GlobalSelect®
International Healthcare Cover

Policy Wording for Individuals and Families

IMG SM
EUROPE LTD
INTERNATIONAL MEDICAL GROUP®

Effective from : **1st June 2012**

GlobalSelect®
International Healthcare Cover
Policy Wording

Index

Important Notice For Insured Persons

30 Day Money Back Guarantee

Please read through the Policy Wording 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, please provide written cancellation instructions and return the Policy Wording with the *Certificate of Insurance* to the *Plan Manager* within 30 days after receipt. *Your Premium* will be promptly refunded in full, provided no claim has been paid, and *Your Plan* will be retroactively cancelled. Of course, if *You* cancel *Your Plan* *You* cannot make a claim under it and neither *You* nor *We* will have any further rights, liabilities or obligations under the *Plan*. If *You* cancel *Your Plan* after 30 days from the date *You* receive this Policy Wording, subject to the Policy *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. 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

Please also read the copy of *Your Application* that accompanies this Policy Wording. Omissions or misstatements in *Your Application* could cause an otherwise valid claim to be denied. Carefully check the *Application* and write to the *Plan Manager* within 10 days if any information shown on it is not correct and complete, or if any past medical history has been left out of *Your Application*. *Your Application* forms a part of the Policy Wording, and *Your Plan* was issued on the basis that the answers to all questions and the information shown on the *Application* are true, accurate, complete and correctly recorded.

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
36-38 Church Road
Burgess Hill, West Sussex
RH15 9AE, United Kingdom

Telephone Numbers

Customer Services (UK)	+44 (0) 1444 46 55 77
Claims (UK)	+44 (0) 1444 46 55 88
Pre-Certification (UK)	+44 (0) 1444 46 55 88
(Calling from outside the USA) (US)	+1 317 655 4500
(Calling from inside the USA) (US)	800 628 4664

Emergency Medical Helpline

Emergency calls only to the UK	+44 (0) 1444 46 55 99
Emergency calls only to the USA	+1 317 655 4500

Useful E-Mail Addresses

Customer Services	info@imgeurope.co.uk
Claims	claims@imgeurope.co.uk
Pre-Certification	acm@imglobal.com

Fax Numbers

UK	+44 (0) 1444 46 55 50
US	+1 317 655 45 05

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 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 at the *Renewal Date* following *Your* 75th birthday.

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.

Acute Condition: A *Medical Condition* which is brief and which is likely to respond quickly to *Treatment* which aims to return *You* to the state of health *You* were in immediately before suffering the *Medical Condition*, or which leads to *Your* full recovery.

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.

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. This definition does not include athletic activities that are non-contact and engaged in by the *Insured Person* 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.

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* representative, and is not an agent or representative for or on behalf of *Us* or *Our Plan Administrator* or the *Plan Manager*.

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

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 permanent.
- *You* need to be rehabilitated or specially trained to cope with it.
- It needs long term monitoring, consultations, check ups, 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 *Excess*.

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

Congenital Disorder: Physical abnormality that is present at birth.

Country of Residence: The country in which *You* have *Your* habitual residence (residing for a period of at least 6 months per *Period of Insurance*) on the *Effective Date* or at each *Renewal Date*.

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.

Criminal Assault: Any wilful or unlawful use of force upon the *Insured Person* with the intent to cause bodily injury to the *Insured Person* and that results in bodily harm to the *Insured Person* and that is a crime in the jurisdiction in which it occurs.

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.

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.

Effective Date: The date shown on the *Certificate of Insurance* on which *You* were first covered under *Your Plan*.

Elective: Planned non-*Emergency Treatment* which is *Medically Necessary*.

Eligible Charges: The *Reasonable* and *Customary Charges* for those costs or 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: An *Acute Condition* of sufficient severity which could reasonably result in placing *Your* life or limb in danger if *Treatment* is not provided within 24 hours, based upon reasonable medical certainty.

Emergency Medical Evacuation: *Emergency* transportation from the *Hospital* or medical facility where the *Insured Person* is located to a non-local *Hospital* or medical facility, recommended by the attending *Medical Practitioner* who certifies, to a reasonable medical certainty that the *Insured Person* has experienced:

- a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the *Insured Person's* 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, the *Certificate of Insurance* or the *Application*, as the case may be.

Excess: The first amount payable by *You* (or on *Your* behalf) per *Eligible Medical Condition*, per *Period of Insurance* in respect of *Eligible Charges* and covers, before any benefits are paid under *Your Plan*, and exclusive of *Co-Insurance*. If *Treatment* has gone on for more than one *Period of Insurance*, *We* will treat it as a new claim for any further *Treatment* after that date and will reapply any *Excess*.

Experimental: Any *Treatment* or supply, including a *Drug*, that: by nature or composition deviates from, or is used or applied in a way which deviates from, generally accepted standards of 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 to which *Your* cover is restricted, 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 (if applicable to *Your* chosen *Sub-Plan*) and only for a period not exceeding the duration in days and up to the monetary value 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, 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, Kyrgyzstan, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Madeira, Malta, Moldova, Monaco, 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, the Vatican City and Yugoslavia.

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

Area 3
Worldwide

Home Country: The country of which *You* are a citizen or national or maintain *Your* primary residence or usual place of abode or of which *You* possess a validly issued passport. Where *You* hold more than one passport, in the absence of other evidence, *Your Home Country* will mean the country declared on the *Application*. *Note:* For citizens of the United States of America, the *Home Country* is always the United States of America.

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.

Illness: A sickness, disorder, pathology, abnormality, ailment, or any other medical, physical or health condition. *Illness* does not include a learning disability, or an attitudinal or disciplinary problem.

Injury: Bodily injury which is caused solely by an *Accident*.

In-Patient: An *Insured Person* who stays overnight or longer in *Hospital*, and is admitted solely to receive *Medically Necessary Treatment* for an *Eligible Medical Condition*.

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.

Intensive Care Unit: An area of a *Hospital* set up for very ill or seriously injured patients who must be 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.

Lifetime Limit: The cumulative total amount of benefit payments or reimbursements available to *You* during *Your* lifetime under the *Plan*.

Local Ambulance / Local Ambulance Transport: Transportation and accompanying care provided by designated 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, unless it is *Medically Necessary* to transfer the *Insured Person* by *Local Ambulance Transport*.

Medical Condition: Any *Injury*, *Illness* (including psychiatric *Illness* and *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*.

Medically Necessary; Medical Necessity: A *Treatment* or supply which is necessary, appropriate and required for an *Eligible Medical Condition* and which is provided in accordance with generally accepted medical standards of current medical practice. A *Treatment* 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*.

Medical Practitioner: A qualified practitioner of the medical arts who is currently licensed by the state or country in which the *Treatment* is provided and who is acting within the scope of that license, other than *You* or a *Relative* or a person who resides or has resided in *Your* home.

Mental or Nervous Disorder: Any mental, nervous, psychiatric or emotional *Illness* which generally denotes an *Illness* of: the brain with predominant behavioural symptoms; or the mind or personality evidenced by abnormal behaviour; or conduct evidenced by socially deviant behaviour. *Mental* or *Nervous Disorder* does not include learning disabilities, or attitudinal or disciplinary problems or *Alcohol* and *Substance Abuse*.

Natural Disaster: Widespread disruption of human lives by disasters such as floods, drought, tidal wave, fire, hurricane, earthquake, windstorm or other storm, landslide, or other natural catastrophe or event resulting in migration or emergency evacuation of the population for its safety.

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

Out-Patient: 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*.

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

Partner: A person who is residing with *You* in a conjugal relationship.

Period of Insurance: The first *Period of Insurance* is the period of 12 consecutive months starting from the *Effective Date*. Thereafter, the *Plan* is renewable for successive one-year periods, and a *Period of Insurance* is the period from one *Renewal Date* to the next *Renewal Date*.

Plan: 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*.

Plan Administrator: 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 liability or obligation of any kind whatsoever under the *Plan*.

Plan Manager: 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, 36-38 Church Road, Burgess Hill, West Sussex, RH15 9AE, United Kingdom, and it has and shall have no direct, indirect, joint, several, separate, individual, or independent liability or obligation of any kind under the *Plan*.

Pre-Certification; Pre-Certified: 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 also involves a general determination of *Medical Necessity*, made in reliance and based upon the completeness and accuracy of the information provided to *Us* at the time thereof. *Pre-Certification* does not guarantee that *We* will pay charges incurred by *You*.

Pre-Existing Condition: Any *Medical Condition* or any *Chronic*, subsequent or recurring complication or consequence associated with or arising or resulting from a *Medical Condition* that, with reasonable medical certainty, existed on or at any time prior to the *Effective Date*; whether or not previously manifested or symptomatic, diagnosed, treated, or *You* were aware it existed, even if disclosed on the *Application* or on 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.

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 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 state 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, son, daughter, son- or daughter-in-law, parent, step-parent, parent-in-law, grandparent, grandchild, brother, sister, brother-in-law or sister-in-law.

Renewal Date: An anniversary of the *Effective Date*.

Self-Inflicted: Action or inaction by the *Insured Person* that the *Insured Person* consciously understands will or may cause or contribute, directly or indirectly, to his or her personal *Injury* or *Illness*. *Self-inflicted* specifically includes failure of an *Insured Person* to follow his or her *Medical Practitioner's* orders, complete prescriptions as directed, or follow any health care protocol or procedures designed to return or maintain his or her health.

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

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 sum insured per *Period of Insurance* for *Your* chosen *Sub-Plan*.

Sub-Plan: One of the four pre-set levels of cover chosen by *You* under the *Plan*, as indicated on the *Certificate of Insurance*. The *Sub-Plans* are Head Start, Basic, Standard and Executive.

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 *Your Plan* would include without limit:

- Specialist referral services which typically involves of a specialist assisting a *Medical 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 over the internet.

