



Master Policy Document




Underwritten by LAMP Insurance Company Limited

ROW-Master Policy-Aug15

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Master Policy

Policy Holder Integra Global Limited

Insured Person An eligible individual & his or her dependents entitled to benefit under this Policy, each of whom is named or described on a completed Enrollment Form or subsequent notification and for whom the appropriate premium has been paid to Us, and whom We have accepted for cover.

This policy is underwritten by LAMP Insurance Company Limited, whose registered office is Suite 934, Europort, Gibraltar. LAMP Insurance Company Limited is licensed by the Chief Executive of the Financial Services Commission under the Insurance Companies Ordinance to carry out Insurance.

The purpose of this insurance policy is to provide cover to Individuals and Groups of Insured Persons who are introduced to Us via the Policyholder.

How the Healthcare Plan Operates

This Policy describes the benefits which are available, **but the cover which will be provided to each Insured Person will be in accordance with the selected Plan as shown in the Certificate issued to the Insured Person and with the Table of Benefits each of which attach to and form part of this Policy.** Any benefit not included in the cover selected and the Table of Benefits does not apply.

We reserve the right to modify the Table of Benefits from time to time, and shall provide a copy of the current Table of Benefits to the Policyholder at the time of such modification. Provisions of the current Table of Benefits to the Policyholder shall constitute delivery to the Insured Person. The Table of Benefits as per Our records shall prevail regardless of whether the Insured Person has received a copy.

Covered Medical Expenses does not cover for the disease or Injury itself. This means that this Policy will pay benefits only for expenses incurred while this cover is in force.

No benefits are payable for health expenses incurred before cover has commenced or after cover has terminated; even if the expenses incurred as a result of an Accident, Injury or disease which occurred, commenced or existed while cover was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. We will determine the pro rata share. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of services or supplies.

We assume no responsibility for the outcome of any covered services or supplies. We make no express or implied warranties concerning the outcome of any covered services or supplies.

The insurance is not intended to be a source of profit. The combined reimbursements from this Policy, another insurance policy or government plan should not exceed the actual costs of the health care received by the Insured Person to treat a medical condition.

Important Notes

The Benefits Payable

After any applicable Deductible, the benefits payable under this Plan are paid at the payment percentage specified in the Table of Benefits which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Policy. Benefits may vary depending upon whether a Preferred Provider Organization (PPO) is utilized. Visit the website shown on Your membership card for information regarding the PPO in the area of North America in which You will be seeking care.

Any charge for a service or supply furnished by a PPO in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the individual cover.

Deductible

Is the fixed amount per Insured Person per Period of Insurance which the Insured Person must pay when specified in this Policy. Flat dollar Co-pays and benefit penalties do not apply toward meeting the Deductible.

Coinsurance/Co-pays

After the Deductible is met We will pay at the percentage level specified in the Table of Benefits of allowable charges to the Out of Pocket maximum if applicable. Thereafter the benefit is payable at 100% of allowable charges.

Annual Maximum

Payment of benefits is subject to the Annual aggregate maximum per Insured Person as long as benefit for such Insured Person remains in force. The Annual Maximum includes all benefit maximums specified in this master Policy, including those specified in the Table of Benefits and in any endorsement.

Lifetime Maximum

Payment of benefits is subject to the Lifetime aggregate maximum per Insured Person as long as benefit for such Insured Person remains in force. The Lifetime Maximum includes all benefit maximums specified in this contract, including those specified in the Table of Benefits and in any endorsement.

Out of Pocket Maximum

This is the cap on the Coinsurance maximum specified in the Table of Benefits.

Medical Underwriting Terms

Full Medical Underwriting

This applies if, at the time of application for this Policy, you have completed an Enrollment Form declaring any Pre-existing Medical Condition; no claim arising directly or indirectly from such conditions will be covered unless and until We have accepted them in writing.

Continued Personal Medical Exclusions(CPME)

This applies if you have joined this Plan as a member of a Group or Company which is transferring from a previous plan which has been fully medically underwritten by another insurer and your Group or Company has selected CPME underwriting terms. Any exclusions, medical underwriting terms, unexpired moratorium, or waiting period which applied to your previous plan will be carried forward and continued under this Plan, provided there has been no break in cover.

Medical History Disregarded (MHD)

This applies if you have joined this Plan as a member of a Group or Company of more than 25 insured, and your Group or Company has selected MHD underwriting terms. No Pre-existing Medical Conditions will be excluded under this Plan. General Exclusion 28 will be waived.

Pre-existing Medical Conditions

Pre-existing Medical Conditions include any Illness, symptoms or Injury that existed at or during the 12 months prior to Your original Date of Entry, including acute, chronic, recurring and congenital conditions. These Illnesses and/or Injuries must be disclosed on Your Enrollment for cover and subject to review by Our medical underwriters they may or may not be specifically excluded by name or description from cover by the policy, or by policy endorsement.

Pre-existing Medical Conditions disclosed in the Enrollment which are accepted for cover by Us will be subject to a 12-month waiting period. This means that they will not be covered during the first 12-months from Date of Entry to this Policy.

Cover for such accepted Pre-existing Medical Conditions, up to the maximum amount specified in the Table of Benefits or otherwise stated, will commence after 12-months from the Date of Entry.

The waiting period of cover for Pre-existing Medical Conditions which have been accepted by Us, may be reviewed by Us if the Insured Person submits satisfactory proof of recovery to Us, and We agree, in writing, to reduce the waiting period.

Note: undisclosed Pre-existing Medical Conditions are not covered and failure to disclose necessary information to evaluate the application can result in rescission (voiding) or the addition of an endorsement limiting cover or benefits for that Pre-existing Medical Condition and the denial of a claim.

International Healthcare Plan

Eligible Expenses

Eligible expenses shall be the reasonable charges for the services and supplies listed below, actually made to the Insured Person and, unless otherwise shown, will be considered eligible only if the expenses are:

1. Given for the diagnosis or treatment of Illness, Pregnancy or Accidental Injury;
2. Ordered or performed by a Physician;
3. Medically Necessary; and
4. Usual, Reasonable and Customary

You and Your Physician decide which services and supplies are given, but the Plan only pays for Covered Medical Expenses, which We deem to be Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at our discretion consider the cost of that alternative to be Covered Medical Expenses. In this case, Covered Medical Expenses are limited to the Usual, Reasonable and Customary Charges for that diagnostic or treatment alternative.

It is the Insured Person's responsibility to keep records of what has been paid. We will not give notification when the maximum is approaching or when the maximum is reached and claims submitted after the maximum is reached will be disallowed.

Covered Medical Expenses

These are expenses for certain Hospital and other medical services and supplies. They must be for the treatment of an Injury or disease.

The Maximum Benefit amount for medical expenses includes any and all other Maximum Benefit amounts shown in this Table of Benefits or added / amended by Policy endorsement. Any unused portion of the Maximum Benefit is only payable for expenses incurred while an Insured Person is eligible for cover and while this Policy is in force.

Hospital Expenses

We will arrange and pay for the Insured Person's inpatient or day-care admission to the Hospital and for the following Covered Medical Expenses and services when recommended and / or approved by Our Medical Coordinator:

• Inpatient Hospital Services

Charges made by a Hospital for giving Accommodation and other Hospital services and supplies to a person who is confined as a full-time inpatient.

• Accommodation

yourLife and yourFamily Plans. In a semi-private room and meals. All charges in excess of the allowable semi-private room & board rate are the responsibility of the Insured Person.

premierLife and premierFamily Plans.

Accommodation applying to Premier Health members is a private room as shown in the Table of Benefits.

• Intensive Care Unit

When Medically Necessary.

• Inpatient Ancillary Services - if Medically Necessary for the diagnosis and treatment of the Illness or Injury for which the Insured Person is Hospitalized, the following services are also covered and benefits paid for charges for:

- Use of operating room and recovery room
- All medicines listed in the US pharmacopoeia or National formulary
- Blood Transfusion, blood plasma expanders, and all related testing, components, equipment and services
- Surgical dressings
- Machine testing
- Durable Medical Equipment
- Diagnostic X ray examination
- Electric shock therapy rendered by a Physician
- Radiation therapy rendered by a radiologist for proven malignancy and/or neoplastic diseases
- Respiratory therapy rendered by a Physician or registered respiratory therapist
- Chemotherapy rendered by a Physician
- Physical and Occupational therapy rendered by a Physician or registered physical or occupational therapist, which relates specifically to the Physician's written treatment plan.

Therapy must:

- a) Produce significant improvement in the Insured Person's condition in a reasonable and predictable period of time, and
- b) Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist or
- c) Be necessary to the establishment of an effective maintenance program.

• Outpatient Hospital Services

Charges made by a Hospital for Hospital services and supplies, which are given to a person who is not confined as a full-time inpatient.

