pre-Existing Conditions*, which *You* fully disclose on *Your Application* and which *We* have accepted and agreed to provide cover in writing and which are not excluded or restricted through an *Endorsement* attached to this *Policy Wording.* Any cover provided shall not include any charges, fees, costs, expenses and/or claims for any *Non-Disclosed Conditions*. Please see Section G Exclusions.

In respect of all *Sub-Plans:* *We* reserve the right to offer alternative *Terms*, decline cover for any specific *medical condition* or to decline any *Application* in its entirety without giving any reason.

B19. Newly Diagnosed Chronic Conditions
We will pay *Eligible Charges* for a *Chronic Condition* which is not a *Pre-Existing Condition.*

B20. Mental & Nervous
We will pay *Eligible Charges* for *Out-Patient Treatment* on all *Sub-Plans* (except Bronze *Sub-Plan*) and for *In-Patient Treatment* on all *Sub-Plans* except Bronze and Silver, administered at all times under the direct control of a registered psychiatrist, including *Specialist* consultations for the *Treatment* of *Mental or Nervous Disorders*, provided *You* have been continuously insured under the *Plan* for not less than 12 months immediately preceding *Treatment*. Benefits are subject to the *Sub-Limits* per *Period of Insurance* and *Lifetime Limit* as indicated for each *Sub-Plan* in the *Schedule of Cover and Excesses*.

All *Treatment* with respect to this benefit must be *Pre-Certified*. However, the initial consultation with a *Medical Practitioner* (not Psychiatric *Specialist*) which results in a Psychiatric referral is covered without the requirement for *Pre-Certification*.

SECTION C: Travel, Transportation and Out of Area Benefits

Subject to all the *Terms* of this Policy Wording, including the *Sub-limits* and *Lifetime Limits,* as indicated in the Schedule of Cover and Excess for each *Sub-Plan*, *We* will pay the following:

C1. *Emergency* Local Ambulance
We will pay *Eligible Charges* incurred by *You* for *Emergency Local Ambulance Transport* to *Hospital* by the most appropriate transport considered *Medically Necessary* by a *Medical Practitioner or Specialist* to *Treat* an *Eligible Medical Condition,* in connection with an *Illness* resulting in *Hospitalisation* and *Injury*.

C2. *Emergency* Evacuation and Transportation
We will pay, subject to the maximum limits as indicated in the *Schedule of Cover and Excesses* for each *Sub-Plan,* and other *Terms* of this *Plan*, including the Conditions and Restriction set forth below, *Reasonable and Customary Charges* incurred by *You* arising out of, or in connection with *Your Pre-Certified Emergency Medical Evacuation* occurring while *Your Plan* is in effect and during the *Period of Insurance*:

1. *Emergency* air transportation to a suitable airport nearest to the nearest appropriate medical facility within *Your* selected *Geographic Area of Cover* for the purpose of admission to *Hospital* where *You* will receive *Medically Necessary Treatment* directly related to an *Eligible Medical Condition;* and

2. *Emergency* ground transportation necessarily preceding *Emergency* air transportation and from the destination airport to the *Hospital* where *You* will receive *Treatment*; and

3. Return ground and air transportation, upon medical release by the attending *Medical Practitioner*, to the country where the evacuation initially occurred or to the *Insured Person's Home Country*, at the *Insured Person's* option.

Conditions and Restrictions: To be eligible for coverage under this Section:

a. *Your Eligible Medical Condition* is an *Emergency* and *You* must be in compliance with all *Terms* of this *Plan;* and

b. The *Medical Condition, Illness, Injury* or occurrence necessitating *Emergency Medical Evacuation* is covered under the *Terms* of this *Plan*; *and*

c. *Emergency Medical Evacuation* must be recommended by *Your* attending *Medical Practitioner*, who must provide certified instructions in writing to *Us* confirming that *Medically Necessary Treatment* for *Your Eligible Medical Condition* is not available locally and transportation by any other method may result in loss of *Your* life or limb based upon reasonable medical certainty within 24 hours; and

d. *You or Your Relative* agree to the *Emergency Medical Evacuation;* and

e. *Emergency Medical Evacuation* is subject to *Pre-Certification and approved by Us* prior to transportation and all arrangements must be coordinated and approved by *Us*; Transportation will be limited to economy class unless it is *Medically Necessary* to do otherwise; and

f. The *Eligible Medical Condition*, *Illness, Injury* or occurrence giving rise to the *Emergency Medical Evacuation* occurred suddenly and/or spontaneously, and without: (i) advance warning, (ii) advance *Treatment,* diagnosis or recommendation for *Treatment* by a *Medical Practitioner*, or *(iii)* prior manifestation of symptoms or conditions which would have caused a prudent person to seek medical attention prior to the onset of the *Emergency.*

We will arrange *Emergency Medical Evacuation* only to the nearest *Hospital* that is qualified to provide the *Medically Necessary Treatment* to prevent *Your* loss of life or limb.

The *Insured Person* may select a different *Hospital* in his/her *Home Country* at his/her option, but in such event shall retain for the *Insured Person's* own account and responsibility all costs and expenses in excess of the amounts that would have been incurred to the nearest qualified *Hospital*. If a *Hospital* other than the nearest qualified *Hospital* is selected by the *Insured Person*, the attending *Medical Practitioner*, *Insured Person*, or a *Relative* of the *Insured Person* shall certify to *Us* the *Insured Person's* understanding and acknowledgement of such responsibility for excess costs and expenses in addition to the matters set forth in subsection c) of the Conditions and Restrictions, above. In all cases the *Plan Administrator* will make the necessary arrangements for the *Emergency Medical Evacuation*.

We will use *Our* best efforts to arrange with independent, third-party contractors any *Emergency Medical Evacuation* within the least amount of time reasonably possible. By acceptance of this *Plan* and request for *Emergency Medical Evacuation* coverage herein, the *Insured Person* understands and agree that the timeliness, duration, and outcome of an *Emergency Medical Evacuation* can be affected by events and/or circumstances which are not within the *Our* direct control or supervision, including but not limited to: availability and performance of competent transportation equipment and staff; delays or restrictions on flights or other modes of transportation caused by mechanical problems, government officials, telecommunications problems, non-availability of routes and/or other travel, geographical or weather conditions; and other acts of God and unforeseeable and/or uncontrollable occurrences. *You* agree to release and hold *Us, Our Plan Administrator, the Plan Manager* and *Our* agents and representatives harmless from, and agree that *We, Our Plan Administrator, the Plan Manager* and *Our* agents and representatives shall not be held liable for any delays, losses, damages, further injuries or illnesses or other claims that arise from or are caused by the acts or omissions of such independent third-party contractors, or that arise from or are caused by any acts, omissions, events or circumstances that are not within the direct and immediate supervision or control of *Us, Our Plan Administrator, the Plan Manager* and/or *Our* authorised agents and representatives, including without limitation the events and circumstances set forth above.

You further agree that upon seeking an *Emergency Medical Evacuation*, *You* will cooperate fully as required above and that failure to so cooperate and/or failure to use or accept *Emergency Medical Evacuation* once it has been arranged by *Us* will require the *Insured Person* to reimburse *Us* for costs incurred for any *Emergency Medical Evacuation* that was arranged, but not used, by the *Insured Person*. Furthermore, the *Insured Person* may be required to arrange for payment of any subsequent *Emergency Medical Evacuation* and seek reimbursement thereafter for eligible costs associated with that subsequent *Emergency Medical Evacuation*, and/or result in denial of future claims for *Emergency Medical Evacuation* or, at *Our* discretion, only reimbursement for eligible costs associated with any *Emergency Medical Evacuation* request subsequently made and paid for by *You*.

C3. <u>Accompanying *Relative*, Travel and Accommodation</u>

Subject to the *Terms* of this *Plan* as shown in the *Schedule of Cover and Excesses*, *We* will reimburse *You,* per *Period of Insurance*, in cases where there has been an *Emergency Medical Evacuation* covered under the *Terms* of this *Plan* and the *Relative* or friend were not responsible for *Injury* or *Illness*.

Subject to the applicable *Excess* and *Co-Insurance* and other limits and *Sub-Limits* as specified in the *Schedule of Cover and Excesses*, and subject to the <u>Conditions and Restrictions</u> set forth below, the following *Pre-Certified* costs and expenses incurred in respect of travel by a *Relative* or friend of the *Insured Person* will be reimbursable to the *Insured Person* upon *Our* recommendation and prior approval:

1. the reasonable cost of an economy return air ticket for one *Relative* or friend from the airport nearest to the location of the *Relative* or friend at the time of the *Emergency* to the airport serving the area where *You* are *Hospitalised* as a result of the *Emergency* or are to be *Hospitalised* as a result of the *Emergency Medical Evacuation* (to be determined pursuant to the *Terms* of the <u>Conditions and Restrictions</u>, below), and return from whichever of such locations is actually selected to the point of the original departure; and

2. reasonable and necessary costs incurred as a result of an *Emergency Medical Evacuation,* for:
   a. travel and transportation to and from medical appointments when *Treatment* is being received as an *In-Patient* or *Day-Patient*;

   b. meals for *You* and *Your Pre-Certified Relative* or friend, up to a maximum of $25/£13.75/€16.75 per person, per day;

c. Accommodation expenses outside of a *Hospital,* (up to a maximum of $180/£100/€120 per person, per day (but excluding entertainment), for *You* and a *Pre-Certified Relative* or friend which immediately precedes or immediately follows *Hospital* admission, and provided that *You* are under the care of a *Specialist*.

Conditions and Restrictions:

a. The allowable period of coverage for this Accompanying *Relative*, Travel and Accommodation benefit shall not exceed fifteen (15) days, including travel days, and all costs and expenses incurred beyond such *Period of Insurance* shall be retained for the sole account and responsibility of the *Insured Person*, *Relative*, or friend; and

b. the Accompanying *Relative*, Travel and Accommodation costs incurred must be due to an *Emergency Medical Evacuation* covered under the *Terms* of this *Plan*; and

c. the *Insured Person* must be so seriously ill that the attending *Medical Practitioner* deems it necessary and recommends the presence of a *Relative* or friend at either the location where *You* are being evacuated from or the destination of the evacuation, whichever is considered by the attending *Medical Practitioner* and *Us* to be the more reasonable; and

d. all Accompanying *Relative* travel, transportation and accommodation arrangements and benefits must be coordinated and approved in advance by *Us* in order to be eligible for coverage under this insurance.

e. The *Insured Person*, *Relative* and/or friend must submit to *Us* upon completion of the Emergency Reunion travel legible and verifiable copies of all paid receipts for the travel and transportation costs and expenses so incurred for which reimbursement is sought.

(This benefit is not available on Bronze and Silver *Sub-Plans.)*

C4. Cremation/Burial or Return of Mortal Remains

In the event *You* die during a *Period of Insurance* as a result of an *Eligible Medical Condition* while *You* are outside of *Your Home Country*, *We* will reimburse the authorised personal representative or *Your* estate for *Reasonable and Customary Charges* toward the costs of: transportation of *Your* mortal remains (but not including any costs of burial of *Your* body) from place of death to *Your Home Country* or *Country of Residence*, and thereafter to the place of burial or other final disposition (but not including any costs of burial or other disposition), provided that all transportation charges are *Pre-Certified* and coordinated by *Us*; **or** preparation, local burial or cremation of *Your* mortal remains at the place of death in accordance with the commonly recognised, accepted cultural and religious beliefs practiced by *You.*

Cover is not provided for burial and cremation costs incurred for religious practitioners, flowers, music, food or beverages. No cover is provided under this Section for any costs incurred where *Your* death has occurred within *Your Home Country.*

C5. Remote Transportation Benefit (Applicable to Platinum *Sub-Plan* Only)

Subject to the *maximum limit* set forth in the *Schedule of Cover and Excesses*, and the other *Terms* of this Policy Wording, including the Conditions and Restrictions set forth below, *We* will reimburse *You* for the following *Pre-Certified* expenses incurred by *You* arising out of or in connection with Remote Transportation expenses occurring during a *Period of Insurance*:

1. Direct costs and other *Reasonable and Customary Expenses* arising out of travel to the nearest *Qualified Facility* where *You* will receive *Treatment;* an

2. Accommodation charges with respect to *Your* transportation to the *Qualified Facility*.

Conditions and Restrictions - To be eligible for coverage for Remote Transportation benefits *You* must be in compliance with all *Terms* of this *Plan*. *We* will provide Remote Transportation benefits only when the *condition, Illness, Injury* or occurrence giving rise to the Remote Transportation is covered under the *Term*s of *Your Plan*.

We will provide Remote Transportation benefits only when all of the following conditions are met:

1. If, after *You* receive the first *Treatment* required to stabilise or diagnose the medical situation in a *Hospital* or a clinic, *Your* condition is still considered to be:

   a. a serious *Medical Condition* that requires non-*Emergency Treatment* and only basic necessary treatment is available at *Your* first *Treatment* facility; or

   b. a critical medical situation for which no official diagnosis can be obtained at the current facility.

2. Remote Transportation is recommended by the attending *Medical Practitioner* who certifies to the matters in subparagraphs 1(a) or (b), above; and

3. Remote Transportation is agreed to by *You* or a *Relative* of *Yours*; and

4. Remote Transportation is approved in advance and all arrangements are coordinated by *Us*; and

5. The severity of the critical medical situation, the absence of a *Qualified Facility*, and the necessity of the Remote Transportation must be confirmed by both the local treating *Medical Practitioner* and *Us*.