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: The systematic or planned use of violence, fear, or the threat of violence in order to intimidate or influence a group, community, population or government, especially as a means of coercion or to obtain a granting of any demand and/or to put the public, or any section of the public, in fear.

Treatment: Any and all professional services and procedures rendered to *You* in the diagnosis, management or care of any *Medical Condition*, including without limitation: any consultation, discussion or visit with a *Medical Practitioner*, *Specialist*, or *Dental Practitioner*; any examination, therapy, diagnostic test or evaluation of any kind; *Palliative Care* and home nursing care; pharmacotherapy or other medication; and *Surgery*.

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*. Any and all benefits listed below which do not appear in the Schedule of Cover and Excesses relevant to *Your* chosen *Sub-Plan* are not covered under *Your Plan*. 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.

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 overall aggregate maximum sum insured per *Insured Person*, per *Period of Insurance*. 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 Excess relevant to *Your* chosen *Sub-Plan*.

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

	GlobalSelect	HeadStart	Basic	Standard	Executive
	OVERALL AGGREGATE MAXIMUM SUM INSURED PER PERIOD OF INSURANCE PER INSURED PERSON	£1,000,000 $1,750,000 €1,200,000	£1,000,000 $1,750,000 €1,200,000	£1,500,000 $2,625,000 €1,800,000	£5,000,000 $8,750,000 €6,000,000
A	**In-Patient & Day-Patient Treatment**				
1	Hospital Accommodation & Theatre	Full Cover	Full Cover	Full Cover	Full Cover
2	Accidents, Emergencies, Intensive Care inc. Surgical Care, Second Surgical Opinion, Anaesthetics, Medical Practitioner charges for Surgery, Treatment, Services and Supplies routinely provided				
3	Surgeons, Consultants, Anaesthetists, Nurses and Ancillary Charges				
4	Medical Practitioners				
5	Prescribed Drugs, Dressings and Durable Medical Equipment				
6	Reconstructive Surgery-following an accident or following surgery for an eligible condition				
7	Diagnostic Tests and Procedures, X-rays, Pathology, & MRI/CT Scans				
8	Cancer Tests, Drugs, Treatment and Consultants, including cover for Chemotherapy and Radiotherapy				
9	Physiotherapy				
10	Parental Hospital Accommodation				
11	Post Hospitalisation Treatment ▪ Received within 90 days of being discharged from hospital				
12	Hospital Cash Benefit	£100/ $175/ €120/night 60 nights	£150/ $263/ €180/night 60 nights	£200/ $350/ €240/night 60 nights	£300/ $525/ €360/night 60 nights
13	Organ Transplant *(major covered organs)*	No Cover	£100,000/ $175,000/ €120,000 Lifetime Limit	£100,000/ $175,000/ €120,000 Lifetime Limit	£200,000/ $350,000/ €240,000 Lifetime Limit
14	Prosthetic Devices		No Cover	Full Cover	Full Cover
15	Psychiatric Treatment ▪ After 12 months continuous cover under the Policy	Full Cover, to a maximum of 30 days	Full Cover, to a maximum of 30 days	Full Cover, to a maximum of 30 days	Full Cover, to a maximum of 30 days
B	**Out-Patient Treatment and Wellness Benefits**				
1	Family Doctor, Treatment & Referrals	No Cover	Up to £300/ $525/ €360 per Period of Insurance	Up to £5,000/ $8,750/ €6,000*	Full Cover*
2	Specialists and Consultants *(fees for consultations)* **Coverage is NOT dependent upon admission*	Up to £400/ $700/ €480 per condition prior to admission*, then up to £1,000/ $1,750/ €1,200 following out-patient surgery or in-patient/ day-patient treatment	Up to £1,500/ $2,625/ €1,800 per condition for pre and post hospital treatment		

	GlobalSelect	HeadStart	Basic	Standard	Executive
B	**Out-Patient Treatment and Wellness Benefits** *(continued)*				
3	X-rays, Pathology, Diagnostic Tests and Procedures **Coverage is NOT dependent upon admission*	Up to £200/$350 /€240 per condition prior to admission* and following out-patient surgery or in-patient/ day-patient treatment	As part of £1,500/ $2,625/ €1,800 per condition for pre and post hospital treatment limit	As part of £5,000/ $8,750/ €6,000*	Full Cover*
4	Prescribed Drugs, Medicines, Dressings and Durable Medical Equipment	No Cover			
5	Out-Patient Surgery	Full Cover	Full Cover	Full Cover	
6	MRI and CT Scans				
7	Cancer Tests, Drugs, Treatment and Consultants				
8	Physiotherapy, Homeopathic and Osteopathic Therapy	No Cover	Maximum 10 visits as part of the £1,500/ $2,625/ €1,800 limit	Maximum 15 visits as part of the £5,000/ $8,750/ €6,000 limit	Up to £2,500/ $4,375/ €3,000 for up to 20 visits
9	Complementary Medical Treatment: Acupuncture, Aroma Therapy, Chiropractic Therapy, Herbal Therapy, Magnetic Therapy, Massage Therapy, Vitamin Therapy, Traditional Chinese Medicine when referred by a Doctor, General Medical Practitioner (GP)		No Cover	Up to £500/ $875/ €600	Up to £2,500/ $4,375/ €3,000
10	AIDS/HIV Treatment			Up to £8,750/ $15,000/ €10,285, with a Lifetime Limit of £28,570/ $50,000/ €34,285	Up to £8,750/ $15,000/ €10,285, with a Lifetime Limit of £57,140/ $100,000/ €68,570
11	Hormone Replacement Therapy-Early Onset			Full Cover 18 Month Lifetime Limit	Full Cover 18 Month Lifetime Limit
12	Home Nursing Care Primary care services of a registered nurse in the Insured Person's home immediately after, or instead of, In-Patient/Day-Patient Treatment	Up to £75/$132/ €90/visit to a maximum of 15 visits	Up to £75/$132/ €90/visit to a maximum of 30 visits	Up to £75/$132/ €90/visit to a maximum of 45 visits	Up to £75/$132/ €90/visit to a maximum of 60 visits
13	Rehabilitation	No Cover	Full Cover Up to 30 Days	Full Cover Up to 90 Days	Full Cover Up to 180 Days
14	Extended Care Facility		Full Cover Up to 6 Months	Full Cover Up to 6 Months	Full Cover Up to 6 Months
15	Hospice Care				
16	Adult Wellness and Health Check ▪ Medical check-up including, cervical smear, mammogram, cancer screening, cardiovascular examinations, neurological examinations, vital sign tests *(e.g. blood pressure, cholesterol checks)* ▪ Hearing Test, Sight Test and Vaccinations/Inoculations ▪ After 12 months continuous cover under the Policy		No Cover	Up to £400/$700/ €480 *(Nil Excess)*	Up to £500/$875/ €600 *(Nil Excess)*
17	Child Wellness and Health Check ▪ Hearing Test, Sight Test and Vaccinations/Inoculations ▪ After 12 months continuous cover under the Policy			Up to £400/$700/ €480 *(Nil Excess)*	Up to £500/$875/ €600 *(Nil Excess)*
18	Psychiatric Treatment ▪ After 12 months continuous cover under the Policy			Up to £2,500/ $4,375/€3,000	Up to £2,500/ $4,375/€3,000

	GlobalSelect	HeadStart	Basic	Standard	Executive
C	**Travel, Transportation and Out of Area Benefits**				
1	Emergency Local Ambulance	Full Cover	Full Cover	Full Cover	Full Cover
2	Emergency Medical Evacuation and Transportation	Full Cover To nearest medical facility within Your Area of Cover	Full Cover To nearest medical facility, Home Country, or country of choice within Your Area of Cover	Full Cover To nearest medical facility, Home Country, or country of choice within Your Area of Cover	Full Cover To nearest medical facility, Home Country, or country of choice within Your Area of Cover
3	Accompanying Relative, Travel and Accommodation	No Cover	Full Cover	Full Cover	Full Cover
4	Cremation/Burial or Repatriation of Remains	Up to £5,715/ $10,000/ €6,860	Up to £5,715/ $10,000/ €6,860	Up to £8,570/ $15,000/ €10,285	Up to £14,285/ $20,000/ €17,140
5	Compassionate Visit ▪ After 12 months continuous cover under the Policy	No Cover	Up to £1,428/ $2,500/ €1,715	Up to £3,000/ $5,250/ €3,600	Up to £3,000/ $5,250/ €3,600
6	USA Elective Treatment within Provider Network Excludes non-emergency travel & accommodation *(Applicable to Insureds who have not selected Area 3 - Worldwide Cover)*		No Cover	Up to £500,000/ $875,000/ €600,000 with 20% Co-Insurance *(Nil Excess)*	Up to £500,000/ $875,000/ €600,000 with 20% Co-Insurance *(Nil Excess)*
7	Worldwide Accident and Emergency Out of Area Cover		30 Days Maximum, up to £15,000/ $26,250/ €18,000	45 Days Maximum, up to £20,000/ $35,000/ €24,000	60 Days Maximum, up to £20,000/ $35,000/ €24,000
D	**Cover in respect of Pre-Existing Medical Conditions and Chronic Conditions**				
1a	**Pre-Existing Conditions – Underwriting/Cover Options** Full Medical Underwriting Option* ▪ After 24 months continuous cover under the Policy *(unless excluded or terms applied as indicated otherwise in writing)*	No Cover	Up to £1,500/ $2,625/ €1,800 with a Lifetime Limit of £15,000/ $26,250/ €18,000	Up to £2,000/ $3,500/ €2,400 with a Lifetime Limit of £20,000/ $35,000/ €24,000	Up to £3,000/ $5,250/ €3,600 with a Lifetime Limit of £30,000/ $52,500/ €36,000
or					
1b	Moratorium Enrolment & Underwriting Option* ▪ After 24 months continuous cover: subject to 24 months without treatment, symptoms, medication or consultation *(refer to Endorsement for further details)**		Full Cover	Full Cover	Full Cover
	*Cover in respect of Pre-Existing Conditions is as selected at time of application and identified on your Certificate of Insurance. Refer to page 16 for further details and Policy Wording for full Policy definitions, terms, conditions and restrictions.				
2	Chronic Conditions and Palliative Care	No Cover	No Cover	Up to £2,000/ $3,500/ €2,400 with a Lifetime Limit of £20,000/ $35,000/ €24,000	Up to £3,000/ $5,250/ €3,600 with a Lifetime Limit of £30,000/ $52,500/ €36,000
3	Stabilisation of Acute Chronic Episode		Up to £5,000/ $8,750/ €6,000	Full Cover	Full Cover
E	**Dental Treatment**				
1	Emergency Dental Treatment *(In-Patient or Day-Patient)*	No Cover	Full Cover	Full Cover	Full Cover
2	Accidental Dental Damage caused to sound natural teeth lost or damaged in an accident. Out-patient Treatment/Dental Surgery must be received within 5 days from the date of the accident occurring		No Cover	Up to £250/ $438/ €300	