• Outpatient Services - charges for emergency room, outpatient or Ambulatory Surgical Center**• Medical/Surgical Benefits** - charges for:

- Surgeon
- Outpatient Physician Visit (Home or Office)
- Inpatient medical treatment
- Inpatient consultation by specialist
- Emergency medical services
- Office surgery
- Assistant surgeon (allowable charges - 20% of primary surgeon's fees)
- Anesthesiologist (allowable charges - 30% of primary surgeon's fee)

Specific exclusions applying to hospital expenses section

In the case of what Our Medical Coordinator considers to be an unreasonable length of stay or unreasonable Hospital charges, We Reserve the right to limit payment to what Our Medical Coordinator considers to be Usual, Reasonable and Customary Costs.

Non-Emergency Care in an Emergency Room

If treatment:

- is received in the emergency room of a Hospital while a person is not a full-time inpatient; and
- the treatment is not emergency care; Covered Medical Expenses for charges made by the Hospital for such treatment will be paid at the same rate as a standard office visit (10 min visit)

Hospital level care will be deemed to be required only if care:

- could not safely and adequately have been provided other than in a Hospital; or
- adequate care was not available elsewhere in the area at the time and place it was needed.

Maternity Care**Per Pregnancy**

Maternity care applies to your Family and Premier Family plans only. We will arrange and pay up to the Policy Limits as per the Table of Benefits for

- Normal delivery.
- Cesarean section and complications related to pregnancy.

The benefits apply to the mother only and are excluded during the first twelve (12) months of the Policy. Covered services include:

- Hospital services rendered in a licensed Hospital or approved birthing center (including anesthesia, delivery and postnatal care) for any condition related to pregnancy, including but not limited to childbirth and miscarriage.
- Obstetrical services (including prenatal, delivery and post-natal care) and anesthesia services by Physicians.

Specific exclusions applying to maternity care section

Any fertility/infertility services, tests, treatments, drugs and/or procedures, including the resulting pregnancy, complications of that pregnancy, delivery and postpartum care.

Newborn, Premature birth, congenital conditions, birth anomalies

We will pay up to the Lifetime Maximum (for newborns covered under the Policy)

Hospital nursery services and medical care by the attending Physician for newborn infants in the Hospital are covered if:

- The mother's pregnancy is covered; and
- Dependent cover has already been elected.
- We must have received the baby's application and applicable premium within thirty (30) days of birth for enrollment under a parent's cover.

Charges for Hospital nursery services and professional services for the newborn infant are covered separately from the mother's maternity benefits and are subject to the satisfaction of the Deductible and Coinsurance amounts in accordance with the Policy and Table of Benefits.

Payment of benefits for the newborn child born of a non-covered pregnancy, children born to mothers who received fertility or infertility treatments or for a newborn that has not been enrolled within the thirty (30) day limit; are conditional upon receipt of an Enrollment form and applicable premium and medical underwriting acceptance by Us. No guarantee is made for acceptance of cover to be agreed.

Coverage for congenital conditions is only available to infants born of a covered pregnancy and having continuous cover effective from the date of birth.

When cover is available, benefits are provided for Medically Necessary inpatient and outpatient treatment, services and supplies for congenital conditions as those conditions are defined herein. Benefits for congenital conditions and premature births are payable up to the Lifetime Maximum for newborn cover.

Diagnostic & Therapeutic Services (Outpatient)

We will pay charges for Medically Necessary diagnostic and therapeutic services rendered to an Insured Person as an outpatient of a Hospital, provider's office or approved independent facility.

Diagnostic Services covered are:

- Imaging services
- Laboratory services (excluding allergy testing)
- Machine testing

Therapeutic Services covered are:

- Chemotherapy rendered by a Physician
- Radiation therapy provided by a Physician for a proven malignancy or neoplastic disease
- Respiratory therapy rendered by a Physician or registered respiratory therapist
- Physical and occupational therapy provided by a Physician or registered physical or occupational therapist. Services must be pursuant to a Physicians written treatment plan, which contains short and long term treatment goals and is provided to Us for review. Services must either:

1. Produce significant improvement in the Insured Person's condition in a reasonable and predictable period of time; and
2. Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed; or
3. Be necessary to the establishment of an effective maintenance program

A Medically Necessary Video Laryngoscope may be performed by a registered Speech therapist for the diagnosis of a swallowing dysfunction.

Specific exclusions applying to diagnostic & therapeutic services section

All other speech therapy services or treatments not mentioned above.

Human Organ Transplant Procedures Benefits

We will pay up to the Policy Limits as per the Table of Benefits for charges for Medically Necessary, non-experimental transplantation of a human organ including related services, supplies, drugs and treatments. Organs covered for transplants are limited to the following: heart, lung, kidney, liver, pancreas, and cornea. Bone marrow transplants are covered only for approved diagnosis.

Benefits are only payable if the Managed Transplant Program is used - all transplants need to be pre-certified.

- Benefits are provided to the insured transplant recipients only. Costs related to organ donors are not covered.
- Transplant must be deemed necessary by two (2) independent medical or surgical consultants in the relevant medical specialty most closely related to the transplant.

Transplants resulting from or made necessary by congenital conditions are not covered under this organ transplant benefit. They are subject to the limitations and benefits applicable to the congenital condition benefit specified in this contract in accordance with the current Table of Benefits.

Specific exclusions applying to human organ transplant procedures section

- Any treatment or service which is not pre-certified or does not use the managed transplant network.
- Organ transplant benefits within the first twenty four (24) months of the Insured Person's cover. This period is determined from the Date of Entry.
- Subsequent transplants if the initial transplant was not covered under this contract for any reason.
- Any Transplant procedures and related services We deem experimental.

Mental Health Benefits (Inpatient and Outpatient)

We will pay up to the Policy Limits in the Table of Benefits for allowable charges in respect of psychotherapeutic treatment and psychiatric counseling and treatment for approved psychiatric diagnosis.

The relevant Annual and Lifetime Maximum Limits will be applied to each Insured Person for benefits paid for both inpatient mental health treatment in a Hospital or approved facility and for outpatient mental health treatment.

- A Physician or a licensed clinical psychologist must provide all mental health care services. Services of a clinical psychologist must be rendered in the provider's office or in the outpatient department of a Hospital.

Specific exclusions to mental health benefits (inpatient and outpatient)

- Aptitude testing, educational testing and services.
- Services for conditions We classify as emotional or personality illnesses.
- Psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation.
- Services for mental disorders or illnesses which are not amenable to favorable modification.
- Services related to drug and alcohol abuse.

Convalescent Facility Expenses

We will pay for charges made by a convalescent facility for the following services and supplies. They must be furnished to a person while confined to a convalescent facility from a disease or Injury. The confinement must start during a convalescent period.

- Accommodation - this includes charges for services, such as general nursing care, made in connection with room occupancy.
- Use of special treatment rooms.
- X-Ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a convalescent facility.
- Medical Supplies.

Benefits will be paid for up to the maximum number of days during any one convalescent period. This starts on the first day an Insured Person is confined in a convalescent facility if he or she:

- was confined in a Hospital for at least 3 days in a row, while covered under this Policy, for treatment of a disease or Injury; and
- is confined in the facility within 14 days after discharge from the Hospital; and
- is confined in the facility for services needed to convalesce from the condition that caused the Hospital stay. These include skilled nursing and physical restorative services.

It ends when the Insured Person has not been confined in a Hospital, convalescent facility, or other place giving nursing care for 90 days in a row.

Specific exclusions to convalescent facility expense section

- Any charge for accommodation in a private room over the semi private room limit.
- Private or special nursing, or Physician services.
- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental Retardation.
- Any other mental disorder.

Hospice Care Expense

We will pay up to the Policy Limits in the Table of Benefits for charges incurred in a hospice facility, Hospital or convalescence facility for Accommodation and other services and supplies furnished to an Insured Person while a full-time inpatient for pain control and other acute and chronic symptom management when given as a part of a Hospice Care program are included as Covered Medical Expenses. We must approve the Hospice Care program to provide a centrally administered program of palliative and support services to terminally ill persons and their families. Terminally ill means the patient has a prognosis of two hundred forty (240) days or less. A medically supervised interdisciplinary team of professionals and volunteers provides services.

Other Expenses

We will also pay for charges made by a Hospice Care agency for:

- Part-time or intermittent nursing care by a R.N or L.P.N for up to 8 hours in any one day.
- Medical social services under the direction of a Physician.

These include:

- assessment of the Insured Person's social, emotional and medical needs, and the home and family situation;
- identification of the community resources which are available to the Insured Person;
- assisting the person to obtain those resources needed to meet the Insured Person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a Physician.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies, drugs and medicines prescribed by a Physician.

Charges made by the providers below, but only if the provider is not a participant of a Hospice Care Agency; and such agency retains responsibility for the care of the Insured Person.

- A Physician for consultant or case management services
- A Physical or occupational therapist
- A Home Health Care agency for:
 - physical or occupational therapy;
 - part-time or intermittent home health aide services for up to 8 hours in any one day; these may consist mainly of caring for the person;
 - medical supplies, drugs and medicines prescribed by a Physician;
 - psychological and dietary counseling.