C6. Security & Political Evacuation & Repatriation Benefit (Applicable to Platinum *Sub-Plan* Only)

If the Bureau of Consular Affairs (or similar Governmental Organisation) or Local Embassy, of the Government of *Your Home Country* issues a mandatory evacuation order of all non-emergency governmental personnel from the country in which *You* are located, that becomes effective on or after *Your* date of arrival in the *Country* and within *Your Period of Insurance*, *We* will pay, up to *Lifetime Limit* as shown in the *Schedule of Cover and Excesses,* for the most appropriate and economical means of transportation, to the nearest place of safety or for repatriation to *Your Home Country* or *Country of Residence*; and

If *You* are evacuated from *Your Country of Residence*, then coverage is extended to an economy return flight to *Your Country of Residence* once the mandatory evacuation order is cancelled, as long as *Your* date falls within *Your Period of Insurance* and the cost of this return airfare is no more than a one way economy departure ticket.

Provided that:

i. The evacuation order applies specifically to *You* and is in effect; and
ii. *You* contact *Us* within 10 days of the evacuation order being issued; and

iii. The Security and Political Evacuation is approved and co-ordinated by *Us*.

In no event will *We* pay for a Security and Political Evacuation if *Your Home Country* government issues a travel advisory or warning that travel is hazardous or not advised, covering the country in which *You* are travelling at the time of purchase or that is in effect on or within six months prior to *Your* date of departure from *Your Home Country*.

C7. Worldwide Accident and *Emergency* Out of Area Cover

When *You* are temporarily travelling outside of *Your* selected *Geographic Area of Cover*, *We* will pay *Eligible Charges* for essential *Treatment* of an *Injury*; *Emergency Treatment* required for a new *Eligible Medical Condition*; and *Emergency Treatment* of an acute episode or exacerbation of an *Eligible Medical Condition*. Complications of *pregnancy* and/or childbirth are not deemed to be *Accident* or *Emergency Treatment* for the purposes of Section C7. Cover is provided up to the maximum of thirty (30) days per *Period of Insurance* (15 days under the Bronze *Sub-Plan*). All *Treatment* must be *Pre- Certified*.

In the event of *Emergency Treatment* being required in the USA, *Treatment* must be received from a Preferred Provider Organisation (PPO).

No cover is provided under Section C7 for charges, costs or expenses:

i. With respect to any condition which existed prior to the first date of travel and was likely to recur or require *Treatment* over the duration of the trip.

ii. Where travel has occurred specifically for the purpose or with the intention of seeking or obtaining *Treatment* or where *You* have travelled knowing that *You* would need *Treatment*.

iii. Where *You* have travelled against medical advice.

iv. For *Treatment* which could have reasonably been delayed until *Your* return to *Your Country of Residence*.

v. Incurred after expiry of the total maximum number of thirty (30) days of travel outside of *Your* selected *Geographic Area of Cover* per *Period of Insurance*.

vi. For *Treatment* incurred in an amount greater than $900/£500/€750 which is not *Pre- Certified* or any *Hospital* admission which is not *Pre-Certified*.

vii. For *Treatment* incurred in the USA outside of the PPO Network.

SECTION D: *Dental Treatment* and Vision Care Benefits

Subject to all the *Terms* of this Policy Wording, including the *Sub-limits* and *Lifetime Limits,* as indicated in the *Schedule of Cover and Excesses*, *We* will pay the following:

D1. *Emergency Dental Treatment* Due to Accident

We will pay *Eligible Charges* for *Emergency Dental Treatment* and dental *Surgery* necessary to restore or replace sound natural teeth lost or damaged in an *Accident* that is covered under this *Plan,* except when the damage has been caused through eating. *Treatment* must be received within five (5) days from the date of the *Accident* occurring.

D2. *Emergency Dental Treatment* due to Sudden and *Unexpected* Pain to Sound Natural Teeth

We will pay *Eligible Charges* for *Emergency Dental Treatment* when given by a *Medical Practitioner* or

Dental Practitioner for *Treatment* for the express relief of *Sudden and Unexpected* pain in sound, natural teeth, including, but not limited to fillings, up to $100/£55//€70 per *Period of Insurance*.
(This benefit is not available on the Bronze or Silver *Sub-Plans*)

D3. – D6. Non *Emergency Dental Treatment* (Applicable to Platinum *Sub-Plan* Only, unless *Your Certificate of Insurance* confirms *You* have paid the applicable additional *Premium* for the Dental & Vision Care Coverage Optional Add-On Coverage)

IMPORTANT NOTE: With respect to Sections D3, D4, D5 and D6 of this *Policy Wording*, coverage for *Dental Treatment* is dependent upon *You* meeting the following conditions:

i. *You* must have had a dental check up with *Your Dental Practitioner* within 12 months prior to the *Effective Date*; and

ii. *You* must complete all *Treatment* which was recommended on or prior to the *Effective Date* and remains outstanding on the *Effective Date*.

If *You* have not done so, *You* will be required to complete all recommended *Treatment* at *Your* next consultation, at *Your* own cost.

At *Our* discretion *We* may request written proof of i) and ii) above from *Your Dental Practitioner*. No cover for *Dental treatment* will be provided under *Your Plan* until the above conditions have been met.

Subject to the *Terms* of this *Plan*, including without limitation the *Annual Excess*, *Co-Insurance*, and the various limits and *Sub-Limits* set forth in the *Schedule of Cover and Excesses* above, and the Section G. Exclusions set forth below and subject to the Conditions and Restrictions below, *We* will reimburse *You* for the following costs, charges and expenses (“Charges”) incurred by *You* during a *Period of Insurance* and after 180 days from the *Effective Date*, so long as the Charges are *Reasonable and Customary* and are incurred for *Treatment* or supplies that are *Medically Necessary* (“Eligible Dental Expenses”).

D4. Class I *Treatment*: (Preventive, Diagnostic and Palliative services not subject to any Dental *Annual Excess* and payable at 90%)

1. Prophylaxis, diagnostic exam and bitewing x-rays (limited to 4 bitewing x-rays per year) including scraping, cleaning and polishing, covered twice in any calendar year with at least a six month period between visits; and

2. *Palliative Treatment*; and

3. Fluoride *Treatment* once per calendar year for *children* under age 19.

D5. Class II *Treatment*: (Subject to Dental *Annual Excess* and payable at 70% of Usual, Reasonable and Customary fees)

1. Radiographs, Full mouth x-rays, including panographic x-rays covered once in a three year period; and

2. Amalgams, plastic and synthetic restorations; and

3. Relines and repairs to prosthetic appliances; and

4. Oral *surgery*, extractions; and

5. Endodontics, including root canals; and

6. Periodontic services, treatment for gum disease; and

7. Re-cementing crowns, inlays, and bridges; and

8. Local and/or General anesthesia determined upon the level or degree of dental procedures being performed.

D6. Class III *Treatment*: (Subject to Dental *Annual Excess* and payable at 50% of Usual, Reasonable and Customary fees)

1. Prosthodontic services, including appliances, bridges, full and partial dentures that replace missing natural teeth that were extracted while the person is covered with this *Plan*. No more than one full upper and lower denture shall be covered in any five year period; and

2. Partial dentures, fixed bridge or removable bridge will not be covered for any one patient more than once in a five year period except where loss of additional teeth requires construction of a new appliance; and

3. Replacement of denture base material or reline is covered once in any 36 month period; and

4. Major restorations such as crowns, jackets, gold-related services required when teeth cannot be restored using other filling material. Crowns, jackets or inlays on the same tooth covered once in any 5-year period. Porcelain crowns, porcelain fused to metal or resin processed to metal type crowns is not covered for patients under 12 years of age.

Conditions and Restrictions - For the purpose of this *Policy Wording*, the below time limitations are to be measured from the date on which those services were last supplied under this *Dental plan*.

1. Benefits for prophylaxes and oral exams are payable twice in any period of 12 consecutive months; and

2. Benefits for bitewing X-rays are payable once in any period of 12 consecutive months. Benefits for full mouth X-ray (which include bitewing x-rays) are payable once in any five-year period. A panographic X-ray (including bitewing x-rays) is considered a complete mouth X-ray and is paid as such.

3. Benefits for full porcelain, porcelain/resin processed to metal, full cast or three quarter cast crowns are not payable if *You* are under 12 years of age; and

4. Benefits for root planting are payable once in any two-year period. Benefits for periodontal *Surgery*, including subgingival curettage, are payable once in any three-year period; and

5. Optional *Treatment*: In all cases in which *You* select a more expensive service than is customarily provided, or for which a valid dental need is shown, *We* will pay only the applicable percentage of the fee for the service, if any, that is customarily provided; and

6. Prosthodontic benefits:
   a. Benefits for one complete upper and once complete lower denture are payable once in any five-year period for any individual; and
   b. Benefits for a partial denture, fixed bridge or removable bridge for any individual are payable only once in any five-year period unless the loss of additional teeth requires the construction of a new appliance; and
   c. Benefits for fixed bridges and removable cast partials are not payable for people under 16 years of age; and

7. Benefits for a reline or the complete replacement of denture base materials are payable once in any three-year period for any individual.

D7. Vision Care
(Applicable to Platinum *Sub-Plan* Only, unless *Your Certificate of Insurance* confirms *You* have paid the applicable additional *Premium* for the Dental & Vision Care Coverage Optional Add-On Coverage)

Subject to the *Terms* of this *Policy Wording*, *We* will reimburse *You* for the following Eligible Expenses incurred for vision care:

1. Exam - Up to $100/£55/€70 every twenty-four (24) months for a routine eye examination; and/or

2. Corrective – Up to $150/£85/€100 every twenty-four (24) months for corrective lenses, contacts to correct vision and frames.

SECTION E: Additional Benefits & Services

E1. High School Sports *Injury*
(Applicable to Platinum Sub-Plan ONLY)

Subject to the *Terms* of this *Plan*, including without limitation the *Annual Excess*, *Co-Insurance*, and limits and *Sub-Limits* set forth in the *Schedule of Cover and Excesses* and the Section G. Exclusions, *We* will reimburse *You* for *Eligible Charges* incurred with respect to *Injury* or *Illness* suffered or sustained by an *Insured Person* (aged under 20 years) while engaged in a high school sports activity, that occurs within a school, or is organised or sanctioned by a school, including when it is part of a school team, competition or interschool league, including but not limited to the following high school sports:

American football, archery, athletic, field and track events, badminton, baseball, basketball, canoeing & kayaking, cheerleading & dance, cricket, cross-country, fencing, field hockey, gymnastics, ice hockey, judo, karate, lacrosse, netball, rock and drywall climbing, rounders, rowing, rugby, sailing, skiing & snow-boarding, soccer, softball, tennis, squash, swimming & diving, volleyball and wrestling.

E2. Recreational Scuba

Subject to the *Terms* of this Policy Wording, including without limitation the *Annual Excess*, *Co-Insurance*, and limits and *Sub-Limits* set forth in the *Schedule of Cover and Excesses* and the Section G. Exclusions, and the Special Exclusions and Limitations below, *We* will reimburse *You* for *Eligible Charges* incurred by *You* with respect to an *Illness* or *Injury* suffered or sustained by *You* while engaged in *Sports Diving* during the *Period of Insurance*, so long as the same is carried out in strict accordance with the guidelines, codes of good practice, and recommendations for safe diving practices as laid down by an Authoritative Diving Body.

Special Exclusions and Limitations:
In addition to the Section G. Exclusions set forth in this *Policy Wording*, this *Plan* does not cover any charges, costs, expenses and/or claims incurred by *You* relating to, arising from, as a consequence of, or in connection with, directly or indirectly, any of the following acts, omissions, events, occurrences or conditions:

1. Diving by *You* without holding a recognised certificate issued by an Authoritative Diving Body for the type of diving being undertaken, or not under professional instruction;
2. Diving without proper and well-maintained equipment in good working order and/or contrary to the guidelines, codes of good practice and/or recommendations as laid down by the Authoritative Diving Body under which *You* have been certified;
3. Diving to depths greater than thirty (30) meters, or diving requiring decompression stops;

4. Solo diving;
5. Any form of cave diving;
6. Flying within twenty-four (24) hours of the last dive or diving within ten (10) hours of flying;
7. Diving for hire, reward, or treasure;
8. Diving while suffering from a cold, influenza or any other condition, *Illness* or *Injury* causing an obstruction of the sinuses or ears, or diving while otherwise medically unfit to dive;
9. Diving by anyone under twelve (12) years of age or over sixty-five (65) years of age;
10. Willfully *self-inflicted Injury* or *Illness*, the effects of Alcohol or *Drugs* (other than as prescribed by a licensed *Medical Practitioner* in full awareness of *Your* sub-aqua activities) and any self exposure to needless peril (unless in an attempt to save human life);
11. Any condition for which *You* were undergoing, recovering from or awaiting *Treatment* immediately prior to the sub-aqua activities;
12. Diving with artificial or other underwater breathing apparatus containing any gas other than compressed air.