	GlobalSelect	HeadStart	Basic	Standard	Executive
E	**Dental Treatment** *(continued)*				
3	Emergency Dental Treatment *(Out-Patient/Dental Surgery)* ▪ For the immediate relief of severe pain, being treatment of an abscess, cracked or broken tooth rebuild or temporary filling within 24 hours from the onset of pain and no more than 5 days from the event	No Cover	No Cover	No Cover	Up To £250/$438/ €300 in aggregate- subject to 25% Co-Insurance *(Nil Excess)*
4	Routine Dental Treatment *(Out-Patient)**** for the restoration of natural teeth a) examinations, check-up and x-rays b) tooth cleaning and polishing c) normal compound fillings, simple or non-surgical extractions ***incurred after 180 days from the Effective Date.				Up To £400/$700/ €480 in aggregate a) £50/$88/€60 visit, maximum two visits each Period of Insurance b) £50/$88/€60 visit, maximum two visits each Period of Insurance c) £50/$88/€60 each tooth *(£80/$140/€96/ wisdom tooth)* Subject to 25% Co-Insurance *(Nil Excess)*
5	Major Restorative Dental Treatment**** ▪ Removal of impacted, buried or unerrupted teeth, removal of roots, removal of solid odontomes, apicetomy, new or repair of bridgework, new or repair of crowns *(not precious metal)*, root canal treatment, new or repair of upper or lower dentures **** incurred after 12 months from the Effective Date.				Up To £750/ $1,313/ €900 in aggregate, subject to 50% Co-Insurance *(Nil Excess)*
F	**Non-Medical Insured Covers and Benefits**				
1	Out of Country Legal Expenses	No Cover	No Cover	Up to £5,000/ $8,750/ €6,000 *(£250/ $438/ €300 Excess)*	Up to £10,000/ $17,500/ €12,000 *(£350/ $613/ €420 Excess)*
2	Vision Contribution Due to Accident Benefit			No Cover	£200/$350/€240 subject to 50% Co-Insurance
3	Security & Political Evacuation & Repatriation			Up to £7,500/ $13,125/ €9,000 Lifetime Limit	Up to £10,000/ $17,500/ €12,000 Lifetime Limit
4	Identity Theft Cover & Assistance			Up to £250/ $438/ €300	Up to £500/ $875/ €600
5	Out of Country Criminal Assault Benefit ▪ When admitted to hospital for 48 hours or more			£500/ $875/ €600 per admitted night to a maximum of £2,500/ $4,375/ €3,000	£1,000/ $1,750/ €1,200 per admitted night to a maximum of £5,000/ $8,750/ €6,000
6	Natural Disaster Evacuation & Accommodation			Up to £150/ $263/ €180 per 24 hours for up to 5 days	Up to £250/ $438/ €300 per 24 hours for up to 5 days

GlobalSelect		HeadStart	Basic	Standard	Executive
G	**Other Services and Benefits**				
1	24 Hour Emergency Helpline	Included	Included	Included	Included
2	USA Medical Concierge Service ▪ For eligible treatment in the USA				
3	Medical Information Service** – Access to board-certified physicians, licensed psychologists, and pharmacists to assist with any routine health related questions	Not Applicable	Not Applicable		

Sub-Plan Excesses				
Standard Sub-Plan Excess-Per Person, Per Condition, Per Period of Insurance *(unless indicated otherwise)*	£100/$180/ €150	£100/$180/ €150	£50/$90/ €75	£25/$45/ €38
Maximum Excess Per Person Per Period of Insurance *(whichever is the greatest)*	10X standard/ voluntary excess	5X standard/ voluntary excess	5X standard/ voluntary excess	10X standard/ voluntary excess
Maximum Total Family Excess Per Period of Insurance *(whichever is the greatest)*	20X standard/ voluntary excess	10X standard/ voluntary excess	10X standard/ voluntary excess	20X standard/ voluntary excess
Voluntary Medical Excesses				
Sub-Plan Excess Options - If chosen by you and as identified on your Certificate of Insurance *(Note: Choose carefully as you cannot select a lower excess at renewal)*	N/A	N/A	Nil	Nil
	N/A	N/A	N/A	£50/$90/€75
	N/A	N/A	£100/$180/ €150	£100/$180/ €150
	£250/$450/ €375	£250/$450/ €375	£250/$450/ €375	£250/$450/ €375
	£500/$900/ €750	£500/$900/ €750	£500/$900/ €750	£500/$900/ €750
	£1,000/ $1,800/ €1,500	£1,000/ $1,800/ €1,500	£1,000/ $1,800/ €1,500	£1,000/ $1,800/ €1,500
	£2,500/ $4,500/ €3,750	£2,500/ $4,500/ €3,750	£2,500/ $4,500/ €3,750	£2,500/ $4,500/ €3,750
	£5,000/ $9,000/ €7,500	£5,000/ $9,000/ €7,500	£5,000/ $9,000/ €7,500	£5,000/ $9,000/ €7,500
	£10,000/$18,000/ €15,000	£10,000/ $18,000/ €15,000	£10,000/$18,000/ €15,000	£10,000/ $18,000/ €15,000

KEY Schedule of Excesses - Unless identified elsewhere within the Policy Wording, the Excesses applicable per Section are:	
	Full Cover after the Standard Sub-Plan Excess *(or your Voluntary Medical Excess)* as identified on your Certificate of Insurance, per Medical Condition claimed per Period of Insurance, unless stated otherwise
	Covered up to the amounts shown after the Standard Sub-Plan Excess *(or your Voluntary Medical Excess)* as identified on your Certificate of Insurance, per Medical Condition claimed per Period of Insurance, unless stated otherwise
Note: With regards to Treatment in the USA - The Excess and Co-Insurance will be reduced by 50% for Eligible Charges incurred within the Plan Administrator's Network of Providers or incurred within a facility arranged via the USA Medical Concierge Service *(with the exception of claims under Section C6 Elective Treatment in the USA and Dental Claims).*	

**Service provided by third party and membership issued under separate documentation included within the IMG GlobalSelect fulfillment pack.

With regard to the foregoing Schedule of Cover and Excesses, any reference to 'continuous cover' means continuous, unbroken cover under the GlobalSelect plan. The applicable benefits described will become first available to the Insured Person only at the end of the continuous cover period so specified.

SECTION A : In-Patient & Day-Patient Treatment

Subject to the *Terms* of this Policy Wording, *We* will pay *In-Patient* and *Day-Patient* charges *You* incur as follows:

A1. Hospital Accommodation & Theatre

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); and 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*. Personal items such as telephone calls, newspapers and guest meals are excluded from cover.

A2. Accidents, Emergencies, Intensive Care

We will pay *Eligible Charges* for: *Surgery*; *Pre-Certified* second surgical opinion; anaesthetics; processing and administration of blood or blood components (including haemodialysis); oxygen; other gasses and anaesthetics; *Medical Practitioner* services; services and supplies routinely provided in an *Intensive Care Unit*; *Emergency Treatment* of an *Injury*, even if *Hospital* confinement is not required; *Emergency Treatment* of an *Eligible Medical Condition*; however, charges for *Your* use of the *Emergency* room itself will not be eligible unless *You* are directly admitted to the *Hospital* as an *In-Patient* for further *Treatment* of that *Medical Condition*.

A3. Surgeons, Consultants, Anaesthetists, Nurses and Ancillary Charges

We will pay *Eligible Charges* for professional services (including *Ancillary Charges*) rendered by surgeons, *Consultants*, anaesthetists 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.

A4. Medical Practitioners

We will pay *Eligible Charges* for professional services rendered by *Medical Practitioners*, including *Surgery*; provided however that standby availability of a *Medical Practitioner* will not be deemed to be a professional service and is not eligible for cover.

A5. 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 *Medically Necessary* rental of *Durable Medical Equipment*, up to the purchase price.

A6. 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.

A7. 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 is not included).

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 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. Post Hospitalisation Treatment

We will pay *Eligible Charges You* receive within 90 days after being discharged from *Hospital* that is directly related to the *Eligible Medical Condition* for which *You* were in *Hospital*.

A12. Hospital Cash Benefit

When *You* are admitted to a *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 of 60 nights in *Hospital* per *Period of Insurance*, as shown in the Schedule of Cover and Excesses relevant to *Your* chosen *Sub-Plan*. No *Excess* or *Co-Insurance* applies to this benefit. To claim this benefit, please ask the *Hospital* to sign and stamp *Your* claim form.

A13. 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 £6,000/$10,000/ €9,000; 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 £3,000/$5,000/€4,500 per *Your* lifetime.

(5) *Eligible Charges* for *Your* related *Out-Patient Treatment* required before and after the *Covered Transplant*.

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*.

We shall have no right, obligation, or authority of any kind to ultimately select *Medical Practitioners*, *Hospitals*, or other healthcare providers for *You* or to make any *Treatment* decisions for or on *Your* behalf regarding transplants.