Not more than Policy Limits as per the Table of Benefits will be paid for all Hospice Care or expenses incurred while the Insured Person is not confined as a full-time inpatient. If the Insured Person condition improves and is no longer considered terminal, then the Insured Person is no longer eligible for Hospice Care.

Specific exclusions to convalescent facility expense section

- Any charge for accommodation in a private room over the semi private room limit.
- Private or special nursing, or Physician services.
- Drug Addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental Retardation.
- Any other mental disorder.
- Charges for any day of confinement in excess of the Maximum number of days for all confinements for Hospice Care.

Charges for:

- Services not prescribed in the approved treatment plan.
- Chemotherapy and radiation therapy except for palliative control.
- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. These include estate planning or the drafting of a will.
- Homemaker or caretaker services. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- Respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Emergency Ambulance Services

- We will pay charges for professional ambulance service including road ambulance and Air Ambulance, if necessary, to transport an Insured Person from the place where he or she is injured or stricken by disease to the first Hospital where treatment is given.

Emergency Air Ambulance

- Covered based on Medical Necessity.
- Evacuation is provided if an Insured Person is involved in an accident or suffers a sudden Illness and adequate medical facilities are not available locally. A medically supervised medical evacuation to the nearest facility capable of providing an adequate level of care will be co-coordinated by Our emergency medical assistance provider.
- Repatriation of mortal remains: Our emergency medical assistance provider will coordinate the necessary clearances for the return of an Insured Person's mortal remains by air transport to the home country.

To comply with the terms and conditions of the Policy the Insured Person must contact Us for pre-authorization before any costs for evacuation and assistance costs are incurred.

Specific exclusions to emergency ambulance services section

Any other expenses in connection with air travel.
Any costs which are not pre-authorized.
Any costs for a road ambulance if the Insured Person could have been transported in a private car, whether or not one was available.

Outpatient Prescription Drugs

Benefit is provided for prescription drugs and medicines, which by law need a Physician's prescription and are approved by Us for use outside of a Hospital.

Contraceptive drugs are excluded even if such drugs are prescribed for other than contraceptive purposes. Weight reduction, smoking cessation, fertility/infertility or hair restoration drugs, over the counter medications are not covered, even if prescribed by the Physician.

Prescribed drugs related to human organ transplants and subsequent treatment are governed by the benefits and limitations listed in the Human Organ transplant section of this contract. All prescription drug benefits are payable in accordance with the current Table of Benefits.

Durable Medical Equipment

We will pay up to the Policy Limits in the Table of Benefits for costs for prosthetic devices (artificial devices replacing body parts), orthopedic braces and Durable Medical Equipment (including wheelchairs and Hospital beds) that are:

1. Prescribed by a Physician and
2. Customarily and generally useful to a person only during an Illness or Injury, and
3. Determined by Us to be Medically Necessary and appropriate.

Rental fees of Durable Medical or surgical equipment must not exceed the allowable purchase price of the Durable Medical Equipment.

The initial purchase of such equipment and accessories needed to operate it; this will only be covered if:

- long term use is planned; and
- the equipment cannot be rented; or
- It is likely to cost less to buy it than to rent it.

Repair or replacement of such purchased equipment and accessories. We will only cover Replacement if:

- it is needed due to a change in the Insured Person's physical condition; or
- it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

Specific exclusions to durable medical equipment section

Charges for more than one item of equipment for the same or similar purpose.

Charges in relation to **Artificial limbs and eyes:** eye exams and eyeglasses; hearing aids; orthopedic shoes or other devices to support the feet.

Visiting Nurse/Home Health Care Expense

We will pay up to the Policy Limits in the Table of Benefits for charges relating to Visiting nurse/Home health expenses if:

- the charge is made by a Home Health Care Agency; and
- the care is given under a Home Health Care Plan; and
- the care is given to a person in his or her home.

Visiting nurse/Home health care expenses are charges for:

- Part-time or intermittent care by an R.N or by an L.P.N if an R.N is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational and speech therapy.
- The following to the extent they would have been covered under this Policy if the Insured Person had been confined in a Hospital or convalescent facility:
 - medical supplies, drugs and medicines prescribed by a Physician; and
 - lab services provided by or for a Home Health Care agency.

In each Period of Insurance there is a maximum to the number of visits covered as per the Table of Benefits. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Specific exclusions to visiting nurse/home health care expense section

Charges made for:

- Services or supplies that are not a part of the Visiting Nurse/Home Health Care Plan.
- Services to an Insured Person by anyone who usually lives with You or is a member of Your or Your wife's or husband's family.
- Services of a social worker.
- Transportation.

Private Duty Nursing (Inpatient Service Only)

We will pay up to the Policy Limits in the Table of Benefits for costs of private duty nursing by an R.N or L.P.N if the person's condition requires Skilled Nursing Care and visiting nursing care is not adequate.

This benefit is provided only when ALL of the following conditions are met:

- The nursing service is available and the service is prescribed by the attending Physician; and
- The service is related to the condition for which Hospital care and treatment are being rendered; and
- The service is Medically Necessary; and
- The service is approved by the Hospital.

We may elect to review a case in advance and then approve benefits for this service for up to 80 hours at a time.

Specific exclusions to private duty nursing section

Benefits will not be paid for private duty nursing:

- For any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private nursing of up to 8 hours will be deemed to be one private duty-nursing shift.
- When it is provided as a convenience for the patient, whether or not prescribed by a Physician, or when it is provided at the request of the patient or his/her family.
- When it is rendered in such special care facilities of the Hospital as self-care, selective care, and intensive care units.

Benefits will not be paid for Skilled Nursing Care for:

- A visit of more than 4 hours for the purpose of performing specific skilled nursing tasks.
- That part or all of any nursing care that does not require the education, training and technical skills of an R.N. or L.P.N; such as transportation, meal preparation, charting of vital signs and companionship activities; or
- Any private duty nursing care, given while the person is an inpatient in a Hospital or other health care facility; or
- Care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- Care provided solely for skilled observation except as follows:
 - more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:
 - change in patient medication.
 - need for treatment of an emergency condition by a Physician or the onset of symptoms indicating the likely need for such treatment.
- Any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a R.N. or L.P.N.

Wellness and Preventive Benefits

(6 month waiting period - not subject to Deductible) Waiting period does not apply if premium is paid annually.

We will Pay the costs up to the Policy Limits in the Table of Benefits for the cost of examinations of the Insured Person (having regard to their age) to ascertain the potential presence of Illness or disease; these may include, (but not limited to):

Vital signs, including blood pressure, cholesterol, pulse, respiration, temperature;
Cardiovascular and neurological examinations;
Cancer screening including mammogram, PAP smear, colon prostrate;
Well Child examination.

- A physical exam may also include the materials for and the administration of immunizations and vaccinations for infectious disease and testing for tuberculosis.

Wellness and Preventative benefits for children are only available with yourFamily and PremierFamily Plans

- For all exams given to Your children under age 6 Covered Medical Expenses will exclude charges for:
 - more than 6 exams in the first year of the child's life;
 - more than one exam in each year of life thereafter.
- For all exams given to Your child age 6 and over, Covered Medical Expenses will exclude charges for more than one exam per Period of Insurance.

Specific exclusions to wellness and preventative benefits section

- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing (except for children under age 15 who are members of yourFamily and PremierFamily Plans) or dental exams.
- Costs where the medical results and report from the examination have not been provided to Us.

Vision Care Benefit

We will pay up to the Policy Limits in the Table of Benefits for:

Ophthalmology

Benefits apply for eye examinations.

Eyeglasses and Contacts

Benefits apply for eyeglasses or contact lenses prescribed as the result of an eye examination to correct defective eyesight.

The benefit applies only if the eyeglasses or contact lenses are prescribed as a result of eye examination made during the Period of Insurance. The date that the eyeglasses or contact lenses are ordered shall be considered to be the date that charges are incurred and the eyeglasses or contact lenses are furnished.

Specific exclusions to vision care section

Experimental surgery, care, treatment, services or supplies. Experimental means:

- Not approved or accepted as essential to the treatment of an Injury or sickness by nationality recognized medical organization or appropriate government agencies.
- Not recognized by the medical community as potentially safe and efficacious for the case and treatment of the Injury or sickness; or
- Not approved for reimbursement under National Medical Programs.

Medical Evacuation and Assistance

Scope of Coverage

Insured Persons have access to the following services. For certain services, specifically Evacuation, Medically Supervised Repatriation and Repatriation of Mortal Remains, reimbursement is subject to the Table of Benefits.

Description of Services

The following services are provided by Our 24-hour assistance company, Healix International. They are provided purely on a referral or arrangement basis. Neither We nor Healix International shall be responsible for any third party expenses, which shall be solely the Insured Person's responsibility.