It is a condition precedent to *Our* liability under this *Plan* that any prospective diver applying for coverage under this insurance is medically fit to dive. If in any doubt, *You* should refrain from participating in Scuba diving until medical advice and approval has been obtained from a qualified *Medical Practitioner*. (This benefit is not available on the Bronze and Silver *Sub- Plan*).

E3. Medical Information Service (Applicable to Platinum *Sub-Plan* ONLY)

You will have worldwide access to a range of medical information services including certified physicians, licensed psychologists and pharmacists to assist with any routine health related questions.

This service is provided by a third party and details issued under separate documentation. Please refer to *Your* separate documentation for a complete description of the service and how to access it – available upon request. Neither *We* nor *Our Plan Administrator* nor the *Plan Manager* accept any liability, directly or indirectly, for any claim or service provided under Section E3 of this *Policy Wording*.

E4. Global Concierge & Assistance Services (Applicable to Platinum *Sub-Plan* ONLY)

Platinum *Sub-Plan Insureds* have exclusive access to a list of additional services handled by a dedicated service team available 24/7. Non-insured assistance services available for *Your* convenience include: Security Updates and Country Profiles online 24/7, Bag Tracking Service for Lost Checked-In Luggage, Pre-Trip Health & Safety Advisories, Embassy & Consulate Referral, *Emergency* Cash Transfer Assistance, *Emergency* Message Relay, *Emergency* Return Home Travel Arrangements, Legal Referrals, Lost Passport & Travel Documents Assistance, Dedicated Worldwide Platinum Customer Service Number and Claims Team, Prescription Drug Replacement Assistance and Drug Translation Service.

We reserve the right to update, add, remove or amend this list of services without notice from time to time.

E5. 24 Hour *Emergency* Helpline

The services of an assistance helpline are available 24 hours a day, 365 days a year to assist *You* where possible with any *Medical Emergency* or *Emergency Medical Evacuation* covered under *Your Plan*. *We* will liaise with *Your Specialist* or *Medical Practitioner* in arranging *Your* admission to *Hospital*, ambulance transfers and air evacuation where *Medically Necessary*.

During an *Emergency Medical Evacuation*, *Our Plan Administrator* will co-ordinate evacuation to a *Qualified Facility* equipped to handle *Your Eligible Medical Condition*. A team of independently contracted pilots and medical professionals will transport *You* as is medically required under the *Terms* of this *Policy Wording*.

Our 24 hour *Emergency* telephone number is:

Outside the USA/Canada (UK): +44 (0) 2920 47 42 35
Within the USA/Canada (USA): +1 317 655 4500

Please ensure that *You* have the following information to hand when *You* call:

- Name of *Insured Person*
- Policy Number
- Telephone and/or fax number
- Location of *Insured Person*
- The medical *emergency*

In the event of an *Emergency* or *Emergency* admission, please do not delay obtaining *Emergency Treatment*.

SECTION F: Maternity Cover

This Section F in its entirety is Applicable to Platinum *Sub-Plan* Only.

IMPORTANT NOTE: No maternity cover is provided, including cover for complications of *Pregnancy*, until *You* have been continuously insured under *Your Plan* for at least 10 consecutive months immediately preceding the incurring of *Eligible Charges* for maternity benefits. In addition, no coverage will be provided under this Section F if the *Pregnancy* is a result of Invitro Fertilisation.

Subject to the *Terms* of this *Policy Wording* including without limitation the *Maternity Annual Excess*, *Co-Insurance*, and limits and *Sub-Limits* set forth in the *Schedule of Cover and Excesses* and the Section G. Exclusions, *We* will pay maternity charges as follows:

F1. Normal *Pregnancy* and Delivery
We will pay *Eligible Charges* for normal *Pregnancy* and childbirth, including complications thereof; *Medically Necessary* pre and post-natal care, routine natal care, check-ups and scans for a natural birth. However, no cover is provided for antenatal classes; midwifery which is not associated with childbirth and delivery.

F2. C-Section Delivery
We will pay *Eligible Charges* for a caesarean section required on medical grounds and *Treatment* consequent upon such delivery. However, no cover is provided for an optional caesarean section or a caesarean section required due to a previous optional caesarean section or as a result of multiple births due to assisted conception *Treatment*, and no cover is provided for *Treatment* consequent upon such delivery.

F3. *Newborn* Wellness
We will pay for routine and *Medically Necessary* care of a *Newborn* during the first thirty-one (31) days of life, if the delivery of the *Newborn* and the charges incurred are eligible for coverage and are covered under the *Terms* of this *Plan.* In addition, *We* will pay *Eligible Charges* for routine wellness and *Medically Necessary* care of the *Newborn* following the first thirty-one (31) days of life through the first 12 months of life, not to exceed $200/£110/€134 *Lifetime Limit* if the delivery of the *Newborn* and the charges incurred are eligible for coverage and covered under the *Terms* of this *Plan*.

F4. Cover for *Newborns* including *Treatment* of Non-Heredity Birth Defects and Congenital Abnormalities
We will pay *Eligible Charges* up to the *Sub-Limits* shown in the *Schedule of Cover and Excesses* for:

i. *In-Patient Treatment* of an *Eligible Medical Condition, including* premature baby *Treatment* (i.e. where birth is prior to 37 weeks gestation) being suffered by *Your Newborn* which manifests itself within 31 days following birth. This benefit is limited to a maximum of 31 days *Hospital* stay.

ii. *Treatment* of birth defects and congenital abnormalities relating to *Your Newborn* which neither parent is aware exists prior to the Effective Date, and neither parent suffers from himself or herself and which is not incurred in either parent's mother, father, brother, sister, grandparent, aunt or uncle. No cover is provided for birth marks.

In the event of a multiple birth, the sum insured is the maximum amount that can be claimed regardless of the number of *children* born.

After the *Newborn* benefit period has expired, *You* may apply for independent cover for *Your Newborn* under his or her own *Plan*.

SECTION G: Exclusions

(Please note: Unless specifically stated otherwise, each exclusion below relates to all *Sub-Plans*)

We will not pay any charges, fees, costs, expenses and/or claims (collectively called "charges") *You* incur which directly or indirectly relate to, or arise from, or are in connection with any of the following acts, omissions, events, conditions, charges, claims, consequences, *Treatments* (including diagnosis, consultations, tests, examinations, and evaluations related thereto), services and/or supplies. All such charges are expressly excluded from coverage under this *Plan*, and *We* shall provide no benefits or reimbursements and shall have no liability or obligation for any coverage thereof or herefor:

1. **Applicable to Bronze *Sub-Plan***: Any *Pre-Existing Condition;*
   Applicable to Silver, Gold and Gold Plus *Sub-Plans*: Any *Pre-Existing Condition*; however, if *You* disclosed *Your Pre-Existing Conditions* in writing on the *Application* which was accepted by *Us*, and *We* have agreed to provide cover in writing, and *You* have been continuously insured under *Your Plan* for at least 24 consecutive months immediately preceding the incurring of *Eligible Charges* for any *Pre-Existing Condition*, then limited cover is provided under Section B18 of this *Policy Wording;*
   Applicable to Platinum *Sub-Plans*: Any *Pre-Existing Condition;* however, if *You* disclosed *Your Pre-Existing Conditions* in writing on the *Application* which was accepted by *Us*, and *We* have agreed to provide cover in writing, then cover is provided under Section B18 of this *Policy Wording*.

2. Any *Non-Disclosed Condition.*

3. Any *Chronic Condition* which is a *Pre-Existing Condition*.

4. **Applicable to Bronze, Silver, Gold and Gold Plus *Sub-Plans***: Any *Congenital Disorders* and conditions arising out of or resulting there from.
   Applicable to Platinum *Sub-Plan* Only: Any *Congenital Disorders* and conditions arising out of or resulting there from which exceed the $250,000/ £137,500/ €167,500 maximum and/or are incurred after the first 31 days of life.

5. **War; Military Action**: Subject to the *Terms* of above and below, *We* shall not be liable for and *We* will not provide coverage or benefits for any claim or charges incurred with respect to any *Illness, Injury* or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising or incurred in

connection with or as a result of any of the following acts or events:

i. War or any act of war (whether declared or not), invasion, act of foreign enemy hostilities, warlike operations, civil war;

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

iii. Attempted overthrow of government, any act of any person acting on behalf of or in connection with any organisation with activities directed towards the overthrow by force of the government de jure or de facto or to the influencing of it by violence of any type;

iv. Martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege; or

v. Any use of any radiological, chemical, nuclear or biological weapons or any other radiological, chemical, nuclear or biological events of any type (including in connection with an act of *Terrorism*).

6. ***Terrorism*:** *We* shall not be liable for and will not provide coverage or benefits for any claim or charges, *Illness, Injury* or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with any act of *Terrorism*; except where *You* sustain injury whilst an innocent bystander and then the maximum limit payable will be $10,000/ £6,700/€5,500; and provided, further, *We* shall not be liable for and will not provide any coverage or benefits for any claim, charges, *Illness, Injury* or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with the *Insured Person*'s active and voluntary planning or coordination of or participation in any act of *Terrorism*.

7. Any charges incurred by *You* for *Treatment* or supplies outside the *Area of Cover* are excluded, other than those specifically provided under Section C7 Worldwide Accident & *Emergency* Out of Area Coverage.

8. **Applicable to Bronze, Silver, Gold and Gold Plus *Sub-Plans*:** *Treatment* of any condition of: allergies; asthma; any condition of the breast or the prostate; tonsillectomy; adenoidectomy; haemorrhoids or haemorrhoidectomy; any disorder of the reproductive system; hysterectomy; intervertebral disc disease; hernia; gall stones or kidney stones; which:

   i. exist, or

   ii. manifest themselves, or

   iii. involve procedures which take place or are recommended, during the first 180 days of cover under *Your Plan,* beginning on the *Original Effective Date*.

   Please note: Cover for *Treatment* relating to any of these conditions may be separately or further limited or excluded under the *Pre-Existing Condition* exclusion and definition and/or the *Chronic Condition* limitation and definition.

9. **Applicable to Bronze, Silver, Gold and Gold Plus *Sub-Plans*:** All charges related to Maternity, *Pregnancy*, including charges for pre-natal care, delivery, post-natal care, and care of *Newborns* including Complications of *Pregnancy*, miscarriage, complications of delivery and/or complications of *Newborns.*

   Applicable to Platinum *Sub-Plan* Only:
   Charges related to *Pregnancy* until this *Plan* has been in force for ten (10) months unless the *Pregnancy* is a result of Invitro Fertilisation, then all charges related to *Pregnancy*, including pre-natal care, delivery, post-natal care, and care of newborns are excluded.

10. Optional abortion or *Pregnancy* termination, other than miscarriage, ectopic *Pregnancy* and still birth.

11. Charges incurred for any *Treatment* or supply that either promotes or prevents or attempts to promote or prevent conception or birth; including but not limited to: birth control, sterilisation (or its reversal), vasectomy (or its reversal), contraception, infertility, fertility, surrogacy, oral contraceptives, impotence, conception, artificial insemination, *Treatment* for infertility or any form of assisted conception or assisted reproduction or any complication thereof including but not limited to premature or multiple births following assisted conception.

12. Rest cures, institutionalisation, isolation, quarantine, or sanatorium care.

13. Any *Charges* for any *Treatment,* service or supply that is:

    i. not incurred, obtained or received by *You* during the *Period of Insurance*;

    ii. not presented to *Us* for payment by way of a complete Proof of Claim within ninety (90) days of the date such *Charges* are incurred;

    iii. not administered or ordered by a *Medical Practitioner*;

iv. not *Medically Necessary*;

v. provided at no cost to *You* or for which *You* are not otherwise liable;

vi. In amount greater than the *Reasonable and Customary Charge*;

vii. provided by or at the direction or recommendation of a Physiotherapist, Homeopathist, Chiropractor or Osteopathist, unless ordered in advance by a *Medical Practitioner*;

viii. performed or provided by a *Relative* of the *Insured Person*;

ix. not expressly included as *Eligible Charges* within a Section of Cover of this *Plan*, above;

x. provided by a person who resides or has resided with the *Insured Person* or in the *Insured Person's* home;

xi. required or recommended as a result of complications or consequences arising from or related to any *Treatment, Injury, Illness* or supply which is excluded from cover or which is otherwise not insured under *Your Plan; or*

xii. any *In-Patient Treatment* which could have been provided on a *Day-Patient* basis or as an *Out-Patient.*

14. Charges for Telephone consultations except *Telemedicine* consultations through an established *Telemedicine* protocol system will be considered individually based on *medical necessity* and appropriateness as determined by *Us* under the *Plan*; completion of *Treatment*; completion of claim forms; or *Your* failure to keep a scheduled appointment.

15. Charges incurred for Surgeries or *Treatment* or supplies which are:

   i. *Investigational*, *Experimental*, or for research purposes; and/or

   ii. related to genetic medicine, genetic testing, surveillance testing and/or wellness screening procedures for genetically predisposed conditions indicated by genetic medicine or genetic testing, including, but not limited to amniocentesis, genetic screening, risk assessment, preventive and prophylactic surgeries recommended by genetic testing, and/or any procedures used to determine or prevent genetic pre- disposition, provide genetic counseling, or administration of gene therapy.

