William Russell
A greater degree of expat protection

Corporate Global Health Essential Plan Agreement

For all Global Health Essential employees whose period of cover starts on or after
1st January 2016

WELCOME

This document explains what is and what is not covered by **your employer's plan** and how **your** claims will be administered.

Please take time to read this document along with **your employer's master certificate**, **your certificate of insurance** and **your application form** as together they form the contract between **your employer, you** and **us**.

Certain words used within this document have a special meaning that **we** would like to draw to **your** attention:

We/us/our – means William Russell Limited on behalf of the **insurer**.

The **Assistance Service** – means the company whom **we** have appointed to provide **you** with 24-hour medical assistance at the time of **your** claim.

You/your – means **you** and all **insured persons** on this **plan**, as shown on **your certificate of insurance**

Plan holder – means **your** company or **employer** who has the contract with **us**.

Throughout this document certain words are shown in **bold** type. The meanings of these are provided in the DEFINITIONS section at the back of this document.

WILLIAM RUSSELL LIMITED

William Russell Limited is the administrator of **your employer's** Corporate Global Health **plan**. William Russell Limited is authorised and regulated by the UK Financial Conduct Authority.

ALLIANZ BENELUX N.V.

Allianz Benelux N.V. Coolsingel 139, Postbus 64, NL-3000 AB Rotterdam, Netherlands, is the **insurer** of **your** Corporate Global Health **plan**. Allianz Benelux N.V is an EEA **insurer** situated in the Netherlands.

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1. THE CORPORATE GLOBAL HEALTH EMPLOYEE PLAN AGREEMENT

This **agreement** is subject to the terms, conditions and exclusions of the **master certificate of insurance we** issue to **your employer**. A copy of this is available from **your employer**.

The terms of this **agreement** apply to **you** and to all of **your eligible dependants** as stated in the schedule of **insured persons** on **your certificate of insurance**.

Eligibility to join your employer's plan

Eligibility to join the **plan** is as agreed between **us** and **your employer** and is shown on **your employer's master certificate of insurance**.

If **you** are eligible to join, **you** must join within 30 days of becoming eligible to do so.

Your eligible dependants must also join the **plan** at the same time as **you** join, or within 30 days of becoming eligible to do so if they only become eligible to join at a later date.

If **you** or **your** dependants do not join within 30 days of becoming eligible to do so **we** may refuse to offer cover, or only offer cover subject to **special terms**.

The purpose of your plan

Your plan provides **you** with cover for treating eligible medical conditions which arise after **your date of entry**.

We will pay for the **reasonable and customary** cost of **medically necessary**, recognised **treatment** for medical conditions covered by **your plan**. **We** will only pay for such **treatment** if it is received during **your period of cover**, and provided **your premium** payments have been kept up to date by **your employer**.

Any reimbursement **we** make may be subject to an **excess** and/or **co-insurance**, and certain benefits are subject to a benefit limit. **Your excess** amount will be stated on **your certificate of insurance**. Any **co-insurance** and benefit limits will be as stated in the **table of benefits** for **your plan type**.

Your obligation to provide information relating to your own, and to your eligible dependants' medical history

We rely on the information **you** supply to **us** in **your application form** when **we** decide whether or not to accept **your application**, and whether or not **we** need to apply **special terms**.

If **your application form** omits facts or contains materially incorrect or incomplete facts, **we** have the right to declare **your plan** void. Alternatively **we** may impose **special terms** on **your** particular **plan** which will apply from **your date of entry**.

If **your** state of health, or the state of health of any of **your eligible dependants** changes between the time **you** complete **your application form** and **your date of entry**, **you** must tell **us** in writing about the change, and **we** may only be able to accept **your application** with **special terms**.

Pre-existing medical conditions and related conditions

Unless **we** have agreed otherwise, **your plan** will not cover any **pre-existing medical conditions** or **related conditions**.

Cover for chronic conditions

If **you** have the Essential Care Plus **plan type**, **your plan** covers **in-patient** and **day-patient treatment** of eligible **chronic conditions**, and **post-hospital treatment** for acute flare-ups of eligible **chronic conditions** within the Annual out-patient benefit limit. **You** are also covered for up to US$1,000 per **period of cover**, within the Annual out-patient benefit limit, for the cost of regular consultations, tests and prescribed medication that are aimed at maintaining or controlling the stability of an eligible **chronic condition**.