Travel Assistance Services

The Insured Person may contact Healix International to obtain the following travel information and services before starting or during his journey:

24 hour Assistance Call Centre
Pre Travel Medical Advice
Hotel Reservation
Air Ticket Reservation
Cash advance

To comply with the terms and conditions of the Policy, the Insured Person needs to contact Us for pre-authorization before any evacuation and assistance costs are incurred. If the Insured Person fails to follow this condition, he will be liable to pay full costs of any transportation. Our contact information is on Your membership card

+ 44 1444 444 952 or

+1 844 284 0210 (toll free from within USA)

Pre-authorisation

A. Hospitalization, outpatient surgery and medical transportation

Pre-authorisation. is required in all cases of Hospitalization, outpatient surgery, and medical transportation (except for local emergency transportation). Plan payments will be reduced to 50% of normal payment if the Insured Person does not follow the instructions below or if a pre-authorisation agreement is not obtained from Us.

- The Insured Person is required to contact Us at the earliest opportunity before entering a Hospital or undergoing outpatient surgery, the telephone numbers are shown on Your membership card. If an emergency Hospitalization occurs, We must be notified within 48 hours of admission.

Outside of the United States of America -

No restrictions are imposed regarding the choice of Physician, laboratory, Hospital, clinic, etc., except that the facilities must be licensed and the treatment performed by legally qualified providers and Physicians practicing within the scope of their license. However pre-authorisation is required.

Within the United States of America, pre-authorisation is required for all medical services

except for local emergency medical transportation, or the normal payment (benefit) will be reduced by 50%. Within the United States Insured Persons are required to utilize Our PPO or be subject to a possible penalty if charges are greater than if the PPO was utilized.

In all cases regardless of location, Deductibles and Co-insurance as specified in the Table of Benefits apply.

B. Dental treatment and orthodontic work (Dental and Orthodontic Covers are Optional)

The Insured Person is required to submit to Us the dentist or the orthodontist's treatment plan and to obtain pre-authorisation of benefits before any work, other than Class I (General and Preventive), is started.

Pre-authorisation of benefits means a review by Us of a dentist or orthodontist's planned treatment and expected charges. If there is a major change in the treatment plan, a revised plan must be sent to Us.

General Exclusions

You are not insured, and will not be paid under any part of this Policy for:

1. Services and supplies:
 - i) Which we deem to be unnecessary for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed, recommended or approval by the attending Physician or dentist.
 - ii) Which any school system is required to provide under any law.
2. Care, treatment, services or supplies that are not prescribed, recommended and approved by the Insured Person's attending Physician or dentist.
3. Expenses covered under Workers' Compensation or similar law or programs.
4. Charges for services or supplies ordered or received prior to the Date of Entry of cover or after the termination date of cover.
5. Health check-ups, inoculations, visits and tests necessary for administrative purposes, for example for determining insurability.
6. Plastic surgery; reconstructive surgery; cosmetic surgery; or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, unless required because of a non-occupational Injury that occurs while covered under the Policy.
7. Treatment for morbid obesity, weight control, gastric bypass or gastric stapling procedure.
8. Tobacco dependence treatment.
9. Infertility and/or fertility procedures and any resulting pregnancy or childbirth(s).
10. Charges related to In-Vitro fertilization, artificial insemination or similar procedures.
11. Travel and hotel expenses related to medical or dental care.
12. Routine podiatry or other foot treatment not resulting from an Illness or Injury.
13. Hearing aids.
14. Treatment for or in connection with pregnancy or childbirth during the first 12 months a person is insured unless so indicated under "Waiting Periods".
15. Radial keratotomy procedures (myopia surgery), lasik, or eye surgery to correct refractive error or deficiencies.
16. Dental care which is not the result of accidental Injury of sound, natural teeth sustained while covered under this Policy.
17. A dental surgical implant of any type.
18. Care in a nursing home or home for the aged or custodial care. Custodial care means care comprised of, or services and supplies including room and board, and other institutional services, which are provided to an individual, whether disabled or not, primarily to assist in the activities of daily living. Such services are considered custodial care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed.
19. Anything not ordered by a Physician or not necessary for medical care, as well as medical and dental services that do not meet professionally recognized standards or are not considered as being necessary for proper treatment.

20. Services or supplies that We deem to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:
 - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or Injury involved; or
 - if required by the FDA, approval has not been granted for marketing; or
 - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
 - the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.
21. Treatment not recognized by the medical community as potentially safe and efficacious for the care and treatment of the Injury or sickness; or
22. Treatment not approved for reimbursement under National Medical Programs.
23. Charges which We deem to be unusual or excessive.
24. Expenses covered by a government program such as Social Security, whether or not a Insured Person applies for reimbursement from that program.
25. Care provided in a government Hospital or medical facility for which an individual would not be charged in the absence of this cover.
26. Expenses reimbursed or reimbursable by another insurance contract or program.
27. Missed appointments.
28. Pre-existing Medical Conditions are not covered by the Policy unless:
 - (a) no symptoms, treatment or diagnosis has been received within a 12 month period prior to the Date of Entry; and
 - (b) such conditions have been disclosed to and accepted for insurance by Us; and
 - (c) until a 12 month waiting period has elapsed from the Date of Entry.
29. Class III dental expenses incurred during the first 6 months from the Insured Person's Date of Entry if the Dental Cover option has been selected.
30. All treatments, services or supplies covered by the optional benefit groups identified as Dental, or orthodontic cover, unless the Insured Person has chosen one or more of these covers and the cover is specifically indicated in the Dental Insurance Option Endorsement.
31. Any injury or sickness in connection with or caused by war or an act of war whether declared or undeclared, riot, civil commotion, or police action whether participating or not.
32. Charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charged made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent; (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to Coinsurance or Deductible amounts).
33. Charges made by an anesthesiologist in excess of 30 percent of the surgeon's allowable charge; (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to Coinsurance or Deductible amounts).
34. Donor expenses connected with organ transplant are not covered.
35. Any expense for male or female: reversal of sterilization; sex change or implantation; or treatment for sexual transformation; sexual dysfunctions or inadequacies.
36. Charges for breast reduction or augmentation and complications arising from these procedures.
37. Personal or comfort items such as radio, television, barber or beauty services or supplies.

38. An Injury or Illness that is self-inflicted, or an attempt at self-destruction, while sane or insane.
39. Any participation in an assault, felony or illegal act, including but not limited to Injuries sustained in fights initiated by You or Your dependent.
40. Any treatment for Alcoholism or drug addiction.
41. Over-the-counter (OTC) drugs or supplies, which do not require a Physician prescription, smoking cessation drugs, appetite suppressant, hair regenerative drugs, anti-photo aging drugs, cosmetics and beauty aids, acne drugs (retin A for cosmetic purposes), Megavitamins, vitamin, prenatal vitamins prescribed or not, nutritional supplements.
42. Charges made by a member of Your family to look after You.
43. Charges relating to acupuncture, acupressure, hypnosis or biofeedback.
44. Charges for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
45. Charges for or related to services, treatment, education testing or training related to learning disabilities or development delays including but not limited to Attention Deficit/Hyperactivity Disorder (ADD/ADHD).
46. Charges for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) as the result of a disease or Injury.
47. Services and supplies related to visual therapy or orthoptics.
48. Orthotics, including all equipment, devices, foot inserts, arch supports, lifts and correct shoes.
49. Diagnostic examinations or laboratory tests performed as a Hospital inpatient for inconvenience or observation when these services can be safely performed as an outpatient.
50. Treatment by naturopaths, homeopaths, naturopathic or homeopathic medications or supplements and any other alternative methods of treatment We do not recognize unless specified in the Table of Benefits.
51. Any condition, Illness, Injury or emergency air services related to nuclear accident.
52. Allergy testing and treatment.
53. Elective abortions and complications thereof.
54. All services supplies and treatment related to primal therapy, rolfing, psychodrama, megavitamin therapy, carbon dioxide therapy and bioenergetics therapy.
55. All services, supplies and treatment related to cognitive therapy both inpatient and outpatient.
56. Participation in a professional sport (not including recreational or amateur participation) or any hazardous sport or activity such as (but not limited to) the following: motor sports, aerial sports, scuba diving below 30 meters or where a PADI Certificate is not held, any sport involving animals, speed competition, skiing off-piste and racing of any form (other than on foot) If a hazardous sport or activity is not specified in this list, the Insured Person must contact Us to ascertain if it is acceptable for insurance before cover will apply.
57. Any claim relating to (i) self-inflicted injury (including suicide or attempted suicide); (ii) self-exposure to peril (except in an attempt to save human life).

General Conditions

Eligibility

Individuals who meet all of the following criteria are eligible for cover as an Insured Person:

- The individual has completed an Enrollment form for cover;
- The individual has signed and returned an Enrollment form to Us;
- The individual resides outside of the United States of America, or any of their territories;
- The individual and/or his or her eligible dependents will not attain 69 years of age during the Period of Insurance; and
- We accept the individual for cover.