16. Confinement primarily to receive Custodial Care or *Educational Care*.

17. Education or training aimed at restoring *Your* ability to function in a normal or near normal manner following a *Medical Condition*; including, but not limited to, vocational therapy, occupational therapy, and speech therapy.

18. *Treatment* or supply received in a health hydro, nature cure clinic, spa, health farm or similar establishment, or private bed registered as a nursing home attached to such establishment or a *Hospital* where the *Hospital* has effectively become *Your* home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

19. Charges incurred for any *Surgery*, *Treatment* or supplies relating to, arising from or in connection with, for, or as a result of:

   i. weight loss or weight modification, obesity (including without limitation morbid obesity), wiring of the teeth and all forms or procedures of bariatric *Surgery* by whatever name called, or reversal thereof, including without limitation intestinal bypass, gastric bypass, gastric banding, vertical banded gastroplasty, biliopancreatic diversion, duodenal switch, or stomach reduction or stapling; or the reversal by *Surgery* of any such *Treatment*; or removal of fat or other surplus tissue from any part of the body, whether or not for medical or psychological purposes, and any associated consequent *Treatment;*

   ii. Any medical prescription relating to a special diet, weight control, *children's* food, baby supplies or vitamin/mineral supplements (unless expressly covered herein); or any alternative medicine (such as optometrists and podiatrists, non-prescription medicines, vitamins, food extracts, or nutritional supplements); vitamin or herbal therapy; *Drugs* not approved by the U.S. Food and Drug Administration, European Medicines Agency, or which are considered "off label" use; non-prescription *Drugs* or medicines, or *Drugs* or medicines not prescribed by a *Medical Practitioner*; *Drugs or medicines* ordinarily available 'over the counter' without prescription, even if prescribed by a *Medical Practitioner;*

   <u>Applicable to Platinum *Sub-Plan* Only</u>: Any *Drugs* purchased at a USA pharmacy that is eligible under the Universal RX Card Program.

iii. Modification of *Your* physical body in order to change or improve or attempt to change or improve *Your* appearance or psychological, mental or emotional well being, (such as but not limited to breast enlargement/reduction, sex-change *Surgery* or *Surgery* relating to sexual performance or enhancement thereof) or *Treatment* directly or indirectly associated with a sex change and any consequence thereof;

iv. *Treatment* to correct or deal with a problem that arises out of any *Treatment You* receive if the charges incurred by *You* for that *Treatment* were not covered under the *Terms* of *Your Plan*;

v. cosmetic or aesthetic reasons, whether or not for psychological purposes, except for reconstructive *Surgery* when such *Surgery* is *Medically Necessary* and is directly related to and follows a *Surgery* which was covered under this *Plan*; body hair removal; or ear or body piercing;

vi. any *Illness* or *Injury* sustained while taking part in:

Amateur Athletics, Professional Athletics, athletic activity that is sponsored or sanctioned by any collegiate sanctioning or governing body, or the International Olympic Committee, and adventure sports and activities, including, without limitation the following (including any combination or derivative of the following):

Athletic/Sporting Activities (except for activities that are non-contact, non-professional and engaged in by *You* solely for entertainment)	Mountaineering (where specialised climbing equipment, ropes or guides are being used)
Aviation (except when travelling solely as a passenger in a commercial aircraft)	Parachuting
Base Jumping	Paragliding
BMX	Parascending
Bobsledding	Racing of any Kind (including without limitation by horse, motor or other vehicle of any type)
Bungee Jumping	Rappelling
Canyoning	Recreational Scuba (if applicable to *Your* chosen *Sub-Plan*)
Caving	Rock Climbing
Hang Gliding	Rodeo (any activity)
Heli-Skiing	Ski Jumping
High Diving	Sky Diving
Hot Air Ballooning	Snowboarding
Inline Skating	Snow Skiing (except recreational downhill and/or cross country; provided no coverage for any *Illness* or *Injury* sustained while skiing in violation of applicable laws, rules or regulations, away from prepared and marked in-bound territories, and/or against the advice of the local ski school or local authoritative body)
Jet Skiing	Spelunking
Jungle Zip Lining	Subaqua pursuits involving underwater breathing apparatus below a depth of 10 meters (except as expressly set forth in Section E2)
Kayaking	Surfing
Kiteboarding	Trekking
Luge	Whitewater Rafting
Motocross (MOTO-X)	Wildlife Safaris
Mountain Biking	

Practice or training in preparation for any excluded activity which results in *Illness* or *Injury* will be considered as activity while taking part in such activity;

vii. any *Medical Condition* sustained while participating in any sporting, recreational or adventure activity where such activity is undertaken against the advice or direction of any local authority or any qualified instructor or contrary to the rules, recommendations and procedures of a recognised governing body for the sport or activity;

viii. any *Medical Condition* sustained while participating in any activity where such activity is undertaken in disregard of or against the recommendations, *Treatment* programs, or medical advice of a *Medical Practitioner* or other healthcare provider;

ix. Treatment of Alcohol and Substance Abuse;

x. any *Medical Condition* sustained as a result of being under the influence of or due wholly or partly to the effects of alcohol, liquor, intoxicating substances, narcotics or *Drugs*, other than *Drugs* taken in strict accordance with *Treatment* prescribed and directed by a *Medical Practitioner*, but not for the *Treatment* of *Substance Abuse*;

xi. any *Medical Condition* sustained while operating a moving vehicle after consumption of intoxicating liquor or *Drugs* other than *Drugs* taken in strict

accordance with *Treatment* prescribed and directed by a *Medical Practitioner*. For the purpose of this exclusion, "vehicle" shall include both motorised devices regardless of whether or not a driver or operator license is required (including watercraft and aircraft) and non-motorised bicycles and scooters for which no permit or license is required;

xii. Suicide or attempted suicide, or any wilfully *Self-inflicted Injury* or *Illness,* or wilful exposure to danger (other than in an attempt to save human life);

xiii. any venereal disease or any other sexually transmitted disease;

xiv. any *Medical Condition* resulting from or occurring during the commission of a violation of law by the *Insured Person*, including, without limitation, the engaging in an illegal or malicious occupation or act, but excluding minor traffic violations;

xv. Professional services performed by a psychotherapist, psychologist, family therapist or bereavement counsellor for the *Treatment* for learning difficulties, hyperactivity, attention deficit disorder, developmental or behavioural problems in *children*; or speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, unless specifically covered herein; or

xvi. any *Illness* or *Injury* resulting from or sustained after entering the *Host Country* and as a result of epidemics, pandemics, public health emergencies, natural disasters, or other disease outbreak conditions that may affect a person's health and about which the World Health Organization has issued an *Emergency* Travel Advisory, U.S. Centers for Disease Control & Prevention has issued a Warning Level 3 (avoid nonessential travel), or Public Health England, or European Centre for Disease Prevention & Control or similar governmental agency of the *Insured Person*'s *Country of Residence* had published, communicated or issued a *Travel Warning* restriction or official declaration informing the public about such health issues before the *Insured Person* traveled to the *Host Country*.

20. **Applicable to Bronze *Sub-Plan* Only:** *Treatment* of *Mental or Nervous Disorders* is excluded.
    Applicable to the Silver *Sub-Plan Only*: *In-Patient Treatment* of *Mental or Nervous Disorder* are excluded. *Out-Patient Treatment* for *Mental or Nervous Disorder* are excluded until *You* have maintained coverage under this *Plan* for at least twelve (12) continuous months.
    Applicable to Gold, Gold Plus and Platinum *Sub-Plans*: *Treatment* of *Mental or Nervous Disorder* are excluded until *You* have maintained coverage under this *Plan* for at least twelve (12) continuous months.

21. Any sleep disorder, including sleep apnoea (temporarily stopping breathing during sleeping), snoring, fatigue, jet lag or work related stress.

22. Orthoptics, visual therapy or visual eye training.

23. Any *Illness* or *Treatment* of the feet, including without limitation: orthopaedic shoes; orthopaedic prescription devices to be attached to or placed in shoes; *Treatment* of weak, strained, flat, unstable or unbalanced feet; metatarsalgia, bone spurs, hammer toes or bunions; and any *Treatment* or supply for corns, calluses or toenails; provided, however, that claims for *Treatment* or supplies for the feet may be eligible for cover under the this insurance at *Our* sole option and subject to all other *Terms* of this *Plan* when related to:

    i. an *Injury* to the foot arising from an *Accident* covered hereunder;

    ii. an *Illness* for which foot *Surgery* is *Medically Necessary* and determined to be the only appropriate method of *Treatment*;

24. hair loss, including without limitation wigs, hair *Treatments*, hair transplants or any *Drug* that promises to promote hair growth, whether or not prescribed by a *Medical Practitioner*;

25. Any exercise program, whether or not prescribed or recommended by a *Medical Practitioner*;

26. Exposure to any non-medical nuclear or atomic radiation, and/or radioactive material(s), chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel, asbestosis or any related condition;

27. Serving in the military, navy or air force in time of declared war, or while under orders for war-like operations, or restorations of public orders, or any *Medical Conditions* sustained whilst on military, naval or air force training exercise.

28. *Treatment* or supplies relating to, arising directly or indirectly from or in connection with, for, or as a result of: any efforts to keep a donor alive for a transplant procedure, whether or not the transplant procedure is a *Covered*

Transplant; any transplant expenses incurred outside *Our* approved independent Managed Transplant System Network; or costs incurred in connection with locating a replacement organ or any costs incurred for removal of the organ from the donor, transportation costs of same and all associated administration costs.

29. Any *Covered Transplant* in excess of one (1) during any twelve (12) month *Period of Insurance,* except re-transplantation charges if incurred during the initial *Covered Transplant Hospitalisation.*

30. Any organ or tissue or other transplant or related services, *Treatment* or supplies unless specifically covered herein;

31. Any artificial or mechanical devices designed to replace human organs temporarily or permanently unless specifically covered herein;

32. *Charges* incurred for any *Treatment* or supply that either promotes, enhances, prevents or corrects or attempts to promote, enhance, prevent or correct impotency, sexual performance or sexual dysfunction or any consequence thereof.

33. *Charges* incurred for *Dental Treatment* (except as provided for under Dental sections); Orthodontic Treatment, gingivitis, gum disease of any kind, or periodontitis; damage to dentures whilst not being worn; dental veneers (unless as a result of damage to existing veneers as a result of an Accident); tooth whitening of any kind; missed dental appointments; *Charges* for services and supplies (to include crowns, dentures and bridges) to replace extracted or missing teeth prior to coverage(other than under the Platinum *Sub-Plan* only, unless *Your Certificate of Insurance* confirms *You* have paid the applicable additional *Premium* for the Dental & Vision Care Benefits Optional Add- On Coverage in which event, cover is provided in accordance with Section D.

34. Except as provided for in the Schedule of Cover, *Treatment*, supplies, examination or fitting related to vision correcting spectacles, eyeglasses or contact lenses; eye refraction for any reason; non-medical or natural degenerative eye defects, including but not limited tomyopia, presbyopia and astigmatism; or any corrective *Surgery* for non-medical or natural degenerative sight defects and eye *Surgery*, such as but not limited to radial keratotomy, when the primary purpose is to correct or attempt to correct nearsightedness, farsightedness, or astigmatism. However, *We* will pay *Eligible Charges* for corrective sight *Surgery* consequent of an *Injury*.

35. *Treatment*, supplies, examination or fitting related to hearing aids; providing, maintaining or fitting any hearing implants or hearing transplants; or any corrective *Surgery* for non-medical or natural degenerative hearing defects.

36. *Charges* incurred for *Treatment* of the temporomandibular joint, unless required as a result of an *Accident*.

37. Any taxes, assessments or surcharges imposed by any governmental agency or authority arising out of or as a result of any *Treatment* or supply received by *You*, or based upon *Our* election hereunder, if any, to pay benefits directly to providers, or for any other reason.

38. Travelling against the advice of a *Medical Practitioner or entering into or remaining in any Host Country for which you do not possess the proper license, permits, authority, or exemption from such requirements.*

39. *Treatment* or supplies obtained or received after the expiry date of *Your Plan* or after termination of *Your Plan* for whatever reason including non-renewal and non-payment of *Premium*.

40. Any second or subsequent medical opinion from a *Medical Practitioner* or *Specialist* which is not required by *Us*.

41. *Routine Physical Exam* or immunisations, except for the eligible benefits and covered expenses provided for under this *Policy Wording*.

42. *Charges* incurred for any travel, meals, transportation and/or accommodations, except as otherwise expressly provided for in this *Plan*.

43. **For Bronze and Silver *Sub-Plans* Only**: Testing for the following: HIV, seropositivity to the *AIDS* virus, *AIDS* related *Illness, ARC* Syndrome, *AIDS*. Charges incurred by an *Insured Person* who was HIV + on or before the *Effective Date* of this *Plan* relating to or arising or resulting directly or indirectly from HIV, *AIDS* virus, *AIDS* related *Illness*, *ARC* Syndrome, *AIDS* and/or any other *Illness* arising or resulting from any complications or consequences of any of the foregoing conditions; whether or not the *Insured Person* had knowledge of their HIV status prior to the *Effective Date*, and whether or not the *Charges* are incurred in relation to or as a result of said status.

44. Any fees or charges relating to Hospital or medical provider membership plans or similar schemes.

45. Any *charges* that are as a result of a tropical disease, if *You* have not had the recommended vaccinations or taken the recommended medication.