If **you** have the Essential Care **plan type**, **your plan** covers **in-patient** and **day-patient treatment** of eligible **chronic conditions**, and **post-hospital treatment** of eligible **chronic conditions** within the Annual out-patient benefit limit, for an acute exacerbation of a **chronic condition**. No cover is provided for the cost of **treatment** that is aimed at maintaining or controlling the stability of a **chronic condition**.

Age limits

You must be under 70 years of age at **your date of entry**.

If dependants are eligible to join the **plan**, then **your** spouse or partner must also be aged under 70 on their **date of entry**. Children must be unmarried and under the age of 18, or less than 25 years old if in continuous full-time education.

Commencement of your cover

Your cover will commence from the **date of entry** stated on **your certificate of insurance**. **We** will not commence **your** cover until **we** have accepted **your application** and **your employer** has paid the **premium**.

If you take up residence in an excluded country and/or region

Under the terms of this **agreement** cover is not available to **you** if **you** take up residence in an excluded or restricted country and/or region, irrespective of **your** nationality.

These countries and/or regions are as follows: USA, Canada, any **Caribbean country or island**, all countries within the European Union, Andorra, Channel Islands, Gibraltar, Greenland, Iceland, Liechtenstein, Monaco, Norway, San Marino, Switzerland, Australia, Bali, China, Hong Kong, Japan, Macau, New Zealand, Singapore and Taiwan.

If **you** take up residence in an excluded or restricted country and/or region **you** must tell **us**. **Your** cover will automatically terminate from the date on which **you** take up residence in the excluded or restricted country and/or region.

2. YOUR AREA OF COVER

Excluded countries or areas

No cover at all is provided in the USA, Canada, any **Caribbean country or island**, and the **London area**.

Restricted countries and regions

Excluded countries/areas:

- No cover at all is provided in the USA, Canada, any **Caribbean country or island**, and the **London area**.

Restricted countries/areas:

- For all countries within the European Union, Andorra, Channel Islands, Gibraltar, Greenland, Iceland, Liechtenstein, Monaco, Norway, San Marino, Switzerland, Australia, Bali, China, Hong Kong, Japan, Macau, New Zealand, Singapore and Taiwan the cover **we** provide is restricted to **emergency treatment you** receive whilst on a temporary trip.

Emergency treatment is essential **treatment** covered by **your plan** and required if **you** suffer an **accident** or a sudden and unforeseen illness **you** have never suffered from before. Cover is only provided in accordance with the benefits of the **plan** stated on **your certificate of insurance** and no cover will be provided in respect of a **pre-existing condition** or **related condition**, or any condition specifically excluded on **your certificate of insurance**. **We** will not pay for **treatment** if **you** have travelled to a restricted country or region knowing that **you** would require **treatment**. **We** only pay for **treatment** that in **our** opinion was essential and could not reasonably have been delayed until **your** return to a country within **your area of cover**.

A temporary trip is a trip of not more than 90 days duration. Any trip of longer than 90 days will not be covered.

An emergency evacuation is not classed as a temporary trip. In the event that **you** suffer a **life-threatening condition** that cannot adequately be treated locally **you** will be evacuated to the nearest **hospital**, in a country other than an excluded or restricted country/area, capable of treating **your** condition.

The maximum benefit **we** will pay in respect of all **emergency treatment you** receive in restricted countries or regions during an annual **period of cover** is US$50,000.

3. THE BENEFITS PROVIDED BY EACH CORPORATE GLOBAL HEALTH PLAN

The following **table of benefits** sets out the cover provided by each **plan type**. The **plan type you** have is as shown on **your certificate of insurance**. **We** will pay only for the **treatment** or services stated in the **table of benefits** relating to the **plan type you** have.

Where there is a lifetime benefit limit, this is the maximum amount **we** will pay in respect of that particular benefit during **your** lifetime.

Certain benefits in the **table of benefits** specify a **waiting period**. **You** must be covered by the same **plan** for the full duration of the specified **waiting period** before **you** can claim for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**.

The limits shown in the **table of benefits** are the maximum amounts **we** will pay after the application of any **excess** and **co-insurance**.

Each benefit limit in the **table of benefits** is expressed in US Dollars, and this is the currency **we** will apply to **your plan**.

IMPORTANT NOTE: The **table of benefits** should be read in conjunction with the Important Notes at the top of each benefits section, and the COSTS NOT COVERED BY YOUR PLAN section.

Where the term full cover appears, this means full refund of **reasonable and customary** charges, less any **excess** applicable to **your plan**, and subject to any **co-insurance** and/or any benefit limits and/or number of **session** limits shown in the **table of benefits**, to include any limits in other benefits elsewhere in the table applying to **your** claim.