Please note: No cover applies under Section A13 to the HeadStart *Sub-Plan*.

A14. Prosthetic Devices

We will pay *Eligible Charges* for *Pre-Certified* basic functional artificial limbs, eyes, larynx or breast prostheses (carried out within 2 years after *Surgery* for breast cancer), but not the replacement or repair thereof. *We* will pay *Eligible Charges* for the following artificial body parts designed to form a permanent part of *Your* body and implanted by *Surgery* for one or more of the following reasons: To replace a joint or ligament; to replace one or more heart valves; to facilitate cardiovascular flow by the use of stents; to replace the aorta or an aertial blood vessel; to replace a sphincter muscle; to control urinary incontinence (bladder control); to act as a pacemaker; or to remove excessive fluid from the brain.

Please note: No cover applies under Section A14 to the HeadStart and Basic *Sub-Plans*.

A15. Psychiatric Treatment

We will pay *Eligible Charges* for *Pre-Certified Treatment* of a *Mental* or *Nervous Disorder* as an *In-Patient* in a recognised psychiatric unit of a *Hospital*, provided *You* have been continuously insured under the *Plan* for not less than 12 months immediately preceding such *Treatment*. Cover is limited to a maximum of 30 days per *Period of Insurance*.

All *Treatment* with respect to this benefit must be *Pre-Certified* and must at all times be administered under the direct control of a registered psychiatrist. Without *Our* written confirmation prior to such *Treatment We* will not be liable to pay any benefit.

SECTION B : Out-Patient Treatment and Wellness Benefits

IMPORTANT NOTE: The HeadStart, Basic and Standard *Sub-Plans* contain special cover restrictions relating to Sections B1, B2, B3 and B4 of this Policy Wording.

A) With respect to Section B restrictions for the HeadStart *Sub-Plan*:

(1) No cover is provided with respect to Section B1.

(2) Cover with respect to Section B2 is limited up to the *Sub-Limit* shown in the Schedule of Cover and Excesses, per *Eligible Medical Condition*, limited to being solely in respect to:

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

b) additional *Consultant* or *Specialist* fees following *Out-Patient Surgery* or *In-Patient* or *Day-Patient Treatment*.

No other cover applies under Section B2.

(3) Cover with respect to Section B3 is limited up to the *Sub-Limit* shown in the Schedule of Cover and Excesses, per eligible medical condition for x-rays, pathology, diagnostic tests and procedures prior to admission in *Hospital*, and following *Out-Patient Surgery* or *In-Patient* or *Day-Patient Treatment*. No other cover applies under Section B3.

(4) No cover is provided with respect to Section B4

(5) Where *You* have previously elected the HeadStart *Sub-Plan* and later elect an alternative *Sub-Plan* at any subsequent *Renewal Date*, any eligible charge associated with *Out-Patient Treatment* of an existing *Eligible Medical Condition* which is over and above the benefits provided by the HeadStart *Sub-Plan* will be excluded.

B) With respect to Sections, B2, B3 and B4 of the Basic *Sub-Plan*:

Total cover is limited in aggregate up to the *Sub-Limit* shown in the Schedule of Cover and Excesses, per *Eligible Medical Condition* and per *Period of Insurance* for pre and post *In-Patient*, *Day-Patient*, or *Out-Patient* Surgery *Hospital Treatment* only. No other cover applies under Sections B2, B3 and B4.

C) With respect to Sections B1, B2, B3 and B4 of the Standard *Sub-Plan*:

Total cover is limited in aggregate to the *Sub-Limit* shown in the Schedule of Cover and Excesses, per *Period of Insurance*. No other cover applies under Sections B1, B2, B3 and B4.

Subject to the *Terms* of this Policy Wording, *We* will pay *Out-Patient Treatment* and *Out-Patient Surgery* and wellness charges *You* incur as follows:

B1. Family Doctor, Treatment & Referrals

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.

Note regarding the HeadStart, Basic and Standard *Sub-Plans*: Please refer to the Important Notes above relating to special cover restrictions.

B2. Specialists and Consultants

We will pay *Eligible Charges* for professional services rendered by *Specialists* and *Consultants*.

Note regarding HeadStart, Basic and Standard *Sub-Plans*: Please refer to the Important Notes above relating to special cover restrictions.

B3. X-rays, Pathology, Diagnostic Tests and Procedures

We will pay *Eligible Charges* for x-rays, pathology, diagnostic tests and procedures undertaken by a recognised medical facility, including *Surgery*.

Note regarding HeadStart, Basic and Standard *Sub-Plans*: Please refer to the Important Notes above relating to special cover restrictions.

B4. Prescribed 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*. Any benefit for *Durable Medical Equipment* is conditioned upon *Pre-Certification*.

Note regarding the HeadStart, Basic and Standard *Sub-Plans*: Please refer to the Important Notes above relating to special cover restrictions.

B5. Out-Patient Surgery

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

B6. MRI and CT Scans

We will pay *Eligible Charges* for *Pre-Certified* MRI and CT scans 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. Physiotherapy, Homeopathic and Osteopathic Therapy
We will pay *Eligible Charges* for physiotherapy, homeopathic therapy and osteopathic therapy prescribed 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 *Pre-Certified* in order to apply for any additional visits up to the maximum number of visits and *Sub-Limit* 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 claim for such *Treatment*. In addition to the above, a medical report will be required for *Treatment* after 10 visits.

Please Note: No cover applies under Section B8 to the HeadStart *Sub-Plan*.

B9. Complementary Medical Treatment
We will pay *Eligible Charges* for acupuncture, aroma therapy, chiropractic 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*. Such *Treatment* is restricted to 10 visits per *Eligible Medical Condition*, after which it must be further reviewed by a *Specialist* and subsequently *Pre-Certified*. A referral letter must be submitted with the first claim for such *Treatment*. In addition to the above, a medical report will be required for *Treatment* after 10 visits. 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*.

Please Note: No cover applies under Section B9 to the HeadStart and Basic *Sub-Plans*.

B10. 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. Cover is provided up to the *Sub-Limit* per *Period of Insurance* and the *Lifetime Limit*, as shown in the Schedule of Cover and Excesses relevant to *Your* chosen *Sub-Plan*.

Please Note: No cover applies under Section B10 to the HeadStart and Basic *Sub-Plans*.

B11. Hormone Replacement Therapy
We will pay *Eligible Charges* for *Medical Practitioner* or *Specialist* consultations and prescribed tablets, implants or patches when hormone replacement therapy is for the female menopause with an onset prior to age 40 years or which has been induced artificially. This cover is provided for the maximum duration of 18 months in total during *Your* lifetime, as shown in the Schedule of Cover and Excesses relevant to *Your* chosen *Sub-Plan* and subject to *Your Plan* being maintained throughout such period.

Please Note: No cover applies under Section B11 to the HeadStart and Basic *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*.

Please Note: No cover applies under Section B13 to the HeadStart *Sub-Plan*.

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*.

Please Note: No cover applies under Section B14 to the HeadStart *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 £200/$360/€300.

Please Note: No cover applies under Section B15 to the HeadStart *Sub-Plan*.

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, sight test, or hearing test (as applicable) and provided *You* have been continuously insured under *Your Plan* for not less than 12 months:

(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 *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. Use of *Your* Wellness Benefit will not affect *Your* No Claims Discount Status.

Please Note: No cover applies under Section B16 to the HeadStart and Basic *Sub-Plans*.

B17. Child Wellness and Health Check

If *You* are under 19 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:

(i) One routine physical examination, hearing test and sight test; and

(ii) Routine inoculations and vaccinations commonly administered to children less than 19 years of age in accordance with standard medical practice.

Wellness expenses are not subject to *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. Use of *Your* Wellness Benefit will not affect *Your* No Claims Discount Status.

Please Note: No cover applies under Section B17 to the HeadStart and Basic *Sub-Plans*.

B18. Psychiatric Treatment

We will pay *Eligible Charges* for *Out-Patient Treatment* 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*.

This benefit is conditional upon *Pre-Certification*. However, the initial consultation with a *Medical Practitioner* (not a psychiatric *Specialist*), which results in a psychiatric referral is covered without the requirement for *Pre-Certification*. Cover is provided up to the *Sub-Limit* per *Period of Insurance*, as indicated on the Schedule of Cover and Excesses relevant to *Your* chosen *Sub-Plan*.

Please Note: No cover applies under Section B18 to the HeadStart and Basic *Sub-Plans*.

SECTION C : Travel, Transportation and Out of Area Benefits

Subject to the *Terms* of this Policy Wording, *We* will pay travel, transportation and out of *Geographic Area of Cover* charges *You* incur as follows:

C1. Emergency Local Ambulance

We will pay *Reasonable and Customary Charges* incurred by *You* during a *Period of Insurance* for *Your* transportation by *Emergency Local Ambulance* to *Hospital* by the most appropriate transport considered *Medically Necessary* by a *Medical Practitioner* or *Specialist* in connection with an *Eligible Medical Condition*, which includes an *Injury*.

C2. Emergency Medical Evacuation and Transportation

With respect to the HeadStart *Sub-Plan*, *We* will pay *Reasonable and Customary Charges* incurred by *You* during a *Period of Insurance* for *Your Pre-Certified Emergency Medical Evacuation* and transportation (including one economy class return journey for *You*) to the nearest appropriate medical facility within *Your* selected *Geographic Area of Cover*, for the purpose of admission to *Hospital* as an *In-Patient* for *Medically Necessary Treatment* directly related to an *Eligible Medical Condition* (excluding all *Treatment* in connection with maternity or childbirth).