Dependents

You may cover Your:

- Wife or husband; except that a person of the opposite sex who has been living with You for a period of at least one year will be deemed to be Your dependent spouse if they have been publicly represented as Your spouse. Such person shall be deemed to be "Your domestic partner". If You have completed and signed a "Declaration of Dependents" and the Declaration is acceptable to Us.
- Unmarried children who are under 19 years of age.

Any other unmarried child under 23 who goes to school on a regular basis and depends solely on You for support will be covered as a dependent.

Your children include

- Your biological children.
- Your adopted children.
- Any other child You support whom You are legally responsible for and who lives with You in a parent-child relationship.

Date of Entry

Your cover will take effect:

- On Your Commencement Date, if by then, You have signed and returned Your Enrollment form, have paid the premium and We have given Our written consent. Additional evidence may be required including a Physician's statement and/or results of a medical examination. You will provide any additional information at Your cost and is to be provided by a Physician You select and We approve.

If You don't sign and return Your Enrollment form by Your Commencement Date, cover will not take effect until this has been done and We give Our written consent.

Dependents

Cover for those who are dependents as of the date and premium has been received by US Your cover takes effect will become effective on that date, if, by then We have received notification of Your written request for cover of such dependents and an Enrollment form has been completed for the dependents, and have given Our written consent and premium has been received by US. The evidence required may include a Physician's statement and/or results of a medical examination performed by a Physician approved by Us. The Evidence of Insurability will be at no cost to Us. Otherwise, cover for such a dependent will not go into effect until You submit Evidence of Insurability for the dependent which We agree is satisfactory and premium has been paid. The Date of Entry will be a date specified by Us in writing.

If You require cover for a new dependent:

- who is Your biological newborn child, cover of that dependent takes effect at birth subject to notification of birth within 30 days, otherwise, the addition will take effect from the date of notification; or
- other than who is Your biological newborn child, cover for the dependent will not go into effect until You submit satisfactory Evidence of Insurability for the dependent. The Date of Entry will be a date specified in writing, by Us. The evidence required may include a Physician's statement and/or results of a medical examination and will be Your cost.

Any dependent age 60 or over must supply the results of a medical exam in addition to the completion of an Enrollment form. The exam will be done at the dependent's expense and performed by a Physician approved by Us. Cover will only become effective if the Enrollment form and medical exam results are to Our satisfaction.

Each dependent must meet the eligibility requirement of this Policy and all Our underwriting requirements.

We reserve the right to issue cover subject to specific medical exclusions, and no benefits shall be payable for services related to those conditions, notwithstanding any other provision of this Policy.

Residency

The Insured Person must reside outside the United States of America. Permanent residence in the United States of America shall be ground for termination of this Policy. For purposes of this Policy, We may determine that an Insured Person reside(s) in United States of America in any case in which the Insured Person is in the United States of America for:

1. one hundred and eighty (180) or more consecutive days; or
2. more than one hundred and eighty (180) total days in any twelve (12) consecutive month period.

A full time student attending school in the United States of America may remain covered upon proof of matriculation, subject to all other eligibility requirements of this Policy. Such proof of matriculation shall be provided at time of application for cover, at each renewal during which the full-time attendance continues, or upon Our request.

Termination of Cover

Cover under this Policy terminates at the first to occur of:

- The date on which You are no longer eligible to be an Insured Person.
- When You fail to make any required payment due to Us.
- The date You become a resident of the United States of America.
- Upon completion of any 180 day period living in the United States of America.
- The end of the Period of Insurance in the year in which You attain the age of 70.

Dependents Coverage Only

Coverage for an Insured Person's Spouse will terminate at the first to occur of:

- The date this Policy terminates.
- The end of the Period of Insurance in which such spouse is legally separated or divorced from the Insured Person.

Coverage for all other dependents will terminate at the first to occur of:

- The date this Policy terminates.
- The end of the Period of Insurance in which the covered dependent marries.
- The end of the Period of Insurance in which the covered dependent ceases to be a defined dependent.

A 'Dependant' will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this Plan no longer allows cover for Dependant.
- The date of termination of the domestic partnership. In that event, You should provide the Policyholder with a completed and signed Declaration of Termination of Domestic Partnership.

Continuation of Cover for a Disabled Dependent Child

Covered Medical Expense benefits for Your fully disabled child may be continued past the maximum age for a dependent child, if the child continues to be fully disabled.

Your child is fully disabled if:

- He or she is not able to earn his or her own living because of mental retardation or a physical disablement which started prior to the date he or she reaches the maximum age for dependent children; and
- He or she depends chiefly on You for support and maintenance.

You must submit to Us, proof that Your child is fully disabled within 120 days after the date Your child reaches the maximum age.

Cover will cease on the first to occur of:

- Cessation of the disablement.
- Failure to give proof that the disablement continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to Your child for any reasons other than reaching the maximum age.

We will have the right to require proof of the continuation of the disablement. We also have the right to examine Your child as often as needed while the disablement continues at its own expense. An exam will not be required more often than once each year after 2 years from the date Your child reached the maximum age.

Premium Payments - Renewal

Your first premium payment for this Policy is due on the Commencement Date shown on the Certificate of Insurance. Renewability is at Our option. If We elect not to renew, notice will be mailed at least thirty (30) days prior to the renewal date. Written notice sent to the Policyholder shall be sufficient.

Unless this Policy is renewed, it will terminate at the end of the Period of Insurance for which a premium has last been paid.

If the Insured Person requests that:

- Insurance be cancelled for one or more of the Insured Persons; or
- That the Policy be cancelled in its entirety;

Such insurance will cease only at the end of the Period of Insurance and there will be no pro rata refund of the premium. Any unpaid Premium for the Policy shall remain due and owing.

Physical Examinations

We will have the right and opportunity to have a Physician of Our choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to You.

Entire Contract - Changes

We must approve any change in this Policy, such approval must be confirmed by a Policy endorsement.

Reinstatement of Policy

If the Policy is terminated or non-renewed for failure to pay Premium in the time required, We may reserve the right, in Our sole discretion, to reinstate the Policy with regard to You, upon such terms and conditions as We deem appropriate, including the payment of a reinstatement fee.

Legal Action

No legal action can be brought to recover under any benefit on this Policy sooner than 60 days after the required proof of claim has been furnished. No legal action can be brought to recover under any benefit after 2 years from the deadline for filing claims.

Fraud/Non-disclosure/Mis-representation

We may terminate cover by giving written notice to the Insured Person for misrepresentation on the Enrollment form or for fraud in obtaining cover. Termination is effective as of the Commencement Date under this Policy and the Policy becomes void ab initio. We will refund all premiums paid on behalf of the Insured Person less benefit payments paid to or on behalf of the Insured Person and his dependents. If the value of the benefits paid exceeds the amount of premium paid, the Insured Person will pay Us an amount equal to such excess.

Recovery of Benefits Paid

As a condition to payment of benefits under this Policy for expenses incurred by an Insured Person due to Injury or Illness for which a third party may be liable:

- We shall, to the extent of benefits it has paid, be subrogated to (have the right to pursue) all rights of recovery of Insured Persons against:
 - such third party; or
 - a person's insurance carrier in the event of a claim under the uninsured or underinsured auto cover provision of an auto insurance policy.
- We may recover from the Insured Person amounts received by judgment, settlement, or otherwise from:
 - such third party or his or her insurance carrier; or
 - any other person or entity, which includes the auto insurance carrier which provides the Insured Person's uninsured or underinsured auto insurance cover.

- The Insured Person (or person authorized by law to represent the Insured Person if he or she is not legally capable) shall (at their own expense);
- execute and deliver any documents that are required; and
- do whatever else is necessary to secure such rights.

Assignment

Cover may be assigned only with Our written consent.

Recovery of Overpayment

If a benefit payment is made by Us, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the Policy, We have the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery We may have with respect to such overpayment.

Claims

Proof of Claim

- Bills identifying patient, date of treatment, cost and describing in detail the medical services performed or the medical products purchased.
- Doctor's prescription for prescription drugs, laboratory tests, physical therapy and eyeglasses and contact lenses.
- The original reimbursement statements from Social Security, government programs, or other insurance plans.

The Insured Person must also answer any questions concerning the Illness or accident and, in particular, provide a complete description of the Illness or accident and indicate, when requested, the date when it was first identified or treated by a medical Practitioner, etc.

Notice of Claim and Time Limitation

A claim must be submitted to Us in writing. It must give proof of the nature and extent of the loss. Please contact Us for a claim form.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim. Late claims may be considered if through no fault of Your own You are unable to meet the deadline for filing a claim.

Your claim will be accepted if You file as soon as possible up to a maximum of 180 days. Late claims will not be covered if they are filed after the deadline.

No action for the recovery of any claim for benefits shall be sustainable unless commenced within 180 days of the event that is at the origin of the claim. After expiration of this term, the Insured Person, has no rights or obligations. After termination of this Policy, claims for expenses incurred while the Policy was in force shall be considered if they reach Us within 90 days of such termination.