46. Any claim if *You* refuse disclosure of the data to a third party, which in turn prevents *Us* from providing cover under this *Plan*.

SECTION H: General Conditions

The following *Terms* shall apply to all sections of this Policy Wording and are precedent to *Our* liability under *Your Plan*:

1. Entire Agreement

The *Application*, the *Certificate of Insurance*, the Policy Wording, any *Endorsements*, *Our* written acceptance, and the *Schedule of Cover and Excesses* relevant to *Your* chosen *Sub-Plan* form *Your* contract with *Us* and shall constitute the entire agreement between *You* and *Us* and must be read together to avoid any misunderstanding.

2. Third Parties, Assignment, Change or Waiver

The only parties to the *Plan* are *You* and *Us*. No other person is a third party beneficiary or has any right to enforce the Policy Wording or any part of it. Any person or company who was not a party to this *Plan* has no rights under the Contracts (Rights of Third Parties) Act 1999 or any subsequent legislation.

Notwithstanding any law, statute, judicial decision, or rule to the contrary which may be or may purport to be otherwise applicable within the jurisdiction, locale or forum state of any healthcare or medical service provider, no transfer or assignment of any of the *Insured Person's* rights, benefits or interests under this *Plan* shall be valid, binding on, or enforceable against *Us* (or the *Plan Administrator*, or *Plan Manager*) unless first expressly agreed and consented to in writing by *Us*. Any such purported transfer or assignment not in compliance with the foregoing *Terms* shall be without effect as against *Us* (or the *Plan Administrator*, or *Plan Manager*), and *We* shall have no liability of any kind under this *Plan* to any such purported transferee or assignee with respect thereto. The *Terms* of the *Plan* shall not be waived, modified or changed except by *Our* express written agreement.

3. Compliance with Policy *Terms*

We shall not be liable under *Your Plan* in the event of any failure by *You* to comply with the *Terms* of this Policy Wording.

4. Reasonable Care/Reasonable Precautions

You shall at all times act in a prudent manner and shall exercise reasonable care and take reasonable precautions to prevent *Injury* or *Illness*, and to minimise any costs incurred, and *You* shall comply with recommended vaccination schedules and take appropriate malaria and other medicinal prophylaxis.

5. Premiums and Plan Duration

Payment of the required *Premium* shall be remitted to *Us* on or before the *Effective Date* of coverage. *Your Plan* is effective for 12 consecutive months and is renewable for successive one year periods, subject to *Your* continued eligibility, the *Terms* of the Policy wording and the *Certificate of Insurance* in force at the time of each *Renewal Date* and the payment of *Premium.* All *Premiums* are payable in advance of any cover under *Your Plan* being provided.

Where *We* have agreed that the *Premium* is paid other than yearly *You* must continue to pay the *Premium* as specified in *Your Plan* schedule in order to maintain the cover provided by *Your Plan* during its 12-month term. If *Premium* payments are discontinued or withheld for whatever reason and *Your Plan* goes into arrears, cover under *Your Plan* may automatically and immediately terminate.

We generally do not pay any claims if *Premiums* are not paid to date at the time *Your Treatment* takes place. If *You* pay monthly, each monthly *Premium* payment is for 1 months cover. If *You* pay quarterly, each quarterly *Premium* payment is for 3 months cover. If *You* pay semi-annually, each semi-annual *Premium* payment is for 6 months cover. If *You* pay annually, each annual *Premium* payment is for 12 months cover.

Premiums are payable in $ US Dollars, £ Sterling or € Euros. The initial *Premium* is based on rates applicable to *Your* attained age on the *Effective Date*. *Your Plan* will not be subject to any alteration in *Premium* rates introduced mid-term. The *Premium* payable may be changed by *Us* at *Your Renewal Date*.

A period of grace of 10 days (notwithstanding intervening Saturdays, Sundays or Public holidays) will be allowed for the receipt of each *Premium* payment except the first. If any *Premium* is unpaid at the end of the period of grace, *We* reserve the right to terminate *Your Plan* with effect from the date the unpaid *Premium* *w*as due, or deduct the unpaid *Premium* due from any valid claim in progress, or deduct the unpaid *Premium* due from the credit card or debit card supplied. *We* shall have no liability to *You* for any claims incurred on or after the date the period of grace ends. *Premium* is considered paid on the date the payment is actually received by *Us.*

We cannot be held liable if *Your Plan* is terminated due to a credit card or debit card being declined or expired.

6. Government Law and Taxes

We reserve the right to amend *Your Plan*, this Policy Wording and the *Premiums* at any time in order to reflect any change in regulatory requirements, insurance law, insurance premium tax or other government levies as may be imposed upon *Us*.

7. Eligibility

Persons of all nationalities are eligible to apply for cover from 14 days of age up to their 75th birthday, (except for citizens of the USA who habitually reside in the USA for more than 180 days per annum) subject to

the following conditions in respect of coverage in the USA with regards to *Insured Person's* selecting their *Area of Cover* as Area 3 - Worldwide.

7.1 Non-USA citizens:
You must comply with at least one of the following conditions:

- **A.** *You* must reside outside the USA at the time of *Application* (or on the *Renewal Date*); or

- **B.** *You* must plan to be located outside of the USA for at least 180 days during each *Period of Insurance.* But if *You* are located inside the USA as at the *Effective Date* (or on *Renewal Date*), *You* must plan to be located outside the USA for at least 180 days during each *Period of Insurance*; or

- **C.** If *You* are located inside the USA at the *Effective Date* (or on the *Renewal Date*): *You* must not be eligible for any other medical insurance which is available to persons similarly situated and located within the USA and *You* must provide *Us* with an *Affidavit of Eligibility*.

7.2 USA citizens:

- A. *You* must be located outside of the USA as of the *Effective Date* (or *Renewal Date*); and

- B. *You* must arrange to reside outside of the USA for at least 180 days during each *Period of Insurance*.

If *You* are a citizen of the USA, who has purchased Area 3 Worldwide as *Your Geographic Area of Cover*, and *You* return to the USA, cover under *Your Plan* will be terminated automatically when the time *You* spent in the USA during any one *Period of Insurance* exceeds 180 days, or *You* become eligible for any other USA Domestic medical insurance which is available to persons similarly situated and located within the USA.

Please Note: If *You* are no longer eligible under Section 7.1 or 7.2, then *Your Plan* will automatically terminate.

8. Newborns
Except for cover provided under Section F of this *Policy Wording*, a *Newborn* shall have no independent cover or rights under *Your Plan*.

9. Acceptance Clause
We are entitled to refuse to accept an *Application* from any person without giving a reason. *We* reserve the right to apply additional *Terms*, options, exclusions or *Premium* increases or to change any existing *Terms* to take into account any information *You* provide to *Us* in *Your Application* or at renewal of *Your Plan*.

10. Choice of Law and Jurisdiction
The law applicable to *Your Plan* shall be as specified in the *Certificate of Insurance*, unless *You* have requested an alternative, which has been accepted in writing by *Us*. If no law is specified then *Your Plan* shall be construed according to the laws of England and Wales and shall be subject to the non-exclusive jurisdiction of the courts of England and Wales.

The subjects, risks and benefits of insurance covered by *Your Plan* are not intended or considered by *You* or *Us* to be resident, located, or to be performed in any particular state of the USA or in any particular country.

11. Fraud
If:

- **A.** there is any false or fraudulent or dishonest representation, statement, misstatement, omission or concealment, or any fraud, whether or not innocently made, in *Your Application*, including any statement, certification or warranty made by *You* or *Your* representatives, agents or proxies, whether in writing or otherwise to *Us*; or

- **B.** *Your* claim is in any way false, fraudulent, dishonest or exaggerated, as regards amount or otherwise;

then *Your Plan* shall be rendered null and void from the *Effective Date* and all claims and benefits under *Your Plan* shall be forfeited and (if appropriate) recoverable by *Us* and *We* shall have no liability for any benefits or claims under *Your Plan.*

In addition, *Your Plan* shall be rendered void without any refund of *Premiums.*

Please note that *We* may use, share or disclose information about *You* and *your* claims with third parties for the purpose of the identification and prevention of fraud and crime. *We* may also take legal action against *You.*

12. Several Liability
The various underwriters which may be referenced in *Your Plan* are several and not joint and are limited solely to the extent of their individual covers. *We* are not responsible for the cover of any other underwriter referenced by *Us* that for any reason does not satisfy all or part of its obligations.

13. Subrogation
We retain all rights of subrogation. Other than with *Our* written consent *You* have no entitlement to admit liability for any eventuality or give promise of any undertaking which is binding upon *You* or *Us*. Any amount recovered by *Us* shall first be used to pay the costs and expenses of collection incurred by *Us*, including reasonable lawyer's fees, and for reimbursement to *Us* for any amount that *We* may have paid or become liable to pay under *Your Plan*. Any remaining amounts recovered shall be paid to *You* or other persons lawfully entitled thereto, as applicable. *We* shall be entitled to conduct all

proceedings arising out of, or in connection with, claims in *Your* name and to have full discretion in the conduct of such proceedings, including (but not limited to) instructing lawyers of *Our* own choice for any such purpose.

14. Other Insurance

You must inform *Us* if any of the benefits covered under *Your Plan* are covered or otherwise payable by any other insurance, membership benefit, reimbursement or indemnification cover, right of contribution, recoupment or recovery, contract, or other third party obligation or provision of benefits. *We* shall not be liable to pay more than *Our* rateable proportion of the claim. *We* shall not be obligated to provide any benefit or to pay any claim in respect to *Treatment* or supplies furnished by any program or agency funded by any government.

Where charges are made for *Treatment* of a *Medical Condition* for which payment is made or available through workers compensation, employer's liability, similar law or government program, any payment made by *Us* will be secondary to any payment or cover available elsewhere. If it is found that *You* were repaid for all or some of those expenses by any other source, *We* will have the right to a refund from *You*. Where necessary, *We* retain the right to deduct such refund from any impending or future claim settlements or to cancel *Your Plan* from the *Effective Date*.

15. Cancellation and *Premium* Refunds

You may cancel *Your Plan* by providing written cancellation instructions (by e-mail, fax or post) and return the Policy Wording with the *Certificate of Insurance* to the *Plan Manager* within 30 days after receipt, to:

IMG Europe Ltd.
Kingsgate
High Street
Redhill, Surrey
RH1 1SH
United Kingdom

Fax : +44 (0) 1737 30 67 10
E-mail : info@imgeurope.co.uk

i. If *You* cancel *Your Plan* within 30 days from the date *You* receive this Policy Wording, subject to the *Plan Terms*, and provided no claims have been paid or are in progress, *You* will receive a full refund of the *Premium* paid.
ii. If *You* cancel *Your Plan* after 30 days from the date *You* receive this Policy Wording, subject to the *Plan Terms* and that no claims have been paid or are in progress, *You* will be eligible to receive a pro-rata refund of *Premium* paid, based on the number of days cover remaining from the date *We* receive *Your* written cancellation request, less the applicable administration charge determined by *Us* at that time.

Of course, if *You* cancel *Your Plan You* cannot make a claim under it and neither *You* nor *Us* will have any further rights, liabilities or obligations under the *Plan*.

Your request for cancellation will be dealt with promptly and *Your Plan* will be retroactively cancelled as from the date of *Your* request for cancellation.

If *You* have any doubts regarding the *Terms of Your Plan*, please contact the *Plan Manager* directly for clarification, otherwise it shall be assumed that all *Terms* are understood and acceptable to *You*.

We reserve the right to require *You* to execute a release of claims as a condition to granting such refund. Upon cancellation and refund, neither *We* nor *You* shall have any further rights, liabilities or obligations under this *Plan*.

16. Break in Cover

Where there is a break in cover, for whatever reason, *We* reserve the right to reapply Exclusion 1 under this *Plan* Wording in respect of *Pre-Existing Conditions* and amend the *Terms* of *Your Plan* from the date of reinstatement.

17. Liability

Our liability shall cease immediately upon cancellation or termination of *Your Plan* for whatever reason, including without limitation non-extension, non-renewal and non-payment of *Premium*, or if *You* are no longer eligible.

18. Arbitration

No claim for benefits for which liability, eligibility, or cover under *Your Plan* has been denied in whole or in part by *Us* nor any other dispute or controversy arising under or related to *Your Plan* shall be arbitrable or subject to arbitration under any circumstances or for any reason, other than in the United Kingdom by the Financial Ombudsman Service.

19. Termination of Cover

We shall not cancel or terminate *Your Plan* because of eligible claims made by *You*. However, *We* may at any time terminate *Your Plan* by giving [14] days' notice in writing where there is a valid reason for doing so. *We* will send *Our* notice to *Your* last known postal address and *We* will set out the reason for the termination. Valid reasons for termination may include, but are not limited to any non-payment of *Premium,* fraud or misrepresentation, non-refund of an over-paid claim, or if *You* no longer meet the eligibility requirements of *Your Plan*.

In any case, cover and benefits for the *Insured Person* under this *Plan* will terminate effective at 12:01 AM, GMT, on the earliest of the following dates:

i. the next day following the end of the *Period of Insurance* for which *Premium* has been fully and timely paid;

ii. the Expiration Date as shown on the *Certificate of Insurance*;

iii. the date the *Insured Person* first fails to meet or no longer meets the eligibility requirements for this *Plan* as outlined in Eligibility of this *Plan*; or

iv. the date specified by *Us* in any notice of cancellation, forfeiture or rescission.