With respect to the Basic, Standard and Executive *Sub-Plans*, *We* will pay *Reasonable and Customary Charges* for *Pre-Certified Emergency Medical Evacuation* and transportation (including one economy class return journey for *You*) to the nearest appropriate medical facility, or *Your Home Country*, or the country of *Your* choice within *Your Geographic Area of Cover*, for the purpose of admission to *Hospital* as an *In-Patient* for *Medically Necessary Treatment* directly related to an *Eligible Medical Condition* (excluding all Treatment in connection with maternity or childbirth). Where *Emergency* transportation to *Your Country of Residence*, *Home Country* or country of *Your* choice is against the advice of *Your* attending *Medical Practitioner*, or unreasonably excessive in comparative risks or costs as determined by *Us*, or such country does not have the appropriate facility to treat *Your Eligible Medical Condition*, cover is restricted to *Emergency Medical Evacuation* to the nearest appropriate medical facility.

Conditions in respect of all *Sub-Plans*: To be eligible for coverage under Section C2:

i) *Your Eligible Medical Condition* is an *Emergency*;
ii) *You* must be in compliance with all *Terms* of this *Plan*;
iii) *Your* condition, illness, injury or the occurrence necessitating *Emergency Medical Evacuation* and transportation is covered under the *Terms* of this *Plan*;
iv) *Your Emergency Medical Evacuation* and transportation 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 at *Your* treating medical facility or through local medical providers and transportation by any other method may result in loss of *Your* life;
v) *You* or *Your Relative* agree to the *Emergency Medical Evacuation* and transportation;
vi) *You* will co-operate fully and that failure to do so, or to use or accept, the *Emergency Medical Evacuation* and transportation once it has been arranged by *Us* will result in denial of future claims under Section C2, or at *Our* discretion, only reimbursement for eligible costs associated with any *Emergency Medical Evacuation* and transportation subsequently made and paid for by *You*;
vii) *Emergency Medical Evacuation* is subject to *Pre-Certification* 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.

Note: We will use *Our* best efforts to arrange with independent, third party contractors any *Emergency Medical Evacuation* and *Emergency* transportation within the least amount of time reasonably possible. *You* understand and agree that the timeliness, duration and outcome of any *Emergency Medical Evacuation* and transportation can be affected by events or circumstances which are not within *Our* direct control. *You* agree to hold *Us*, *Our Plan Administrator*, the *Plan Manager* and *Our* agents and representatives harmless from and not liable for any delays, losses, damages 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 reasonably within the direct and immediate control of *Us*, *Our Plan Administrator*, the *Plan Manager* and *Our* agents and representatives.

C3. Accompanying Relative, Travel and Accommodation

In the event *Your Emergency Medical Evacuation* and transportation is covered under *Your Plan*, where *Medically Necessary*, *We* will pay for costs incurred during a *Period of Insurance* that are *Pre-Certified* and coordinated by *Us* as follows:

(i) The reasonable costs for one *Pre-Certified Relative* to travel with *You* to the *Hospital* as *Your* escort; or the reasonable cost of an economy class airfare from an airport serving the area where such *Pre-Certified Relative* is located to the airport serving the area where the *Hospital* to which *You* have been or are to be admitted is located.

(ii) The reasonable and necessary costs incurred in relation to the *Emergency Medical Evacuation* for:

(a) *Your* transportation to and from medical appointments when *Treatment* is being received as a *Day-Patient*;

(b) A *Pre-Certified Relative's* travel to and from the *Hospital* to visit *You* following admission as an *In-Patient*;

(c) Meals for *You* and a *Pre-Certified Relative*, up to a maximum of £10/$18/€15 per person, per day;

(d) Accommodation outside of a *Hospital* for *You* and a *Pre-Certified Relative* up to £100/$180/€150 per person, per day which immediately precedes or immediately follows *Hospital* admission, and provided that *You* are under the care of a *Specialist*.

(iii) The reasonable costs for *You* to return by economy class airfare to *Your Country of Residence* or to the country from where *Your Emergency Medical Evacuation* occurred; and the reasonable costs for a *Pre-Certified Relative* to travel with *You* or to travel to the point of his or her original departure.

Please Note: No cover applies under Section C3 to the HeadStart *Sub-Plan*.

C4. Cremation/Burial or Repatriation of 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 pay *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*, 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 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 Section C4 for any costs incurred where *Your* death has occurred within *Your Home Country*.

C5. Compassionate Visit

Provided *You* have been continuously insured under *Your Plan* for not less than 12 months, *We* will pay *Reasonable and Customary Charges* toward the costs incurred by *You* during a *Period of Insurance* for an economy class round-trip airfare to visit a *Relative* of attained age of 75 years or less, who is suffering from a serious *Medical Condition* in which his or her vital signs are unstable, prognosis is uncertain and death is imminent; or to attend the funeral, burial or cremation ceremony of a *Relative* who died at attained age 75 or less during a *Period of Insurance*. All round-trip airfare charges must be *Pre-Certified*. Cover is limited to one trip per *Insured Person* per *Period of Insurance* and up to the *Sub-Limit* shown in the Schedule of Cover and Excesses applicable to *Your* chosen *Sub-Plan*.

Please Note: No cover applies under Section C5 to the HeadStart *Sub-Plan*.

C6. USA Elective Treatment Within the Provider Network

For *Insured Persons* covered under a Standard or Executive *Sub-Plan*, who have not selected the "Area 3 - Worldwide" *Geographic Area of Cover*, cover under *Your Plan* is extended to provide *Elective Treatment* in the USA within *Our Plan Administrator's* network of providers, but excluding non- *Emergency* travel & accommodation.

Where *In-Patient*, *Day-Patient* or *Out-Patient Treatment* is received under the *Terms* of Section C6 within *Our Plan Administrator's* network of providers, costs will be reimbursed subject to 20% *Co-Insurance* (no *Excess* applies) and up to the maximum per *Insured Person* per *Period of Insurance*, as shown in the Schedule of Cover and Excesses relevant to *Your* chosen *Sub-Plan*. No benefit is payable for any *Treatment* or supply received under Section C6 which is outside of *Our Plan Administrator's* network of providers. All planned *In-Patient* or *Day-Patient* claims must be notified to *Us* and *Pre-Certified* prior to commencement of *Treatment*.

Please Note: No cover applies under Section C6 to the HeadStart and Basic *Sub-Plans*.

C7. Worldwide Accident and Emergency Out of Area Cover

When *You* are temporarily traveling 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 number of days and *Sub-Limit* per *Period of Insurance* shown in the Schedule of Cover and Excesses relevant to *Your* chosen *Sub-Plan*. All *Treatment* must be *Pre-Certified*.

In the event of *Emergency Treatment* being required in the USA, *You* should contact *Us* either before or as soon as possible after admission to *Hospital*.

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 first total maximum number of days of travel outside of *Your* selected *Geographic Area of Cover* per *Period of Insurance* as specified in the Schedule of Cover and Excesses relevant to *Your* chosen *Sub-Plan*.

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

Please Note: No cover applies under Section C7 to the HeadStart *Sub-Plan*.

SECTION D : Cover in Respect of Pre-Existing Conditions and Chronic Conditions

IMPORTANT NOTE: No cover for *Pre-Existing Conditions* or *Chronic Conditions* is provided until *You* have been continuously insured under *Your Plan* for at least 24 consecutive months immediately preceding the incurring of *Eligible Charges*.

***Your* coverage, if any, in respect of *Pre-Existing Conditions* depends upon *Your* chosen GlobalSelect *Sub-Plan* policy and the method of underwriting option *You* selected at time of *Application*. The following wording Section D1a relates to the 'Full Medical Underwriting' option, if *Your* chosen underwriting option as identified on *Your* original *Application* differed from Full Medical Underwriting, then the following section D1a will be void and is replaced by the coverage detailed in the *Policy Wording Endorsement* that was issued with *Your Certificate of Insurance*.**

Subject to the *Terms* of this Policy Wording, *We* will pay charges incurred by *You* in respect of *Pre-Existing Conditions* and *Chronic Conditions* as follows:

D1a. Pre-Existing Conditions
Full Medical Underwriting Option:
Your chosen *Sub-Plan* determines the cover, if any, that is provided for any *Pre-Existing Condition*.

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 following a period of continuous cover for at least 24 consecutive months, We will pay *Eligible Charges* which are directly related to those disclosed and accepted *Pre-Existing Conditions*, up to a maximum per *Period of Insurance* and subject to a *Lifetime Limit*, as shown in the Schedule of Cover and Excesses under Sections D1 and D2 in aggregate and D3 relevant to *Your* chosen *Sub-Plan*.

We reserve the right to offer alternative *Terms*, decline cover for any specific *Medical Condition* or decline any *Application* in its entirety without giving any reason.

Please Note: No cover applies under Section D1 to the HeadStart *Sub-Plan*.

D2. Chronic Conditions and Palliative Care
Following a period of continuous cover for at least 24 consecutive months, *We* will pay *Eligible Charges* for: routine check-ups associated with a *Chronic Condition* that is not a *Pre-Existing Condition*; *Medically Necessary Drugs* and dressings prescribed for management of a *Chronic Condition* that is not a *Pre-Existing Condition*; *Medically Necessary Hospital* accommodation, nursing services, *Ancillary Charges*, *Surgery* and *Palliative Care* in connection with a *Chronic Condition* that is not a *Pre-Existing Condition*. Cover is provided up to the *Sub-Limit* per *Period of Insurance*, not to exceed the *Lifetime Limit*, as shown in the Schedule of Cover and Excesses relevant to *Your* chosen *Sub-Plan* under Sections D1 and D2 combined in aggregate, and subject to *Your Plan* being maintained throughout such period.

Please Note: No cover applies under Section D2 to the HeadStart and Basic *Sub-Plans*.

D3. Stabilisation of Acute Chronic Episode
We will pay *Eligible Charges* for the stabilisation of an acute episode or exacerbation of a *Chronic Condition* that is not a *Pre-Existing Condition*, which could result in death or serious impairment of bodily functions if not treated within 48 hours of onset. Cover is provided only if *You* are likely to respond quickly to the *Treatment* for such episode or exacerbation, and the *Treatment* is likely to lead to *Your* complete recovery or to *You* being restored fully to *Your* previous state of health, without having to continue receiving the *Treatment*. Once *Your* condition is stabilised, cover is provided as set out in Section D2 of this Policy Wording, subject to the *Terms* of the Policy Wording.