Payment of Benefits

All benefits are payable to You. However, We may pay any health benefits to the service provider. This will be done unless You have told Us otherwise, by the time You file the claim.

Age Limit

If We accept a Premium for an Insured Person after the date such person would cease to be insured due to age, that person's cover will terminate and premium will be refunded less any claims paid out.

If an Insured Person's age is misstated and if, according to the true age, the cover provided by this Policy for that person would not have been effective or would have ceased before acceptance of premium, Our liability will be limited to the refund, on request, of all premiums paid for the period not covered by the Policy.

Currency

Premium payments will be made to Us in the respective Policy's denominated currency: USD; EUR; GBP. Or in any other major currency as agreed with Us. All references in this Policy to dollars and cents mean dollar and cents of lawful United States of America money. Euros and cents means the lawful currency of the European Monetary Union and Pounds and pence means the lawful currency of the United Kingdom of Great Britain.

Record of Expenses

Keep complete records of the expense of each person. They will be required when a claim is made. Very important are:

- Names of Physicians, and others who furnish services
- Dates of expenses are incurred
- Copies of all bills and receipts

Medical Services

We are not responsible for the availability, quantity, quality or results of any medical treatment received by an Insured Person or for the failure of an Insured Person to obtain medical services.

Meaning of Words

Certain words and phrases used in this Policy are defined below. Other words and phrases may be defined where they are used:

Accident: A sudden, unexpected and unforeseen bodily Injury caused by violent, visible and external means, which necessitates the Close Relative being admitted to a Hospital bed on the advice of a Physician for a minimum of three consecutive nights.

Air Ambulance means a vehicle medically equipped to transport ill or Insured Persons that:

- is licensed by local, county or state regulations, and/or
- has attendants who are fully trained in emergency care, such as emergency medical technician (EMT) or paramedics.

Ambulatory Surgical Center means a facility which: (a) has as its primary purpose to provide elective surgical care; and (b) admits and discharges a patient within the same working day; and (c) is not part of a Hospital. “Ambulatory Surgical Center” does not include: (1) any facility whose primary purpose is the termination of pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained by a dentist for the practice of dentistry.

Birth Center means a facility which: a) is mainly a place for the delivery of a child or children at the end of a normal pregnancy; b) and meets one or both of the following tests: (1) it is licensed as a Birth Center under the laws of the jurisdiction where it is located; and/or (2) it meets all the following requirements: (i) it is operated in accordance with the laws of the jurisdiction where it is located; (ii) it is equipped to perform all necessary routine diagnostic and laboratory tests; (iii) it has trained staff and equipment required to properly treat potential emergencies of the mother and of the child; (iv) it is operated under the full-time supervision of the Physician or a Registered Nurse (R.N.); (v) it has at all times a written agreement with at least one Hospital in the area for immediate acceptance of a patient in the event of a complication; (vi) it maintains medical records for each patient; (vi) and it is expected to discharge or transfer each patient within 24 hours after the delivery.

Authorisation, Certify and Certified mean that We, following advance notification of a Scheduled Confinement in a U.S. Hospital, have acknowledged the Scheduled Confinement, provided the Insured Person with the names and addresses of U.S. Hospitals that are members of the Participating Provider Organization, to which the Insured Person may have access as a Insured Person under the Policy, and confirmed that such Confinement is Medically Necessary.

These terms also mean that We have received notification:

- a) within 48 hours of an emergency U.S. Hospital Confinement;
- b) 48 hours before Outpatient Skilled Nursing Care in the U.S.; or
- c) within 48 hours of an Insured Person being identified as a candidate for a heart, heart and lung, single lung, pancreas and kidney, or liver transplant;

in advance of any Hospital stay, Skilled Nursing Care, surgery or medical care; it means We have acknowledged such notifications, and reviewed the Confinement, the Outpatient Skilled Nursing Care, and/or the proposed transplant services and procedures for Medical Necessity, and, when applicable, provided the Insured Person with the names and addresses of U.S. Hospitals which are members of the Participating Provider Network.

Close Relative means mother, mother-in-law, father, father-in-law, stepmother, stepfather, daughter, daughter-in-law, son, son-in-law, (including legally adopted daughter or son), stepchild, sister, sister-in-law, brother, brother-in-law, of an Insured Person.

Commencement Date means the date Your cover becomes effective under this Master Policy.

Complications of Pregnancy means

A. when pregnancy is not terminated, conditions that require Hospital Confinement, whose diagnoses are distinct from pregnancy but are adversely affected by or are caused by pregnancy, such as:

- Acute nephritis;
- Nephrosis;
- Cardiac decompensation;
- Missed abortion; and

B. when pregnancy is terminated by:

- Non-elective cesarean section;
- Ectopic pregnancy that is terminated; or
- Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include false labor; occasional spotting; Physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum; and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct Complication of Pregnancy.

Confinement means admission to a facility as a registered inpatient. Two or more Confinements will be deemed one period of Confinement unless the discharge from the readmission to the facility is separated by at least 60 days.

Country of Residence means the country in which You are resident and working for at least 9 months of any 12 month period.

Covered Medical Expenses means the Usual, Reasonable and Customary charges incurred by a Insured Person, while covered under this Policy, for Medically Necessary services, treatments or supplies described under the provisions titled Covered Medical Expenses and, if applicable, Covered Dental Expenses.

Custodial Care means treatment or services which could be rendered safely and reasonably by a person not medically skilled, regardless of who recommends them and where they are provided, and which are designed mainly to help the patient with daily living activities. Such activities include but are not limited to: a) help in walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing; b) preparing meals or special diets; c) moving the patient; d) acting as a companion or sitter; and e) supervising medication which can usually be self-administered.

“Custodial Care: includes: (1) the provision of

accommodation, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and (3) rest cures, respite care and home care provided by family members. Upon receipt and review of a claim, We or an independent medical review will determine if a service or treatment is Custodial Care.

Date of Entry means either the Commencement Date or the date from which an Insured Person's cover become effective.

Deductible means the dollar amount of Covered Expenses which an Insured Person is responsible to pay before benefits are payable under this Policy. Such amount will not be reimbursed under the Policy. After the Deductible amount has been paid by the Insured Person, benefits for Covered Medical Expenses will be payable under this Policy at the percentage rates shown on the Table of Benefits.

Domestic Partner means a person of the opposite sex who has been living with You for a period of at least one year. This person will be deemed to be Your dependent spouse if they have been publicly represented as Your spouse.

Durable Medical Equipment means requirement that is: a) Medically Necessary; b) made for and mainly used in the treatment of an Injury or an Illness; c) not useful in the absence of an Illness or Injury; d) made to withstand repeated use over an extended period of time; e) suited for use in the home; and f) used to improve a permanent medical condition. Durable Medical Equipment does not include: insulin pumps; glucometers; motor driven wheelchairs or beds; comfort items such as telephone arms and over-bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies such as exercycles, More wheels, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment; and similar items.

Emergency Confinement means a Hospitalization required as the result of a serious Injury or the onset of a life-threatening condition that requires immediate medical or surgical care to prevent loss of life or permanent damage to the organs or systems of the body. Examples of such Injuries or conditions include, but are not limited to: heart attack, stroke, poisoning, loss of breath, severe bleeding, loss of consciousness, convulsions and severe trauma.

Enrollment means, for the purpose of evaluating enrollments, such satisfactory evidence that an individual is in good health, based on medical information, as We require.

Evidence of Insurability means a statement of health provided by a Physician.

Experimental or Investigative means that a medical, dental or surgical procedure, treatment, course of treatment, equipment or drug or medicine is: a) under investigation or is limited to research; b) restricted to use in disciplined clinical efforts and scientific studies; c) not proven in an objective way to have therapeutic value or benefit; d) medically questionable with respect to effectiveness; and e) not generally accepted by the medical community. We may be contacted to determine if a particular procedure, treatment, device, drug or drug therapy is considered to be Experimental or Investigative.

Extended Care Facility means an institution that meets all of the following requirements: a) it must be operated pursuant to law; b) for U.S. facilities, it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested; c) it must be primarily engaged in providing, in addition to room and board accommodations, skilled nursing services under a licensed Physician's supervision; d) registered or licensed practical nurses must supervise 24-hours-a-day; and e) a daily record for each patient must be maintained. Extended Care Facility does not include any institution that is primarily a clinic; a rest home; a home for the aged; a place for alcoholics or drug addicts; a place for Custodial Care; or a facility for mental illness.

Home Health Care Agency means an agency or organization, or subdivision thereof, which: a) is primarily engaged in providing Skilled Nursing Care and other therapeutic services in the Insured Person's home; b) is duly licensed, if required, by the appropriate licensing facility; c) has policies established by a professional group associated with the agency or organization, including at least one Physician and one registered graduate nurse (R.N.), to govern the services provided; d) provides for full-time supervision of such services by a Physician or by a Registered Nurse (R.N.); e) maintains a complete medical record on each patient; and f) has a full-time administrator.