20. Reinstatement of Cover
In the event *Your Plan* is terminated for *Your* failure to pay *Premium*, *You* may apply to *Us* in writing to request reinstatement of *Your Plan*. Reinstatement is at *Our* sole option and shall be subject to *Our* retained right, without obligation or liability of any kind, to reassess and make determination of acceptable risk in *Our* sole and absolute discretion.

21. Right of Recovery
In the event of overpayment by *Us* of any claim for benefits under *Your Plan*, for any reason, *We* shall have the right to a prompt refund and to recover the amount of overpayment from *You,* the *Hospital, Medical Practitioner,* or other provider of services or supplies, as the case may be.

If *You* or the *Hospital, Medical Practitioner* or other provider of services or supplies does not promptly make any such refund to *Us, We* may, in addition to any other rights or remedies available to *Us*: reduce or deduct from the amount of any future claim that is otherwise eligible for cover or payment under *Your Plan*, to the full extent of the refund due to *Us*; and/or terminate *Your Plan* by giving 30 days advance written notice by mail to *Your* last known residence or mailing address; and/or charge such amount to any valid credit card if the details of which are held by *Us,* if the overpayment was made to *You.*

22. Renewal
Your Plan is provided on an annual basis and will be renewed subject to the *Terms* in force at each *Renewal Date*. *We* will write to *You* and/or *Your* Intermediary through whom *You* applied for cover, with *Our* renewal *Terms* and provide *You* with a renewal *Premium* notice prior to each *Renewal Date*. The renewal *Premium* must be received by *Us* prior to the *Renewal Date*, and no cover is in effect until such time as *We* have confirmed *Your* renewal has been accepted in writing by *Us*.

If *We* have not received *Your* written renewal instructions by *Your Renewal Date*, then at *Our* sole discretion *We* reserve the right to decline renewal, alter, or amend the *Terms* of *Your Certificate of Insurance*, or apply or amend Personal Medical Exclusions or other *Endorsements*.

If *You* have paid *Your Premiums* by credit card or debit card, provided *You* remain eligible and are residing outside of the United States, and that the card details *We* hold for *You* are still valid, *We* will automatically debit *Your* card with *Your* renewal *Premium* on or before *Your Renewal Date*.

At each *Renewal Date*, *We* reserve the right to alter, amend or discontinue the benefits, *Terms*, discounts, surcharges and/or *Premiums* of *Your Plan* and *We* shall give *You* reasonable notice of such changes or provide *You* with the current *Plan Terms* and *Renewal Premium* prior to the *Renewal Date* to *Your* last known mailing address. Failure to receive notice for whatever reason shall not invalidate the change. If *You* do not wish to renew *Your Plan* or *You* are no longer eligible for cover, *You* must inform *Us* in writing as soon as *You* receive *Your* renewal *Premium* notice and prior to the *Renewal Date*.

If *You* are not satisfied with the *Plan* that has been renewed, please provide written cancellation instructions and return the *Policy Wording* with the *Certificate of Insurance* to the *Plan Manager* within 30 days following the *Renewal Date*. Provided *You* have not made a claim and no claim exists, *We* will refund *Your Premium*, and *Your* policy will be retroactively cancelled from the *Renewal Date*. Of course, if *You* cancel *Your Plan* upon renewal, *You* cannot make a claim under it and neither *You* nor *Us* shall have any further rights, liabilities or obligations under *Your Plan*.

No alteration or amendment to the *Plan Terms* will be valid unless it is in writing from *Us*.

23. Information & Change of Information
You must take reasonable care to provide complete and accurate answers to the questions *We* ask in *Your Application* when *You* take out, make changes to, or renew the *Plan*. Please note that *Your* disclosure of *Pre-Existing Conditions* will not result in waiver of Exclusion 1 of this Policy Wording in relation to *Pre- Existing Conditions*.

You must also inform *Us* as soon as reasonably possible of any changes relating to information given in connection with the *Application*. This includes any information as documented on the *Application* which may have altered prior to the *Effective Date*. *We* reserve the right to alter *Your Plan Terms*, decline acceptance of *Your Application* or cancel *Your* cover following a change of risk. If *You* fail to notify *Us* of any change, or if any information that is provided by *You* is not complete or accurate:

- *Your Plan* may be declared void and *We* may treat the *Plan* as though it never existed; or
- *We* may cancel *Your Plan*; or
- *We* may refuse to pay a claim; or
- *We* may not pay any claim in full; or
- *We* may revise the *Premium* and/or charge additional *Excess*; or
- The extent of the cover under *Your Plan* may be affected.

24. Transfers, Changes at Renewal, Mid Term Adjustments

i. *You* may only apply to change *Your Sub-Plan* at Renewal. Transfer is only allowed when changing to a lower *Sub-Plan*. If *You* wish to obtain cover under a higher *Sub-Plan*, *You* must reapply. All waiting periods will begin again and no credit will be provided for the time covered under another *Sub-Plan* unless

'Takeover Application' is submitted and approved by *Us*.

ii. Transfer from a group to an individual policy is subject to written approval from *Us*. *Terms* of cover may be subject to variation.

iii. Transfer from any other similar private medical cover provided by any other insurance company is subject to completion of a GlobalFusion 'Takeover *Application* Form', submission of a copy of the expiring policy, subject to there being no break in cover and *Our* written acceptance of the *Application*.

iv. At *Renewal Date*:
   a. *You* may change the *Geographic Area of Cover* for *Your Plan* at the *Renewal Date* and the underwriting will remain continuous,

   b. *You* may increase *Your* level of *Annual Excess,* but *You* may not reduce it*,* however;

   c. *You* may not change *Your Sub-Plan'*s base currency relevant to payment of *Premiums.*

v. Mid-term changes in *Your Geographic Area of Cover* extending *Your* selected *Geographic Area of Cover* will only be considered if *You* have a life change event (career or job role, change of residence), which causes *You* to either travel or reside in a country that *You* previously did not have cover in. An additional *Premium* will be payable along with an administration fee. *We* reserve the right to refuse any mid-term adjustments without giving a reason.

We reserve the right at all times to decline an *Application or Mid Term Adjustment* without giving any reason, and *We* reserve the right at all times to offer alternative *Terms*.

25. Medical Evaluation

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

26. Waiver

Waiver by *Us* in any instance of any term of *Your Plan* will not prevent *Us* from relying on such term in other instances.

27. Local Insurance Law, Taxation & Regulations

We accept no liability in the unlikely event that *You* infringe any local insurance law, regulation or taxation issue by purchasing the *Plan*. *Your Plan* is deemed made and issued in London, England.

You warrant that *You* are not infringing any local insurance law, regulation or taxation issue by purchasing *Your Plan*, and *You* understand and agree that *Your Plan* is not designed to comply with any particular local insurance law or regulation. It is agreed by *You* and *Us* that the subjects of this insurance are not considered to be resident, located, or to be performed in any particular state of the USA, or any particular country. *You* further agree that *You* are solely responsible for compliance with any other laws applicable to *You*. *We* shall not be deemed to provide cover and *We* shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose *Us* to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

28. Insolvency

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors or dissolution of *You* or *Us* shall not impose upon *Us* any liability or obligation other than that specifically included under the *Terms* of this Policy Wording.

29. Patient Protection And Affordable Care Act (PPACA) - Important Notice

This *Plan* is not subject to, and does not provide benefits required by, PPACA. On 1 January 2014, PPACA will require USA citizens and certain USA residents to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Penalties may be imposed on USA citizens and USA residents who are required to maintain PPACA compliant coverage but do not do so. Eligibility to purchase, extend or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is solely *Your* responsibility to determine if PPACA is applicable to *You*.

How to Make a Claim

Please follow the guidelines below to help *Us* process *Your* claims promptly and efficiently.

- All claims should be submitted to *Us* with a fully completed claim form, original invoices, receipts and all other supporting documentation within 90 days of *Your* initial *Treatment*. *We* may deny cover for any claim submitted thereafter.

- Before *You* make a claim, it is important for *You* to review the *Terms* of this Policy Wording with respect to covers for the *Treatment You* are seeking and *Pre-Certification* requirements. *You* must follow any and all *Pre- Certification* procedures. Please note that *Pre-Certification* is a general determination of *Medical Necessity* only and does not assure, authorise, verify or guarantee that *We* will pay charges incurred by *You*. Cover remains subject to the *Terms* of the *Plan*.

- *We* supply a personalised membership card to *You*, which contains essential contact numbers and addresses. *We* therefore suggest *You* keep this card with *You* at all times and that *You* also take a printed copy of this Policy Wording with *You* on *Your* trip.

A. *Emergency* Admissions

In the event of *Emergency* admissions, *You* should contact the *Pre-Certification* helpline as soon as possible after admission, giving full details of the *Medical Condition* and *Treatment* (including dates and name of procedure if known) together with the name of the *Specialist* and *Hospital* details. (The telephone number is provided on the back of *Your* membership card and below). Please do not delay obtaining *Emergency Treatment*.

B. Planned *In-Patient & Day-Patient Treatment*

In the event of a planned admission on an *In-Patient* or *Day-Patient* basis to a *Hospital*, *You* should contact *Our Pre-Certification* helpline as soon as possible prior to *Your* admission, giving full details of the *Medical Condition*, proposed *Treatment* (including dates and name of procedure if known) together with the name of the *Specialist* and *Hospital* details. (The telephone number is provided on the back of *Your* membership card and below).

Where possible *We* will make arrangements with the *Hospital* or *Treatment* provider for all *Eligible Charges* to be settled directly (*Direct Settlement*). Where this has been arranged, *You* should send the original claim form and the unpaid invoices (if given to *You* by the *Hospital*) to *Us*. *You* are responsible for paying any *Excess* and *Co-Insurance* to the *Treatment* provider. If *Direct Settlement* has not been arranged, *You* should pay all of the charges and submit the originals to *Us*, together with the claim form.

C. Out-Patient Treatment

You should pay for any *Treatment You* receive as an *Out-Patient* and then submit *Your* charges, as per the cover and instructions in this Policy Wording.

- Whenever *You* visit a *Medical Practitioner* or *Specialist* on an *Out-Patient* basis, please make sure *You* take *Our* claim form with *You*.
- Fill in the section that is assigned to *You*, then date and sign the claim form. Make sure that *Your Medical Practitioner* or *Specialist* provides all relevant medical information in the specified section and then dates, signs and stamps the claim form.
- Attach all original supporting documentation, invoices and receipts to the claim form (e.g. *Medical Practitioner* invoices, pharmacy receipts with related prescriptions), and post to *Us* at the address below.

ALL CLAIM FORMS SHOULD BE SENT TO:

Global Response Limited
IMG Claims
P.O. Box 1114
Cardiff
CF11 1UL
United Kingdom
Tel: +44 (0) 2920 47 42 36
Fax: +44 (0) 2920 468 797
E-mail: claims@imgeurope.co.uk

The above numbers are for the Claims Department only and should be used to discuss claims submitted and on-going issues. The *emergency* medical assistance helpline number can be found on the back of *Your* membership card.

Claims Handling Service Standards

Upon receipt of all complete final claims documentation required by *Us*, *We* will aim to complete *Your* claim and make payment to *You* or the *Hospital* or provider as follows:

USD, Sterling, and Euro payments: within 15 working days

For other payments: within 20 working days

General Claims Conditions and Information

1. Proof of Claim: When *We* receive notice of a claim for benefits under this *Plan* from or on behalf of an *Insured Person We* will provide the *Insured Person* with Claimant's Statement and Authorisation Forms ("Claim Forms") for filing Proof of Claim. The following items must be submitted by or on behalf of the *Insured Person* to be considered a complete *Proof of Claim* eligible for consideration of coverage under this insurance ("Proof of Claim"):

   (a) a duly completed, timely submitted, and signed Claim Form and authorisation for release of information; and

   (b) all original itemised bills and statements of services rendered from all *Medical Practitioners*, *Hospitals* and other healthcare or medical service providers involved with respect to the claim; and

   (c) all original receipts for any costs, fees or expenses that have been incurred or paid by or on behalf of the *Insured Person* with respect to the claim, including without limitation all original receipts for any cash and/or credit card payments.

The *Insured Person* shall have ninety (90) days from the date the charges are incurred to submit a complete Proof of Claim.

We, at *Our* option, may deny liability for any claim where:

- Proofs of Claim have been submitted after ninety (90) days of the charges being incurred;
- Incomplete *Proofs of Claim* have been submitted; and/or
- There has been a failure to submit any Proof of Claim*.*

We, at *Our* option, may waive the requirements of subsection (a) above, regarding submission of a new Claim Form for subsequent claims incurred by an *Insured Person* relating to a continuing *Illness*, *Injury* or other *Eligible Medical Condition* for which a properly completed and signed Claim Form has previously been submitted and received.

2. Claims may only be made for *Treatment* actually given during a *Period of Insurance* and benefits will be considered only for *Eligible Charges You* incur prior to expiry or termination of *Your Plan*.