Please Note: No cover applies under Section D3 to the HeadStart *Sub-Plan*; and cover for the Basic *Sub-Plan* is provided up to the *Sub-Limit* shown in the Schedule of Cover and Excesses relevant to the Basic *Sub-Plan*, per *Period of Insurance*.

SECTION E : Dental Treatment

IMPORTANT NOTE: With respect to Sections E3, E4 and E5 of this Policy Wording, no cover is provided under the HeadStart, Basic, and Standard *Sub-Plans*. Under the Executive *Sub-Plan*, before cover for *Dental Treatment* commences, the following conditions must be met:

i) *You* must have had a dental check up with *Your Dental Practitioner* within the 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 after the above conditions have been met.

Subject to the *Terms* of this Policy Wording, *We* will pay dental charges *You* incur as follows:

E1. Emergency Dental Treatment (In Patient or Day Patient)
We will pay *Eligible Charges* for *In-Patient* or *Day-Patient Emergency Dental Treatment* and dental surgery received in an emergency room in a *Hospital* necessary to restore or replace sound natural teeth lost or damaged in an *Accident*, except when the damage has been caused through eating.

Please Note: No cover applies under Section E1 to the HeadStart *Sub-Plan*.

E2. Accidental Dental Damage
We will pay *Eligible Charges* for *Out-Patient Treatment* at a *Hospital* or dental surgery, when given by a *Medical Practitioner* or *Dental Practitioner*, necessary to restore or replace sound natural teeth lost or damaged in an *Accident*, except when the damage has been caused through eating.

Out-Patient Treatment or dental surgery must be received within 5 days from the date of the *Accident* occurring.

Please Note: No cover applies under Section E2 to the HeadStart and Basic *Sub-Plans*; and for the Standard *Sub-Plan*, cover is provided up to the *Sub-Limit* shown in the Schedule of Cover and Excesses, per *Period of Insurance*.

E3. Emergency Dental Treatment (Out-Patient)

We will pay *Eligible Charges* for *Emergency Dental Treatment* at a *Hospital* or dental surgery, when given by a *Medical Practitioner* or *Dental Practitioner* for the express and immediate relief of severe pain, limited to *Treatment* obtained within 24 hours from the initial onset of pain and no more than 5 days from the event that subsequently gave rise to the pain; solely to *Treatment* of an abscess, cracked or broken tooth rebuild or temporary filling. Cover is provided up to aggregate *Sub-Limit* and subject to 25% *Co-Insurance* (no *Excess* applies), as shown in the Schedule of Cover and Excesses, per *Period of Insurance*. Please refer to the Important Note above relating to conditions of cover.

Please Note: No cover applies under Section E3 to the HeadStart, Basic and Standard *Sub-Plans*.

E4. Routine Dental Treatment (Out-Patient)

We will pay *Reasonable and Customary Charges* toward the costs incurred by *You* during a *Period of Insurance* and after 180 days from the *Effective Date* for fees of a *Dental Practitioner* carrying out the following routine *Dental Treatment* in a dental surgery: *Examinations*, check-ups, x-rays, tooth cleaning, polishing, normal compound fillings, and simple or non-surgical extractions. No cover is provided for charges *You* incur for tooth whitening of any kind (including laser whitening); or dental consumables (such as toothbrushes, mouthwash and dental floss), unless available only under prescription. Cover is subject to the aggregate limit and *Sub-Limits* per *Period of Insurance*, as shown in the Schedule of Cover and Excesses relevant to the Executive *Sub-Plan*, subject to 25% *Co-Insurance* (no *Excess* applies). Please refer to the Important Note above relating to conditions of cover.

Costs incurred within 180 days from the *Effective Date* are excluded.

Please Note: No cover applies under Section E4 to the HeadStart, Basic and Standard *Sub-Plans*.

E5. Major Restorative Dental Treatment

We will pay *Reasonable and Customary Charges* toward the costs incurred by *You* during a *Period of Insurance* and after 12 months from the *Effective Date* for fees of a *Dental Practitioner* and associated costs for the following specified procedures:

- Removal of impacted, buried or unerrupted teeth
- Removal of roots
- Removal of solid odontomes
- Apicetomy
- New or repair of bridgework
- New or repair of crowns (not precious metal)
- Root canal *Treatment*
- New or repair of upper and lower dentures

Cover is subject to the aggregate limit and *Sub-Limits* per *Period of Insurance*, as shown on the Schedule of Cover and Excesses relevant to the Executive *Sub-Plan*, and subject to 50% *Co-Insurance* (no *Excess* applies).

Please refer to the Important Note above relating to conditions of cover.

Please Note: No cover applies under Section E5 to the HeadStart, Basic and Standard *Sub-Plans*.

SECTION F : Non Medical Covers and Benefits

Subject to the *Terms* of this Policy Wording, *We* will pay non-medical charges *You* incur as follows:

F1. Out of Country Legal Expenses

We will pay for reasonable legal costs and expenses incurred by *You* (or on *Your* behalf) during a *Period of Insurance* in pursuit of a claim against a third party who has caused *Your* physical *Injury* or *Your* death whilst on a trip outside of *Your Country of Residence* during a *Period of Insurance*, with *Our Pre-Certification*.

We will not cover:

(i) Any expense incurred which is in an amount less than the *Excess*.

(ii) Any claim where the legal costs are anticipated or expected by *Us* to exceed the amount of any likely recoverable damages or compensation.

(iii) Legal expenses incurred which are not *Pre-Certified*.

(iv) Legal expenses and costs incurred which are outside our *Plan Administrator's* legal network.

(v) Any claim where *Our* costs and fees are estimated to exceed the amount of a reasonable settlement.

(vi) Legal costs and expenses incurred in the pursuit of a claim against *Us*, *Our Plan Administrator*, the *Plan Manager*, their agents or providers, or any member of *Your* family or a *Relative*.

It is a condition of Section F1 that any legal cost or expense paid by *Us* or agreed to be paid by *Us* will be deducted from any settlement amount awarded, prior to any disbursements being made.

Please Note: No cover applies under Section F1 to the HeadStart and Basic *Sub-Plans*.

F2. Vision Contribution Due to Accident Benefit

If, as a result of an *Accident* during a *Period of Insurance*, *You* are newly diagnosed as requiring vision correcting spectacles or contact lenses, *We* will pay 50% of the *Reasonable and Customary Charges* toward the costs *You* incur during a *Period of Insurance* for an amount greater than £25/$45/€38 for vision correcting spectacles or contact lenses only, up to the *Sub-Limits* shown in the Schedule of Cover and Excesses relevant to the Executive *Sub-Plan*.

Please Note: No cover applies under Section F2 to the HeadStart, Basic and Standard *Sub-Plans*.

F3. Security & Political Evacuation & Repatriation Benefit

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 the country in which *You* are located, that becomes effective within your *Period of Insurance*, *We* will pay 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 of return falls within *Your Period of Insurance*.

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*.

Please Note: No cover applies under Section F3 to the HeadStart and Basic *Sub-Plans*.

F4. Identity Theft Cover and Assistance

We will pay for *Your* reasonable, customary and necessary costs, solely and in direct relation to, a stolen identity event, occurring and incurred, during the *Period of Insurance* for:

i) Restoring, re-filing, loan or other credit applications that are rejected;
ii) notarisation of legal documents including replacement passports and driving licences, long distance telephone calls and postage that has solely been incurred as a result of reporting, amending and/or rectifying records;
iii) up to three credit reports obtained from a credit reference agency within one year of *Your* knowledge of the stolen identity event;
iv) stopped payment orders placed or missing or unauthorised cheques.

Please Note: Cover is not provided where the Identity Theft Event was undertaken by a *Relative* of *You*. No cover applies under Section F4 to the HeadStart and Basic *Sub-Plans*.

F5. Out of Country Criminal Assault Benefit

In the event *You* are admitted to a Hospital for a period of 48 hours or more as a result of being a victim of a *Criminal Assault*, as defined herein, and as determined by a police report from the local law enforcement authorities, that occurs whilst on a trip outside of *Your Country of Residence* during the *Period of Insurance*, *We* will pay this additional benefit to *You* separate from any medical benefit under this *Plan* provided that the *Criminal Assault* is not:

i) a moving or traffic violation as defined under the applicable government motor vehicle laws;
ii) an act of a *Relative* or immediate family member, another *Insured Person*, or an Individual who resides with *You* on a permanent basis.

Please Note: No cover applies under Section F5 to the HeadStart and Basic *Sub-Plans*.

F6. Natural Disaster Evacuation and Accommodation

We will pay for *Your* reasonable, customary and necessary emergency travel, accommodation and subsistence costs solely and in direct relation to a *Natural Disaster*, arising during the *Period of Insurance* if *You* are displaced from *Your* home or planned, paid accommodation due to evacuation during or resulting from a *Natural Disaster*. The evacuation must have been ordered by the responsible civil or military authorities governing the location of the predicted or actual *Natural Disaster*.

Please Note: No cover applies under Section F6 to the HeadStart and Basic *Sub-Plans*.

SECTION G : Other Services and Benefits

G1. 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* program administrator will co-ordinate evacuation to a qualified facility equipped to handle *Your Eligible Medical Condition*. A team of independent 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) 1444 46 55 99
Within the USA/Canada (USA):	+1 317 655 45 00

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*.

G2. USA Medical Concierge Service

The USA 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 when scheduling *Non-Emergency In-Patient, Day-Patient* and certain *Out-Patient Treatments*.