Home Health Care Plan means a program: a) for the care and treatment of the Insured Person in his home; b) established and approved in writing by his attending Physician; and c) Certified, by the attending Physician, as required for the proper treatment of the Injury or Illness, in place of inpatient treatment in a Hospital or in an Extended Care Facility.

Hospice Care means an agency which provides a coordinated plan of home and inpatient care to a terminally ill person and which meets all of the following tests: a) has obtained any required state or governmental license or Certificate of Need; b) provides service 24--hours-a-day, 7 days a week; c) is under the direct supervision of a Physician; d) has a nurse coordinator who is a Registered Nurse (R.N.); e) has a duly licensed social service coordinator; f) has as its primary purpose the provision of Hospice services; g) has a full-time administrator; and h) maintains written records of services provided to the patient.

Hospital means an institution which is licensed as a Hospital under the laws of the jurisdiction where it is located, and: a) is primarily engaged in providing, for payment and on its own premises, inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities; b) is under the direction of a staff of Physicians; c) provides 24-hour nursing service rendered or supervised by a registered graduate nurse; has facilities on its premises for major surgery (or a written contractual agreement with an accredited Hospital for the performance of surgery); and for U.S. facilities, is accredited by the Joint Commission on Accreditation of Health Care Facilities.

“Hospital” does **not** include a facility, or part thereof, which is principally used as: a rest or Custodial Care facility; nursing facility; convalescent facility; Extended Care Facility; or facility for the aged or for the care and treatment of drug addicts or alcoholics, unless specifically provided in this Policy and/or as mandated by local law. It does not mean any institution in which the Insured Person receives treatment for which he is not required to pay.

Illness means: a bodily disorder or infirmity; Complications of Pregnancy; and Pregnancy.

Injury means a bodily Injury that is: 1) sustained by a Insured Person while insured under this Policy; and 2) caused by an accident directly and independently of all other causes. A Insured Person must begin receiving services, supplies or treatment within 72 hours from the time of Accident in order for it to be considered an Injury. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

Insured Event means an Accident or the sudden and unexpected onset of Serious Illness, or the sudden and unexpected death or imminent demise of a Close Relative, which do not arise from a Pre-Existing Medical Condition, during the Period of Insurance within the permanent place of Residence of the Close Relative.

Insured Person means an eligible individual & his or her dependents entitled to benefit under this Policy, each of whom is named or described on a completed Enrollment form or subsequent notification and for whom the appropriate premium has been paid to Us, and whom we have accepted for cover.

L.P.N. means a Licensed Practical Nurse

L.V.N. means a Licensed Vocational Nurse

Medical Emergency means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected to result: a) in placing the patient's body in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Medically Necessary means that a treatment, service, supply, drug or Hospital or Extended Care Facility Confinement (or part of a Confinement): a) is appropriate and essential to diagnose or treat the patient's Illness or Injury; b) does not exceed, in scope, duration, or intensity, the level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment; c) is prescribed by a Physician; d) is consistent with widely accepted professional standards of medical practice in the jurisdiction where treatment is rendered; e) is not primarily for the personal comfort or convenience of the patient, the family, Physician, or other provider of care; f) is not a part of or associated with the scholastic education or vocational training of the patient; g) is not Experimental or Investigative; and h) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a Physician has prescribed, recommended, approved or provided a treatment, service, supply, or Confinement does not, in itself, make it Medically Necessary. We may examine all conditions listed above in reviewing a claim for treatment, service, supply, drug or Hospital or Extended Care Facility Confinement or part thereof.

Medicare means Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or subsequently amended.

Medical Coordinator or Our Medical Coordinator means an organization with a staff who performs the Certification processes in conjunction with consultant Physician(s) qualified or specializing in the treatment of the condition (including mental Illness, alcohol or drug abuse), and arrange or approve certain Medical Transportation.

Nurse Midwife means a person: a) Certified to practice as a Nurse Midwife; b) and licensed by a board of nurses as a Registered Nurse (R.N.); and c) who has completed a program for the preparation of Nurse Midwives, approved by the jurisdiction in which the person is practicing.

Out of Pocket means expenses that the Insured Person pays towards costs.

Period of Insurance means the period which is shown on Your Certificate of Insurance.

Physician/Practitioner means, with respect to any medical care and service, a person: a) Certified or licensed, under the laws of the jurisdiction where treatment is rendered, as qualified to perform the particular medical or surgical service for which a claim for cover under this Policy is made and who is practicing within the scope of such Certification or licenser; and b) any other health care provider if, and as, mandated by a state's or other jurisdiction's law. This term does not include: (1) an intern; or (2) a person in training.

Policy means this document, including the Policyholder's Enrollment, and any subsequent amendment or policy endorsement, which We issue for attachment to the Policy.

Policy Limit means the limit of applicable benefit shown in the Schedule of Benefits.

Policyholder means Integra Global Limited.

Pre-existing Medical Condition is a known medical or psychological condition from which the Insured Person or Close Relative has suffered or for which the Insured Person or Close Relative has received medical treatment (including prescription drugs or medicines) or of which symptoms have manifested themselves during the 12 month period prior to the Insured Person being first included for cover under this Policy.

Preferred Provider Organization (PPO) means the Hospitals, Physicians, or other providers who have entered into a contractual agreement with Us to provide Hospital and medical services to Insured Persons at negotiated fees.

Reconstructive Surgery means surgery which does not itself restore the function of an abnormal body structure and which is incidental to, or the result of, a previous surgery necessary due to Illness, Injury, or congenital defect.

R.N. means a Registered Nurse.

Scheduled Hospitalization or Scheduled Confinement means a Hospital Confinement, which has been planned in advance by an Insured Person's Physician for a fixed future time.

Serious Illness means any sudden and detrimental alteration in health as duly diagnosed by a Physician, which necessitates the Close Relative being admitted to a Hospital bed on the advice of a Physician for a minimum of three consecutive nights.

Skilled Nursing Care means services provided by, and which require the special skills of, a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Usual, Reasonable and Customary Charge/Allowable charge means the lower of: a) the provider's usual charge for furnishing the treatment, service or supply; or b) the charge which We determine to be the general rate charged by others who render or furnish such treatments, services or supplies to persons: (1) who reside in the same area; and (2) whose Injury or Illness is comparable in nature and severity. (We will determine the Usual, Reasonable and Customary Charge for a treatment, service or supply that is unusual, or not often provided in the area, or that is provided by only a small number of providers in the area. We will consider such factors as: (1) complexity; (2) degree of skill needed; (3) type of specialist required; (4) range of services or supplies provided by a facility; and (5) the prevailing charge in other areas.

The term "area" means a city, a county or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment.)

We, Us, Our means LAMP Insurance Company Limited.

You, Your means an Insured Person.

Complaints Procedure

We aim to provide a first class service at all times. However, if an Insured Person has any complaint regarding the standard of service received under this Policy, the following procedure is available to resolve the situation:

In the first instance the Insured Person should write to the

Director, Healthcare and Special Financial Risks
LAMP Insurance Company Limited,
Suite 934,
Europort,
Gibraltar

If We cannot give you a final decision within 4 weeks from the date We receive your complaint, We will explain why and tell you when We hope to reach a decision.

Our decision is final and based on the evidence presented. If you feel that there is any new evidence or information that may change Our decision you have the right to make an appeal.

Should the Insured Person remain dissatisfied or fail or receive a final answer within eight weeks* of Us receiving your complaint, you have the right to refer the matter directly to the

Managing Director
LAMP Insurance Company Limited
Suite 934,
Europort,
Gibraltar

*NOTE: The timescales given above are dependent on you responding immediately to any correspondence We send you.

Data Protection Notice

We collect and maintain personal information in order to underwrite and administer the Policies of insurance that We issue. All personal information is treated with the utmost confidentiality and with appropriate levels of security. We will not keep your information longer than is necessary. Your information will be protected from accidental or unauthorized disclosure. We will only reveal your information if it is allowed by law, authorized by you, to prevent fraud or in order that We can liaise with Our agents in the administration of this Policy. You have the right to ask for a copy of any information We hold on you upon payment of an administrative fee and to require a correction of any incorrect information held. Any inaccurate or misleading data will be corrected as soon as possible. The above principles apply whether We hold your information on paper or in electronic form. Enquiries in relation to data held by LAMP Insurance Company Limited should be directed to Data Protection, LAMP Insurance Company Limited, Suite 934, Europort, Gibraltar

Dental Insurance Option Endorsement

Dental Insurance: Description of Benefits

The expenses described in the three dental classes following are reimbursed at the indicated percentage subject to the annual Deductible and Annual Maximum benefit below:

Annual Deductible Per Person:

As per Table of Benefits

Annual Maximum Benefit Per Person:

As per Table of Benefits

Class I Dental Services are not subject to the Deductible. Class III Services are not covered during the first six (6) months of insurance cover.