3. All documents, medical reports and other materials that *We* require and request to support a claim shall be provided without expense to *Us*. In instances where medical information is required by *Us* for consideration of a claim but it is not available to *Us*, it is *Your* responsibility to obtain such information from *Your* current or previous *Medical Practitioner*, as appropriate.

4. Where *We* deem a consequence is not covered under *Your Plan* by reasons of an exclusion in the Policy Wording, the burden of proof to the contrary shall be upon *You*.

5. In the *Application*, provision is made for details of *Your Medical Practitioners* for a period of time prior to the application date. If such details are not provided in the *Application* and *You* submit a claim after the *Effective Date* which *We* deem as being for a *Pre-Existing Condition*, such claim will be rejected.

6. Where an *Excess* applies to *Your Plan*, the payment of any benefit will occur only if the total amount of *Eligible Charges* for *Treatment* and supplies covered under *Your Plan* exceeds the *Excess* in each *Period of Insurance*. *You* are liable for the amount of the *Excess* and any *Co- Insurance*, and this should be settled directly with the relevant medical provider.

7. *We* will reapply the *Annual Excess* in each *Period of Insurance*, regardless of whether or not the *Treatment* is for a continuation of a *Medical Condition* for which *Treatment* had been previously sought in a prior *Period of Insurance*.

8. *You* may choose to have *Your* claim reimbursement paid in any currency convenient to *Your* location. However, the payment to *You* will be converted to the equivalent amount in the base currency of *Your Plan*. If *We* have to make a conversion from one currency to another, *We* will choose a fair exchange rate on the date on which *You* paid for *Your Treatment*, or if *Your Treatment* spanned a period of time and *We* pay the provider, *We* will choose a fair exchange rate at the date of processing the payment. *We* are not responsible for any loss *You* may incur due to fluctuations in exchange rates, or for any bank charges *You* may suffer when *You* cash a foreign currency draft, a cheque or when *You* receive a bank transfer or payment from *Us*.

9. Without delay, *You* must give *Us* immediate written notification of any claim or right of action against any third party arising out of circumstances which may give rise to a claim under *Your Plan*. *You* must continue to keep *Us* fully informed in writing and take all steps reasonably required in making a claim upon that other party. To the extent permissible under the laws of *Your Home Country*, *We* shall be entitled to take legal action in *Your* name for *Our* own benefit and claim for indemnity or damages or otherwise which relates to any benefit and cost paid or payable under *Your Plan*. *We* shall have full discretion in the conduct of any such proceedings and in the settlement of any claim.

10. In the event *We* deny all or part of a claim, the *Insured Person* shall have a reasonable opportunity to appeal the denial under which there will be a review of the claim and the determination. *Insured Person*s shall have sixty (60) days from the date that the notice of denial was mailed to the *Insured Person*'s last known residence or mailing address within which to appeal the determination, and shall have the opportunity to submit written comments, documents, records, and other information relating to the claim. *Our* review will take into account all comments, documents, records, and other information submitted by the *Insured Person* relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. *Insured Persons* must file two (2) appeals of a claim denial prior to bringing any legal action. Upon receipt of a written appeal, *We* shall have an opportunity for further reasonable investigation and/or review, and will respond in writing as soon as reasonably practicable, and in any event within ninety (90) days from receipt thereof. An appeal is considered to be part of the claims process and not a complaint. For the avoidance of any doubt, any legal action should be brought against the *Insurer* (Sirius International Insurance Corporation), and not the *Plan Administrator* (International Medical Group, Inc.) or the *Plan Manager* (IMG Europe Limited)."

11. *You* cannot bring a legal action to recover under *Your Plan* within the first 90 days after *We* have been furnished with proof of claim in accordance with the requirements or after 12 months from the date proof of loss is required to be given to *Us*. *You* must file two (2) appeals of a claim denial

prior to bringing any legal action under the *Plan*. No action at law or in equity can be brought after the expiration of three (3) years after the time written Proof of Claim is required to be furnished.

12. *You*, and *Your Medical Practitioners*, Hospitals and other healthcare and medical service providers and suppliers shall undertake to cooperate fully with *Us* in reviewing, investigating, adjudicating, considering an appeal of, and/or administering any claim for benefits, including granting full right of access to all relevant, pertinent or related records, medical documentation, medical histories, reports, lab or test results, x-rays, and all other available evidence relating to or affecting the review, investigation, adjudication or administration of the claim. *We* shall have the right and opportunity to examine all evidence related to a claim when and as often as it may reasonably require during the pendency of a claim hereunder and to request an autopsy in case of death where it is not forbidden by law. *We* at *Our* option may suspend or pend adjudication of a claim, and/or may deny benefits and/or coverage for a claim, when there has been: (i) a refusal to so cooperate, (ii) an unreasonable delay in such cooperation, and/or (iii) any other act or omission on the part of the *Insured Person* and/or his/her healthcare providers which hinders, delays, impairs, or otherwise prejudices the performance of *Our* obligations under this insurance.

13. *Eligible Charges* will be paid by cheque, or electronic funds transfer, or direct payment onto *Your* preferred VISA or MasterCard, to *You* at *Your* last known residence or mailing address, or, at *Our* sole option and discretion directly to the provider. All claim settlements are subject to the applicable *Excess* and *Co-Insurance*, and to all limits and other *Terms* of this Policy Wording. Where *Direct Settlement* has been undertaken *You* are responsible for direct payment of the *Annual Excess* and *Co-Insurance* amounts and any non-*Eligible Charges.* In the rare event that a provider refuses *Direct Settlement*, or *We* are prevented from making *Direct Settlement* for operational or legal reasons (such restrictions on payments with certain countries which may be subject to a comprehensive sanctions programs as published by the United States Office of Foreign Assets Control), then *You* will be responsible for settling direct with the provider and seeking reimbursement from *Us*.

14. Under *Your Plan*, *You* can claim benefit from start of *Treatment* until the time when it is medically confirmed that the *Treatment* is no longer necessary, or until *Your Plan* is no longer in force, whichever is the earlier. If *You* subsequently claim for a new course of *Treatment*, which is not in any way connected with the former *Treatment*, the subsequent claim will be regarded as a new claim.

15. If *You* are under 18 years of age, claim payments will be made payable to the parent or guardian who signed *Your Application*.

16. In the event of any verbal or telephone enquiry, every attempt will be made to help the *Insured Person* and his/her healthcare providers and suppliers understand the status, scope and extent of available benefits and coverage under this *Plan. While this information may be provided,* no statement made by any agent, employee or representative of *Us,* the *Plan Administrator* or *Plan Manager* will be deemed or construed as an actionable representation, promise, or an estoppel, or will create any liability against *Us*, or the *Plan Administrator* or *Plan Manager* or be deemed or construed to bind *Us* or to modify, replace, waive, extend or amend any of the *Terms* of the *Plan* or this Policy Wording, unless expressly set forth in writing and signed by an authorised agent or representative of *Us*.

17. Actual eligibility determinations, benefit verifications, final coverage decisions and claim adjudications, and final payments and/or reimbursements of benefits or claims shall be determined and adjudicated only after or at the time a proper and complete *Application* and/or *Proof of Claim* is submitted (as the case may be), an opportunity for reasonable investigation and/or review is provided, cooperation required hereunder received, and all facts and supporting information, including relevant data, information and medical records when deemed necessary or appropriate by *Us*, are presented in writing. Appealed claims may be further investigated and/or reviewed.

18. The *Terms* of *Plan* govern all available coverage and payments made or to be made. If a definite answer to a specific benefits or coverage question is required for any reason, the *Insured Person* or his/her healthcare providers may submit a written request to *Us*, including all pertinent medical information and a statement from the attending *Medical Practitioner* (if applicable), and a written reply will be sent by *Us* and kept on file. If *We* elect to verify generally and/or preliminarily to a provider or the *Insured Person* that an *Injury*, *Illness*, diagnosis or proposed *Treatment* is or may be covered under this *Plan*, or that benefits for same are or may be available as outlined in this *Plan*, any such verification of benefits does not guarantee either payment of benefits or the amount or eligibility of benefits.

19. Final eligibility determinations, coverage decisions, claim appeals, and actual reimbursement or payment of claims or benefits are subject to all *Terms* of this *Plan*, including without limitation filing a proper and complete Proof of Claim under General Claims Conditions Section and cooperation under General Claims Conditions Section.

Medical Management Services

*1. **Pre-Certification***

For many of the benefits under *Your Plan You* are required to notify *Us* PRIOR to incurring or undertaking any *Treatment* and before being admitted to *Hospital*. *Pre-Certification* is a general determination of *Medical Necessity* only and all such determinations are made by *Us* in reliance and based upon the completeness and accuracy of the information provided by *You* or on *Your* behalf at the time of *Pre-Certification*. Subject always to all of the *Terms* of this Policy Wording, if *You* comply with the *Pre-Certification* requirements under *Your Plan*, *We* will pay *Eligible Charges* for the costs or *Treatment* which is *Pre-Certified* as *Medically Necessary*.

We reserve the right under the *Terms* of this Policy Wording to challenge, dispute, or retrospectively revoke a prior determination of *Medical Necessity* based on information obtained.

Pre-certification is not an assurance, authorisation, preauthorisation, or verification of *Treatment* or coverage, a verification of benefits, or a guarantee of payment; and cover remains subject to the *Terms* of the *Plan*. The fact that *Treatment* or supplies are *Pre-certified* by *Us* does not guarantee the payment of benefits, the availability of cover, or the amount of or eligibility for benefits.

Notification to *Us* for purposes of *Pre-Certification* may be undertaken by *You*, *Your Medical Practitioner*, the *Hospital* administrator or a *Relative*.

i. *Pre-Certification* is required within 48 hours after an *Emergency* admission to the *Hospital*.

   Pre-Certification for *Medical Necessity* must always be obtained through the *Plan Administrator* or *Plan Manager* before any of the following *Treatments* and/or supplies:

- Incurring any costs in an amount beyond $900 / £500 / €750 (if *You* are unsure, always check with *Your Medical Practitioner*, *Hospital* or *Medical Provider* before incurring any costs).
- *In-Patient* or *Day-Patient: Admission, Treatment and/or supplies of any kind,* or *Surgery* in *Hospital* **
- *Out-Patient Surgery* **
- *Second Surgical Opinion*
- *Psychiatric/Mental/Nervous Treatment of any kind*
- CAT and MRI scans, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cystoscopy **
- *Home nursing care* **
- Care in a *hospice Extended Care Facility* or rehabilitation facility **
- Incurring charges for *Emergency* evacuation / repatriation
- Incurring charges for travel and accommodation
- Cremation/burial or repatriation of *Your* remains
- Worldwide *Accident* and *Emergency Treatment* out of *Your Geographic Area of Cover* in an amount beyond $900/£500/€750 or any *Hospital* admission
- The expiration of the first 90 days of *Pregnancy*
- Incurring charges for *Durable Medical Equipment*
- *Physiotherapy, Chiropractic, Homeopathic and Osteopathic therapy of more than 10 visits*
- Incurring charges for prosthetic devices or artificial limbs
- Receiving *Covered Transplant Treatment* or supplies **

****Important Note: *Pre-Certification* of *Treatment* within the USA**:**
The above ** marked items, services, expenses or treatments if due to be incurred within the USA on a non-*Emergency* basis must be co-ordinated through *Our* USA Medical Concierge Service on: Telephone (USA) : +1 877 654 6229. The USA Medical Concierge Service will provide *Your* information to *Pre-Certification* also.

Items that are not marked with a **, or those expected to be incurred outside the USA, should be *Pre- Certified* using our standard *Pre-Certification Service* in iii) below.

(See Section 2 USA Medical Concierge Service below for further details including the special benefits and reduction in *Your Annual Excess* that will apply when utilising a USA Medical Concierge Service provider)

ii. Loss of Cover for Non-Compliance with *Pre-Certification* Requirements: If *You* are not *Pre-Certified* or fail to comply or co-operate with the *Pre-Certification* requirements the following reductions in cover will apply:

   a. For *Treatment* and supplies requiring *Pre-Certification*, *eligible charges* will be reduced by 50%;

   b. For *Treatment* and supplies relating to a transplant, all *Covered Transplant* benefits shall be forfeited and waived; and

   c. For *Treatment* provided under Section C7 Worldwide Accident and *Emergency* Out of Area Cover for an amount greater than £500/$900/€750 or any *Hospital* admission, all benefits shall be forfeited and waived.

iii. For *Pre-Certification You* must follow the following procedure:
   Contact *Us* at the telephone numbers printed on the membership card, as follows:

Outside USA/Canada (UK):	Tel +44(0) 2920 47 42 36
Within USA/Canada (USA):	Tel +1 800 628 4664
(Collect if necessary)	Tel +1 317 655 4500
E-mail:	acm@imglobal.com

- Contact *Us* as soon as possible, preferably at least four weeks prior to admission or before *Treatment* is obtained.

- In the event of an *Emergency Hospital* admission, *Pre-Certification* must be completed within 48 hours after the admission, or as soon as is reasonably possible.
- For transplant *Pre-Certification*, contact *Us* as soon as possible but always within 72 hours of becoming a candidate for a *Covered Transplant*.

  a. Comply with *Our* instructions and submit any information or documents required by *Us*; and

  b. Notify all *Medical Practitioners*, *Hospitals* and other healthcare providers that *Your Plan* contains *Pre-Certification* requirements and ask them to fully cooperate with *Us*.