With the USA Medical Concierge, *You* will receive (where available) important information to help *You* choose *Your* medical provider, including information on the number of procedures performed by the highest quality providers, the reported quality of outcomes, the cost of *Treatment* and other information, prior to receiving the eligible *Medically Necessary Non-Emergency In-Patient, Day-Patient* and *Out-Patient* medical *Treatments* and *Medical Services* and Procedures marked with a ** within the *Pre-Certification* Section of this Policy Wording. Thereby maximising the benefits provided under *Your* Plan.

Your personal Medical Concierge will review *Your* specific non-emergency medical condition and provide *You* with complete information on provider ratings, past outcomes and general costs – all in the area *You* are planning treatment.

IMG's Medical Concierge helps *You* maximise *Your* outcome when seeking eligible medical care within the USA, with the added bonus that *You* can receive a reduction in *Your Excess* and *Co-Insurance*, where the service is appointed and received through the USA Medical Concierge – whether or not they are in the USA PPO Network. Refer to the Section 1. *Pre-Certification* and 2. USA Medical Concierge Service sections within the Medical Management Section of this Policy Wording for further details.

Please note due to the high level of data required for this service, the Medical Concierge service and ratings are restricted to the most common and many specialist medical facilities within the USA.

G3. Medical Information Service

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 G3 of this Policy Wording.

Exclusions

We will not pay any charges, fees, costs, expenses or claims (collectively called "charges") *You* incur which directly or indirectly relate to or arise from or are in connection with:

1. 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 Sections D1, D2 and D3 of this Policy Wording dependent upon *Your* chosen GlobalSelect *Sub-Plan* and *Your* choice of Underwriting Option as identified on *Your Application* form.

2. Any *Chronic Condition* which is a *Pre-Existing Condition*; or any *Palliative Care*, unless specifically provided under Section D2 or D3 of this Policy Wording.

3. *Chronic* supportive *Treatment* of renal failure, including dialysis. *We* will, however, pay *Eligible Charges* for renal dialysis incurred immediately pre and post operatively, or in connection with acute secondary failure when dialysis is part of intensive care.

4. Any *Medical Condition* caused by 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) Act of *Terrorism*, unless *You* sustain *Injury* whilst an innocent bystander. There is no cover for *Treatment* of a *Medical Condition* which is in any way caused or contributed to by an act of *Terrorism* involving the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent.

5. *Treatment* of acne; allergies; asthma; any condition of the breast or the prostate; tonsillectomy; adenoidectomy; haemorrhoids or haemorrhoidectomy; any disorder of the reproductive system; diverticulitis; hysterectomy; hernia; intervertebral disc disease; gall bladder disease or gall stones; or kidney stones, which exist or manifest themselves or involve procedures which take place or are recommended during the first 90 days of cover under *Your Plan*, beginning on the *Effective Date*. 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.

6. Any charges related to Pregnancy, including pre-natal care, Pregnancy Complications, Child Birth and Delivery including pre-natal care, delivery, post-natal care, and care of Newborns.

7. Congenital disorders and conditions arising out of, or resulting there from.

8. An optional abortion or pregnancy termination, other than miscarriage, ectopic pregnancy and still birth.

9. Birth control, sterilisation (or its reversal), vasectomy (or its reversal), contraception, infertility, fertility, impotence, any *Treatment* or supply that either promotes or prevents or attempts to promote or prevent conception, 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.

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

11. Any *Treatment* or supply that is:

   (i) Not 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 90 days of the date charges are incurred for such *Treatment* or supply;
   (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) Performed or provided by a *Relative* or by a person who resides or has resided in *Your* home;
   (viii) Required or recommended as a result of complications or consequences arising from or related to any *Treatment* or supply which is excluded from cover or which is otherwise not insured under *Your Plan*; or
   (ix) Any *In-Patient Treatment* which could have been provided on a *Day-Patient basis* or as an *Out-Patient*.

12. 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 *Your* Plan); completion of *Treatment*; completion of claim forms; or *Your* failure to keep a scheduled appointment.

13. Any *Treatment* or supply which is *Experimental*; or related to genetic medicine or genetic testing, including amniocentesis, genetic screening, risk assessment, prevention or determination of genetic pre-disposition, genetic counselling, and gene therapy.

14. Confinement primarily to receive custodial care.

15. 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.

16. *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.

17. Any *Treatment* or supply for weight loss or weight modification, any *Treatment* of obesity, including morbid obesity (such as wiring of the teeth and all forms of bariatric *Surgery*, intestinal bypass, gastric bypass, gastric banding, vertical banded gastroplasty, biliopancreatic diversion, duodenal switch, or stomach reduction or stapling *Surgery*); 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*.

18. 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 chiropodists, 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 or which are considered "off-label" use; or medicines not prescribed by a *Medical Practitioner*.

19. 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.

20. *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*.

21. Cosmetic *Treatment*, 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 the *Terms* of this Policy Wording; or ear or body piercing.

22. Any *Medical Condition* sustained while taking part in: *Amateur Athletics, Professional Athletics* and adventure sports and activities, including, without limitation the following (including any combination or derivative of the following) abseiling, mountaineering activities where specialised climbing equipment, ropes or guides are normally or reasonably should have been used; athletic or sporting activities (except for activities that are non-contact, non-professional, and engaged in by *You* solely for recreational, entertainment or fitness purposes); aviation (except when travelling soley as a passenger in a commercial aircraft); kiteboarding; hang gliding, and parachuting; bicycle, motorcross or BMX; BASE jumping, bobsledding, bungee jumping; canyoning/caving; high diving; heli-skiing, hot air ballooning, inline skating, jet skiing, jungle zip lining, kayaking, luge, mountain biking, paragliding, parascending, rappelling; racing of any kind including by horse, motor vehicle (of any type) or motorcycle; rock climbing, rodeo; snow skiing (except for recreational downhill and/or cross country snow skiing (no cover provided whilst 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), snowboarding, snowmobiling, ski jumping, sky diving surfing, trekking, windsurfing, wildlife safaris, spelunking, whitewater rafting and subaqua pursuits involving underwater breathing apparatus below a depth of 30 metres. Practice or training in preparation for any excluded activity which results in *Injury* will be considered as activity while taking part in such activity.

23. 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 or procedures of a recognised governing body for the sport or activity.

24. Any *Medical Condition* sustained while participating in any activity where such activity is undertaken against medical advice.

25. *Treatment* of *Alcohol and Substance Abuse* or any *Medical Condition* sustained while under the influence of or due wholly or partly to the effects of any intoxicating liquors, controlled substances, narcotics or *Drugs*, other than *Drugs* taken in strict accordance with *Treatment* prescribed and directed by a *Medical Practitioner*.

26. Suicide or attempted suicide, or any wilfully *Self-Inflicted Injury* or *Illness,* or willful exposure to danger (other than in an attempt to save human life).

27. Any venereal disease or any other sexually transmitted disease.

28. Any *Medical Condition* sustained as a result of *Your* commission of a violation of law, including without limitation, *Your* engaging in an illegal or malicious occupation or act, but excluding minor traffic violations.

29. Any *Alcohol* and *Substance Abuse* or any addictive condition of any kind and any *Medical Condition* arising directly or indirectly from such abuse or addiction.

30. Professional services performed by a psychotherapist, psychologist, family therapist or bereavement counselor; *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.

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

32. Orthoptics, visual therapy or visual eye training.

33. The feet, including without limitation: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; *Treatment* of weak, strained, flat, unstable or unbalanced feet; metatarsalgia, bone spurs, hammer toes or bunions; and any *Treatment* or supply for corns, calluses or toenails; provided, however that claims for *Treatment* or supplies for the feet may be eligible for cover under the *Terms* of this Policy Wording when related to (i) an *Injury* to the foot; or (ii) an *Illness* for which foot *Surgery* is *Medically Necessary* and determined to be the only appropriate method of *Treatment*.

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

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

36. 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.

37. 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.

38. *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.

39. 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.

40. Orthodontic *Treatment*; gingivitis, gum disease of any kind, or periodontitis; damage to dentures whilst not being worn; the cost of any precious metals used in any dental procedures; dental veneers (unless as a result of damage to existing veneers as a result of an *Accident*); tooth whitening of any kind; or missed dental appointment fees.

41. *Treatment*, supplies, examination or fitting related to vision correcting spectacles or contact lenses; eye refraction for any reason; non-medical or natural degenerative eye defects, including but not limited to myopia, 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*.

42. *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.

43. *Treatment* of the temporomandibular joint, unless required as a result of an *Accident*.

44. 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.

45. Travelling against the advice of a *Medical Practitioner*.

46. *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*.

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

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 the basis of *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

The only parties to the *Plan* are *You* and *Us*. No other person has any right to enforce the Policy Wording or any part of it.

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. Your Duty of Care

You shall at all times act in a prudent manner and shall exercise reasonable care and take reasonable precautions to prevent *Injury* or *Illness*, 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

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 the *Premium*. All *Premiums* are payable in advance of any cover under *Your Plan* being provided.

Premium is payable for the whole year regardless of the mode of *Premium* instalments and *You* are responsible for the whole year's *Premium* even if *We* have agreed that *You* may pay by instalments. Other than yearly, if *Premium* payments cease, or are discontinued or withheld, for whatever reason, cover under *Your Plan* may be automatically and immediately terminated. Whilst a *Plan* is in arrears, all claim settlements will be suspended until all outstanding *Premiums* are paid in full and received by *Us*.

Premiums are payable in £ Sterling, $ US dollars or € Euros. The initial *Premium* is based on rates applicable to *Your* attained age on the *Effective Date*. The *Premium* payable may be changed by *Us* from time to time. If *You* move into a higher age band, the *Premium* will increase at the next *Renewal Date*. However, *Your Plan* will not be subject to any alteration in *Premium* rates generally introduced until the next *Renewal Date*.