Class I Dental Services

Benefits are paid at 100% of Usual, Reasonable and Customary cost with no Deductible for necessary diagnostic examinations and preventive treatment subject to the Annual Maximum.

Covered Expenses include

- 1) Oral exams but not more than twice in any one Period of Insurance
- 2) X-rays
 - a) Full mouth x-rays but not more than once every five years
 - b) Bitewing x-rays but not more than once in a calendar year
- 3) Preventative Treatment
 - a) Cleaning and scaling of teeth (oral prophylaxis) but not more than twice in any one Period of Insurance
 - b) Topical fluoride treatment for a covered child under 19 years of age but no more than once in any one Period of Insurance
- 4) Space maintenance for a covered child under 19 years of age

Class II Dental Services

Benefits are paid as per Table of Benefits of Usual, Reasonable and Customary cost after the Deductible for basic restoration, endodontic, periodontal treatments and oral surgery subject to the Annual Maximum.

Covered expenses include

- 1) Fillings - amalgam, silicate, acrylic, synthetic porcelain or composite fillings
- 2) Extractions
- 3) Root canal treatment
- 4) Treatment of periodontal disease and other diseases of the gums and tissues of the mouth
- 5) Oral surgery except procedures covered under any medical plan

- 6) Administration of general anesthesia, when Medically Necessary in connection with oral surgery
- 7) Emergency palliative treatment
- 8) Injections of antibiotic drugs

Class III Dental Services

Benefits are paid as per Table of Benefits of Usual, Reasonable and Customary cost after the Deductible for necessary crowns, bridges and dentures subject to the Annual Maximum.

Covered Expenses include necessary supplies and services of a Physician for installation or replacement of:

- 1) Those services needed to replace one or more natural teeth that are lost while dental expense benefits for the Insured Person are in effect for:
 - a) Installation of fixed bridgework done for the first time
 - b) Installation for the first time of:
 - i) A partial removable denture ; or
 - ii) A full removable denture
 - c) Replacing an existing removable denture or fixed bridgework if:
 - i) It is needed because of loss of one or more natural teeth after the existing denture or bridgework was installed; or
 - ii) It is needed because the existing denture or bridgework can no longer be used and was installed at least 5 years prior to its replacement
 - d) Replacing an existing immediate temporary full denture by a new permanent full denture when:
 - i) The existing denture can not be made permanent; and
 - ii) The permanent denture is installed within 12 months after the existing denture was installed
 - e) Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed
- 2) Inlays and onlays
- 3) Crowns and their replacements, but not more than one replacement per crown every five years
- 4) Repair or re-cementing of:
 - a) Crowns; or
 - b) Inlays or onlays; or
 - c) Dentures; or
 - d) Bridgework

Orthodontic Treatment: Description of Benefits

Benefits are paid as per Table of Benefits of Usual, Reasonable and Customary cost for Orthodontic treatment with no Deductible, subject to the Lifetime Maximum indicated below. Once this limit is reached, the Insured Person has no right to any further Orthodontic treatment benefit.

Lifetime Maximum Per Insured Person:

As per Table of Benefits

Orthodontic treatment is not covered during the first three (3) months of insurance cover.

Medical Concierge Services

Medical Concierge Benefits - complimentary access to the following exclusive services is available as a benefit to Premier Health Plan members

**Diagnosis Verification and Treatment Program (Remote Second Opinion)
(in partnership with Preferred Group Health, a global patient organization)**

A dedicated Diagnosis Verification and Treatment Planning care management program. In the event that you are diagnosed with a specified critical illness, the program provides access to an appropriate specialist from a top rated US hospital who will remotely review your medical reports to confirm your diagnosis and advise, in conjunction with your treating Physician on your treatment options, to provide the best outcome.

Covered Conditions: A remote second opinion will be available for:

- Narrowed or blocked coronary arteries and Valvular abnormalities.
- Interventional Cardiology Procedures (coronary angioplasty) to correct narrowing of two or more coronary arteries by means of dilating or opening the vessels.
- Major Vascular Procedures to repair one or more of the aorta, carotid, iliac, femoral and cerebral arteries.
- Cancer Treatment for all forms of cancer except non-invasive skin cancer and cancer in the presence of Human Immuno-deficiency Virus (HIV).
- Intracranial Neurosurgical Procedures performed to remove a tumor or to repair an intracranial blood vessel. (Conditions related to trauma or injury are excluded.)
- Major Organ Transplants, from a living donor, of the lung, liver, kidney, pancreas or bone marrow.

Conditions/Diagnoses/Situations which are excluded:

- Cosmetic reconstruction/plastic surgery;
- First diagnosis, which is, the initiation of physical assessment and diagnostic testing to determine an initial diagnosis; and

Traditional medicine and therapy is the focus of the opinion; not holistic, homeopathic, and/or alternative medicine.

Initiating a Remote Second Opinion

1. The Insured Person must have an initial diagnosis;
2. We will then ask You to complete a consultation request form
3. You will then be provided with Contact details of Preferred Group Health
4. Preferred Group Health will then liaise with Your Physician(s) and treating Hospital(s) to gather relevant clinical data.
5. You will be provided with the second Opinion or consultation report 15 working days. All remote second opinion reviews will be carried out by specialists at leading US Hospitals.
6. You will then be able to liaise with Preferred Health Group in relation to the information provided.

Blood Care Program

(in partnership with the Blood Care Foundation, a charitable, not-for-profit organization)

A blood care program which delivers screened blood, in an emergency, to its members in any part of the world. The Foundation operates alarm centres and a global network of blood banks, which work to internationally approved standards. The service provides peace of mind to expatriates and their families, that in the event of a medical emergency, particularly in developing countries, where a blood transfusion may be required, screened blood, resuscitation fluids, and sterile transfusion equipment are always only a phone call away.

If you need to activate a request for screened blood please call the Blood Care alarm centre on **+33 1-41-61-25-63 and quote Membership number SBA 2005.**

Travel for Family Emergency

If the Insured Person needs to make an unscheduled journey to the permanent place of residence of the Close Relative during the Period of Insurance as a result of an Insured Event and within one month of the Insured Event taking place:

- a) We will pay reasonable and necessary costs, up to the \$2,500 for one return trip, by economy/tourist class air travel for the Insured Person to travel from their Country of Residence to the location where the Close Relative is situated in their permanent place of residence.
- b) In the event of the Insured Person needing to make more than one unscheduled journey to the Close Relative's permanent place of residence as a result of separate, unrelated and subsequent Insured Events, We will arrange and pay for up to a maximum of three return trips or an overall maximum of \$5,000 in total under this Policy during any one Period of Insurance.

Specific exclusions to travel for family emergency section

We will not pay charges:

- a) for any trip which is not taken within one month of the date of Insured Event occurring.
- b) for any claims arising directly or indirectly as a result of any Pre-Existing Medical Condition(s);
- c) for any claim in respect of any Close Relative aged 75 or over;
- d) for any Illness claim arising within the first three months after the Commencement Date.
- e) for any claim where We have not received all medical evidence We consider necessary from the Close Relative's Physician(s).
- f) for the Close Relative's failure to seek or follow medical advice.
- g) for any claim arising or resulting directly or indirectly from suicide, attempted suicide, or intentional self-injury.
- h) for any claim resulting directly or indirectly from provoked assault, fighting (except in genuine self-defence), or whilst engaged in or taking part in civil commotion or riot, or from the Close Relative's own criminal act.
- i) for any claim resulting from the following:
 - Sexually-transmitted diseases, including HIV or any related condition.
 - Any psychiatric, mental or nervous disorder, including stress or depression.
 - Pregnancy, childbirth or any related medical complication.
- j) for any claim if We have not been contacted prior to travel arrangements being made.
- k) for any claim arising from being under the effects or influence of alcohol or non prescribed drugs.

eHealth records account (in partnership with, and powered by Medelinked).

The eHealth Records Account is available to all adults covered under our yourLife, yourFamily, PremierLife and PremierFamily plans. We have teamed up with Medelinked a leading online electronic health records storage service to keep your health records secure and accessible from anywhere, 24 hours a day.

The unique system enables you to build your health picture online which you can then share securely with your trusted health partners. Bringing your records together is easy, you update your known information and connect with your health providers such as your doctor, specialist or optician to request them to upload records and contribute to your health picture.

Your eHealth Records Account empowers you to have greater control over your health by having your information available when you need it. It enables your health providers to make more informed health decisions based on your essential medical information. All of your health plan documentation has been conveniently loaded onto your account for easy access in times when you might not have access to your Member ID Card or plan documents.



For further questions and information
contact us by phone, email or visit the website

U.K: +44 808 101 3483 (free phone in UK)

North America: 1 888 753 1377 (toll-free)

Worldwide: +1 888 753 1377

Email: member-care@integraglobal.com

www.integraglobal.com