Pre-Certification will be confirmed to *You* in writing. A verbal confirmation does not constitute pre-approval. If in doubt, please contact the *Pre-Certification* helpline, as shown on *Your* membership card.

If *You* give *Us* less than 30 days' notice, *We* will endeavour to confirm *Your* cover, but this may not be possible due to short timescales and the inability of outside parties (such as the *Hospital*, *Specialist* or *Your Medical Practitioner*) to assist in the process.

iv. Pre-Certfication Appeal Process - If *You* disagree with a *Pre-Certification* decision, *You* may ask *Us* to reconsider the decision within 90 days of *Our* decision and may supply additional documentation to support *Your* appeal. *We* will reconsider *Our* decision based on review of the additional documentation and facts, if any. *We* will advise *You* of *Our* decision.

2. USA Medical Concierge Service

The Medical Concierge Service is a proprietary service of IMG that helps *You* navigate the US Healthcare system to identify the highest quality, most cost-effective providers for scheduled *In-Patient, Day-Patient* and certain *Out-Patient Treatments*. With Medical Concierge, when *You* are scheduling *In-Patient* or *Out-Patient Treatment* in the USA *You* will receive important information to help *You* choose *Your Medical Practitioner*, including information on the number of procedures performed by the highest quality practitioners, the reported quality of the outcomes, the cost of the *Treatment* and other important information, thereby maximising the benefits provided under the *Plan*.

For non-*Emergency In-Patient Treatment* and the additional services marked by a ** in the above *Pre-Certification* Section or as listed below incurred within the United States, use of *Our* USA Medical Concierge Service will provide *You* with the ability to choose *Your Medical Practitioner,* Medical Provider or *Hospital* from a list of high quality, yet competitively priced providers within the geographical area *You* are located when *Treatment* is *Medically Necessary.*

Special Benefit When Using the USA Medical Concierge Service:

When *You* obtain *Treatment* and incur *Eligible Charges* from a *Medical Practitioner,* Medical Provider or *Hospital* appointed through our USA Medical Concierge Service, irrespective of whether the provider is within the US PPO Network - *We* will:

i. Reduce by 50% (up to a maximum reduction of $2,500 / £1,375 / €1,675) any part of the *Annual Excess* applicable to such claims; and

ii. Waive any and all *Co-Insurance* applicable to such claim.

In order to qualify and maximise the effectiveness of the Medical Concierge for these enhanced benefits, *You* must notify *Us* immediately upon recommendation of *Your Medical Practitioner* of any of the following:

- *In-Patient* or *Day-Patient Treatment* or *Surgery* in *Hospital*
- *Out-Patient Surgery*
- CAT and MRI scans, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cystoscopy
- *Home nursing care*
- Care in a *Hospice*, *Extended Care Facility* or rehabilitation facility
- Receiving *Covered Transplant Treatment* or supplies

Contact *Us* as soon as possible prior to the scheduling of *Treatment* on:

Telephone (USA): +1 877 654 6229
(Toll Free within the USA)

or Email: mcs@akesocare.com

3. Concurrent Review

While *You* are an *In-Patient*, *We* reserve the right to conduct an ongoing review of *Your Treatment* for purposes of detecting unnecessary *Treatment*, to help assure quality medical care and to contain costs. Beginning with *Your* admission as an *In-Patient*, *We* will approve a limited number of days of confinement based upon the *Eligible Medical Condition*. Thereafter, if additional days of *In-Patient Treatment* are necessary, *Your* continued stay in *Hospital* must again be reviewed and approved.

4. Plan Administrator's Provider Network - United States Preferred Provider Organisation (PPO)

You are free to choose the provider and location for *Your Treatment* within *Your Geographic Area of Cover*. It is not a requirement of *Your Plan* that *You* seek *Treatment* or supplies exclusively from a provider

within *Our Plan Administrator's* network of providers. However, *Your* use or non-use of *Our Plan Administrator's* network of providers may affect the scope and extent of benefits available under *Your Plan*, including the applicable *Excess* and *Co- Insurance*, as set forth in the Schedule of Cover:

i. Special benefit When Using the United States PPO Network

If *Treatment* or supplies eligible for coverage under this *Plan* are received directly from *Our* approved list of independent PPO providers while *You* are in the USA:

a. *We* will pay eligible expenses subject to the *Co-Insurance and* reduce by 50% (up to the maximum as indicated in the Schedule of Cover any part of the *Annual Excess* applicable *to such claim for Out-Patient* and *Emergency In-Patient Treatment* and*.*

b. *We* will waive any and all *Co-Insurance applicable to such claim for Out-Patient* and *any In-Patient Treatment.* However, all *Eligible Charges* received in the USA from a provider that is not within *Our Plan Administrators* United States PPO will remain subject to the applicable *Annual Excess* and *Co-Insurance* stated on the *Certificate of Insurance*, unless such *Eligible Charges* and *Treatment* is received from a *Medical Practitioner,* Medical Provider or *Hospital* appointed through our USA Medical Concierge Service.

ii. Utilisation of the Provider Network

You may contact *Our Plan Administrator* and request a directory of providers within the USA PPO Network, or within the network for the area where *You* will be receiving *Treatment* (therein listing the *Medical Practitioners*, *Hospitals* and other healthcare providers within the provider network by location and speciality), or *You* may obtain such information by accessing the website www.imgeurope.co.uk

PPO Information. *We*, through the *Plan Administrator*, endeavor to maintain a contractual arrangement with independent Preferred Provider Organisations (PPOs) that have established and maintained networks of U.S. and Non-US based *Medical Practitioners*, *Hospitals* and other healthcare and health service providers who are contracted separately and directly with the PPO and who may provide re-pricings, discounts or reduced charges for *Treatment* or supplies provided to *You.* Neither *Us* nor the *Plan Administrator, or Plan Manager* have any authority or control over the operations or business of the PPO, or over the operations or business of any provider within the independent PPO network. Neither the PPO nor any provider within the PPO network nor any of their respective agents, employees or representatives has or shall have any power or authority whatsoever to act for or on behalf of *Us,* the *Plan Administrator* or the *Plan Manager* in any respect, including without limitation no power or authority to:

i. approve applications or enrollments for initial, renewal or reinstated coverage under this insurance *Plan* or to accept *Premium* payments,

ii. accept risks for or on behalf of *Us*,

iii. act for, speak for, or bind *Us* or the *Plan Administrator* in any way,

iv. waive, alter or amend any of the *Terms* of this *Plan* or waive, release, compromise or settle any of *Our* rights, remedies, or interests thereunder or hereunder, or

v. determine *Pre-Certification*, eligibility for coverage, verification of benefits, or make any coverage, benefit or claim adjudications or decisions of any kind.

5. **Medical Case Management**

We reserve the right to make recommendations in respect of any *Treatment* or supply with respect to an *Eligible Medical Condition.* Such recommendations will be based on *Our* assessing, coordinating and collaborating with *You*, *Your* guardians, family members, *Medical Practitioners* and other healthcare providers to help ensure a well-coordinated continuity of care.

You are under no obligation to accept or follow any of *Our* recommendations. However, by accepting or following any of *Our* recommendations, *You* are agreeing to hold *Us* harmless from same, and *We* shall not be held liable or otherwise responsible for any *Treatment* or supply provided to *You* except for the payment of *Eligible Charges* under the *Terms* of this Policy Wording.

After *You* have been notified of *Our* medical case management recommendations, *We* reserve the right, at *Our* option and in *Our* sole discretion without liability, to:

a. pay for *Treatment* and supplies which, although not expressly covered under *Your Plan*, may be beneficial to *You* and cost effective to *Us*; and

b. deny cover or benefits for any charges which exceed the amount *We* would have covered had *You* accepted and followed *Our* recommendations.

6. **Mandatory Second Surgical Opinion** Except in the case of an *Emergency*, if a *Medical Practitioner* recommends one or more of the *Surgeries* listed below, *We* may require, as a condition to becoming eligible for benefits under *Your Plan*, that *You* consult with another independent *Medical Practitioner* for a second opinion as to the *Medical Necessity* of the *Surgery* ("Second Surgical Opinion").

1. *We* will notify *You* if a Second Surgical Opinion is required as soon as is reasonably possible after *You* Pre-certifies such *Surgery* in accordance with the *Pre-Certification* provision set forth in this above.

    a. Cataract Removal;
    b. Cholecystectomy;
    c. Coronary Bypass;
    d. Hemorrhoidectomy;
    e. Herniorrhaphy;
    f. Hysterectomy;
    g. Knee *Surgery*;
    h. Laminectomy;
    i. Ligation & stripping of varicose veins; and
    j. Lithotripsy;
    k. Submucous resection;
    l. Septo-rhinoplasty;
    m. Spinal Fusion;
    n. Tonsillectomy and/or adenoidectomy;
    o. any *Covered Transplant*.

2. The *Medical Practitioner* providing the second opinion must:
    a. not be a *Relative* of *Yours* or the first recommending *Medical Practitioner*; and
    b. not be financially or professionally or in any other way associated with the first recommending *Medical Practitioner*; and
    c. provide *Us* with a written opinion and any and all documents and records reasonably requested by *Us* in support of such opinion.

If the second opinion is required by *Us*, *We* will reimburse *You* for *Eligible Charges* incurred for the consultation, including any required diagnostic tests or procedures which were not carried out by the first recommending *Medical Practitioner*, without application of any *Annual Excess* or *Co-Insurance*. If the second opinion concurs with the recommending *Medical Practitioner*, then *We* will reimburse *You* for *Eligible Charges* in accordance with the *Terms* of this *Plan*.

If the second opinion differs from the recommending *Medical Practitioner*, *You* may be required to consult with another *Medical Practitioner* for a third opinion as to the *Medical Necessity* of the *Surgery*. The third *Medical Practitioner* must also meet the requirements of sub-item 2 (a)-(c) immediately above.

If the third opinion is required by *Us*, *We* will reimburse *You* for *Eligible Charges* incurred for the consultation, including any required diagnostic tests or procedures which were not carried out by the first or second *Medical Practitioner*, without application of any *Annual Excess* or *Co-Insurance*.

You must notify *Us* immediately in the event any one or more of the *Surgeries* listed above is recommended by a *Medical Practitioner*. *We* will promptly advise *You* whether or not *We* will require a second opinion. Upon receipt of a second opinion that differs from the recommending *Medical Practitioner*, *We* will promptly advise *You* whether or not *We* will require a third opinion. If *We* do not require a second opinion, *We* will reimburse *You* for *Eligible Charges* in accordance with the *Terms* of this *Plan.*

If *You* are requested or required to obtain a second or third opinion and do not, all benefits otherwise available under this *Plan* for reimbursement of *Eligible Charges* that are directly or indirectly related to or arise as a consequence of the *Surgery* shall be reduced by 50% percent .

If *You* obtain three opinions, *We* will reimburse *You* for *Eligible Charges* incurred in accordance with the *Terms* of this *Plan* based on the concurring recommendations of two of the three *Medical Practitioners*' opinions. If *You* elect not to follow the recommendations of the two concurring *Medical Practitioners*, all benefits otherwise available under this *Plan* for reimbursement of *Eligible Charges* which are directly or indirectly related to or arise as a consequence of the *Surgery*, or which are directly or indirectly related to or arise as a consequence of *Your* refusal to undergo the recommended *Surgery*, shall be reduced by 50% percent.

Making a Complaint

Our aim is to provide *You* with a first class standard of service at all times. Nevertheless, there may be an occasion when *You* may feel this objective has not been achieved by *Us*. In the unlikely event of this happening, should *You* have any issues or query regarding the service provided by *Us* under *Your Plan*, then please contact one of *Our* customer service advisors in the first instance.

IMG Europe Ltd
Telephone (UK): +44 (0) 1767 36 07 10
Fax (UK): +44 (0) 1737 860 600
E-mail: Admin@imgeurope.co.uk

If *You* wish to make a complaint, *You* are advised to write explaining the nature of *Your* query or complaint to:

Sirius International Insurance Corporation (publ) UK Branch
Floor 4, 20 Fenchurch Street
London EC3M 3BY
United Kingdom

Please quote *Your Certificate of Insurance* number and give full information regarding the query or complaint. Also include details of where *You* can be contacted. *We* will send a written acknowledgment of receipt and give *You* details of who is handling *Your* complaint and how to contact him or her.

We will resolve, or issue a final response to *Your* complaint within 8 weeks of receiving the complaint.

In the unlikely event *You* are not satisfied with *Our* final response, *You* may refer eligible complaints within 6 months to the Financial Ombudsman Service (FOS) if *You* are: a personal customer, or a business customer with a turnover under £1 million per year. The FOS can

be contacted at:

The Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London E14 9SR
United Kingdom

For the avoidance of any doubt, any complaint to the FOS should be brought against the *Insurer* (Sirius International Insurance Corporation), and not the *Plan Administrator* (International Medical Group, Inc.) or the *Plan Manager* (IMG Europe Limited). Please make sure *You* follow the above procedure for submitting or escalating *Your* complaint or query, since failure to do so may inadvertently delay *Our* response to *You*.

IMG Europe Ltd is authorised and regulated by the Financial Conduct Authority.