A period of grace of 10 days (notwithstanding intervening Saturdays, Sundays or legal holidays) will be allowed for the receipt of payment of each instalment of *Premium* 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* was due, or deduct the remainder of the annual *Premium* due from any valid claim in progress, or deduct the balance of the *Premium* 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 for cover from 14 days of age up until the *Renewal Date* following 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 not be present in the USA at the time of the *Effective Date* (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 the *Renewal Date*), *You* must plan to be located outside of 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:

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

(ii) *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.

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

8. Newborns

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 to reflect any circumstances *You* advised in *Your Application* or declared to *Us* as a material fact.

10. Choice of Law

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 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. Misrepresentation/Fraud

Any claim under *Your Plan* in which *You* fail to act with utmost good faith, or any claim that is in any respect fraudulent, unfounded, misrepresented, or any claim where *You* otherwise fail to observe the *Terms* of the Policy Wording, shall render *Your Plan* null and void and all claims and benefits under *Your Plan* shall be forfeited and waived and (if appropriate) recoverable by *Us*, and *We* shall have no liability for such benefits or claims. In addition, *Your Plan* shall be cancelled and rendered void from the *Effective Date* without refund of *Premiums*.

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*. *Your* submission of a claim or acceptance of cover or benefits under *Your Plan* shall be deemed to constitute an assignment of such subrogation rights by *You* to *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 instruct 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. Premium Refunds

After the first 30 days of cover if *You* cancel *Your Plan*, subject to the *Policy 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. *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 Policy 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-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

Whilst *We* shall not cancel *Your Plan* because of eligible claims made by *You*, *We* may at any time terminate *Your Plan* in the event of 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*. *We* may at *Our* discretion reinstate the cover, though *Terms* of cover may be subject to variation.

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 *You* have paid *Your Premiums* by credit card or debit card, provided *You* remain eligible 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*.

Renewal Premiums will be charged at the rates applicable to *Your* attained age at each *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* 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. Material Fact & Change of Risk Disclosure

You must disclose all material facts to *Us* in *Your Application*. Failure to do so may affect *Your* rights under *Your Plan*. A material fact is information likely to influence *Us* in the assessment or the acceptance of *Your Application* for cover. If *You* are in any doubt as to whether a fact is "material," then *You* should disclose it to *Us*. 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 material changes relating to *You* which may affect 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.

24. Transfers, Changes at Renewal, Mid Term Adjustments

(i) *You* may only apply to change *Your Sub-Plan* at Renewal. If *You* transfer to the *Plan* from any other of *Our* existing covers or whilst covered under a different *Sub-Plan*, and *You* apply for and receive any enhanced benefits or cover, then any enhanced benefits and cover are restricted to new *Medical Conditions* which have not been previously suffered from, whether or not diagnosed, occurring after the date of transfer. Cover for any *Medical Condition* manifesting itself prior to the date on which *We* accept *Your* transfer or *Your* change will be restricted to the level of cover that was provided under the cover or *Sub-Plan* at the date of onset of such *Medical Condition*.

(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 'Switch Terms' 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 *Excess*, but *You* may not reduce it, however;

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

d) *You* may not elect to include, apply for, or purchase any of the Optional additional add-on coverages that were not selected at time of *Your* original *Application*,

(v) Mid-term changes in *Your Geographic Area of Cover* will only be considered if *You* are extending your selected *area of cover*. 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.

(vi) Where *You* switch to a different *Sub-Plan* with benefits and cover not available under *Your* previous *Sub-Plan*, where such new benefits require a wait period, such wait period will commence from the *Effective Date* of *Your* new *Sub-Plan*.

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 applicable laws outside of England and Wales.

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.

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.
- *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.

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). 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).

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:

Claims Department
IMG Europe Ltd
36-38 Church Road
Burgess Hill
West Sussex
RH15 9AE
United Kingdom

Tel : +44 (0) 1444 46 55 88
Fax : +44 (0) 1444 46 55 50

The above numbers are for the Claims Department only and should be used to discuss claims submitted and on-going issues. The 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:

Sterling, Euro and USD payments:	within 15 working days
For other payments:	within 20 working days

General Claims Conditions and Information

1. 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*.

2. 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.

3. 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*.

4. In the *Application*, provision is made for details of *Your Medical Practitioners* over the last 2 years. 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.

5. 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*. The *Excess* will be deducted from all *Eligible Charges* in respect of each new *Eligible Medical Condition* per *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.

6. *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 from *Us*.

7. Without delay, *You* must give *Us* written notification of any claim or right of action against any third party arising out of circumstances which gave 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 Country of Residence*, *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.

8. In the event *We* deny all or part of a claim, *You* shall have 90 days from the date that the notice of denial was mailed to *You* to file a written appeal with *Us*. Upon receipt of a written appeal, *We* will respond in writing as soon as reasonably practicable and in any event within 90 days from receipt thereof. An appeal is considered to be part of the claims process and not a complaint.

9. *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*.

10. *You*, and *Your Medical Practitioners*, *Hospitals* and other healthcare and medical service providers and suppliers shall undertake to cooperate fully with *Us* in relation to any claim for benefits under *Your Plan*, including granting full right of access to all relevant or related medical documentation, medical histories, reports, lab or test results, x-rays, to examine *You* whenever and as often as may be reasonably required within the duration of the claim, and other available evidence, relating to or affecting the investigation, adjudication or administration of the claim. *We* may deny cover for a claim when there has been a refusal or material failure to so cooperate.

11. *Eligible Charges* will be paid by cheque or wire transfer 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 *Excess* and *Co-Insurance* amounts and any non-*Eligible Charges*.

12. 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.

13. If *Treatment* has gone on for more than one *Period of Insurance*, *We* will treat it as a new claim for any further *Treatment* after that date and will reapply any *Excess*.

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

Medical Management Services

1. Pre-Certification

For many of the benefits under *Your Plan You* are required to notify *Us* PRIOR to incurring any cost 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 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.

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* is also required before:

- Incurring any costs in an amount beyond £500/$900/€750
- *In-Patient* or *Day-Patient Treatment* or *Surgery* in *Hospital***
- *Out-Patient Surgery***
- Second surgical opinion
- CT and MRI scans, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cytoscopy**
- Psychiatric *Treatment* of any kind
- Home nursing care**
- Care in a hospice, *Extended Care Facility* or rehabilitation facility**
- Incurring charges for *Emergency Medical Evacuation*/ repatriation
- Incurring charges for travel and accommodation
- Cremation/burial or repatriation of *Your* remains
- Incurring charges for a compassionate visit
- USA *Elective Treatment*
- Worldwide *Accident* and *Emergency Treatment* out of *Your Geographic Area of Cover* in an amount beyond £500/$900/€750 or any *Hospital* admission
- The expiration of the first 90 days of pregnancy
- Incurring charges for *Durable Medical Equipment*
- Incurring charges for prosthetic devices, Physiotherapy, homeopathic and osteopathic therapy of more than 10 visits
- Complementary medical *Treatment*
- 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* Excess and *Co-Insurance* that will apply when utilising a USA Medical Concierge Service Provider).

(ii) Loss of Cover for Non-Compliance with *Pre-Certification* or USA Medical Concierge Service Requirements: If You are not *Pre-Certified* or fail to comply or co-operate with the *Pre-Certification* and/or USA Medical Concierge Service 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:

(a) Contact *Us* at the telephone numbers printed on the membership card, as follows:

Outside North America:	Tel	+44 (0) 1444 46 55 88
Within North America:	Tel	1-800-628-4664
		+1-317-655-4500
		(Collect if necessary)
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*.

(b) Comply with *Our* instructions and submit any information or documents required by *Us*; and

(c) 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) 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 within 90 days from receipt of *Your* written appeal.

2. USA Medical Concierge Service

For non-*Emergency In-Patient Treatment* and the additional services marked by a ** in the above Section 1. *Pre-Certification* (i) incurred within the United States of America, 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*.

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, *You* will be eligible for "Special Benefit When Using the Provider Network or USA Medical Concierge appointed Provider" as shown in Section 4 (i) below if *You* comply with the following:

In order to qualify 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
- CT and MRI scans, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cytoscopy
- 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 E-Mail:	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

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 below:

(i) Special Benefit When Using the Provider Network or USA Medical Concierge appointed Provider:
Other than *Treatment* incurred specifically under Section C6 - USA Elective Treatment Within the Provider Network and under Section E (*Dental Treatment* claims), if *Eligible Charges* are received directly from a provider within *Our Plan Administrator's* network of providers or appointed through *Our* USA Medical Concierge Service (irrespective of whether the provider is within the Provider Network), while *You* are in the USA:

(a) *We* will reduce by 50% any part of the *Excess* applicable to *Eligible Charges*, and

(b) *We* will reduce by 50% all *Co-Insurance* applicable to *Eligible Charges*.

However, all *Eligible Charges* received in the USA from a provider that is not within *Our Plan Administrator's* network of providers, or appointed through Our USA Medical Concierge Service, will remain subject to the applicable *Excess* and *Co-Insurance* stated on the Certificate of Insurance.

(ii) Utilisation of the Provider Network:
You may contact *Our Plan Administrator* and request a directory of providers 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 specialty), or *You* may obtain such information by accessing the website at www.imglobal.com.

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 *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.

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 complaint or query regarding *Your Plan* and/or the service provided by *Us*, then please contact one of the customer service advisors at the *Plan Manager* in the first instance.

IMG Europe Ltd :
Telephone (UK : +44 (0) 1444 46 55 77
Fax (UK) : +44 (0) 1444 46 55 50
E-mail : info@imgeurope.co.uk

They will try and resolve *Your* complaint.

If *You* are unhappy with the response, *You* are advised to write explaining the nature of *Your* complaint to:

The General Manager
Sirius International Insurance Corporation (publ)
The London Underwriting Centre
3 Minster Court,
Mincing Lane,
London
EC3R 7DD
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 or *Our Plan Manager* 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

Please ensure *You* follow the above procedure for submitting or escalating *Your* complaint or query, failure to do so may inadvertently delay *Our* response to *You*.