KEY ○ FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT ○ PARTIAL OR LIMITED COVER ○ NOT COVERED

	ESSENTIAL CARE	ESSENTIAL CARE PLUS
Annual benefit limit The overall maximum limit that each **insured person** can claim during any one **period of cover**.	**US$250,000**	**US$500,000**
COVER WHEN YOU ARE ADMITTED TO HOSPITAL IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR ALL BENEFITS INCLUDED IN THIS SECTION		
Hospital accommodation charges **Hospital** accommodation charges limited to the cost of a standard single room with an ensuite bath or shower room, when **you** are an **in-patient** or **day-patient**.	**FULL COVER** ○	**FULL COVER** ○
In-patient and day-patient treatment **Treatment you** receive whilst **you** are an **in-patient** or **day-patient**, including surgeons', anaesthetists' and **doctors**' fees, nursing care, drugs and surgical dressings, theatre charges and intensive care, pathology, x-rays, scans, **diagnostic tests** and physiotherapy.	**FULL COVER** ○	**FULL COVER** ○
Parent accommodation charges The cost of one parent staying in **hospital** with a child under 18 years of age while the child is receiving eligible **treatment** covered by their **plan**.	**FULL COVER** ○	**FULL COVER** ○
Road ambulance The cost of a private road ambulance if **you** need **in-patient** or **day-patient treatment** for which **you** are covered by **your plan**, and if it is **medically necessary** for **you** to travel to the **hospital** by local road ambulance.	Cover up to US$1,200 **per period of cover** ○	Cover up to US$1,600 **per period of cover** ○
In-patient emergency restorative dental treatment Required to restore sound, natural teeth following an **accident** covered by **your plan**, if received within 15 days of the **accident**. All **treatment** under this benefit must be carried out by a **dentist** in a **hospital** emergency room or dental surgery.	Cover up to US$5,000 **per period of cover** ○	Cover up to US$10,000 **per period of cover** ○

KEY FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT | PARTIAL OR LIMITED COVER | NOT COVERED

IF YOU ARE DIAGNOSED WITH CANCER
IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR ALL BENEFITS INCLUDED IN THIS SECTION

In-patient and day-patient cancer treatment Cancer **treatment** required as an **in-patient** or **day-patient** including chemotherapy and radiotherapy.	**FULL COVER**	**FULL COVER**
Out-patient cancer treatment **Out-patient** consultations, tests, and scans.	Cover for a maximum period of five years from the later date of the surgery, or the completion of chemotherapy or radiotherapy	**FULL COVER**
Cancer genome tests The cost of test(s) to sequence the genes of cancer cells.	Cover up to US$2,000 **per period of cover**	Cover up to US$2,000 **per period of cover**

IF YOU NEED RECONSTRUCTIVE SURGERY
IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT

Surgery to restore **your** appearance after an **accident**, or after surgery for breast cancer, provided the original **treatment** for the **accident** or breast cancer surgery was paid for by **us**, and provided the reconstructive surgery takes place within two years of the **accident** or the original breast cancer surgery.	Cover for **in-patient**, **day-patient** and **post-hospital treatment**	**FULL COVER**

IF YOU NEED A TRANSPLANT FOR AN ORGAN, BONE MARROW OR TISSUE
IMPORTANT NOTES: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR ALL BENEFITS INCLUDED IN THIS SECTION
- **We** only cover transplants carried out in internationally accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO (World Health Organisation) guidelines.
- **We** do not cover any costs associated with the acquisition of the organ.

Transplant and related treatment Costs incurred whilst hospitalised, and all related **out-patient treatment** required prior to and after the transplant.	**FULL COVER**	**FULL COVER**
Donor costs Medical costs associated with the donor as an **in-patient** or **day-patient**.	Cover up to US$25,000 **per transplant**	Cover up to US$25,000 **per transplant**

KEY FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT | PARTIAL OR LIMITED COVER | NOT COVERED

IF YOU NEED KIDNEY DIALYSIS IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT		
Short-term kidney dialysis of up to 4 weeks, if **you** need this immediately before or after a kidney transplant operation covered by **your plan**. **We** will also pay for dialysis for up to 4 weeks if this is needed temporarily for sudden kidney failure resulting from a disease or injury, covered by **your plan**, which affects another part of **your** body. **We** do not cover regular or long-term kidney dialysis.	**FULL COVER**	**FULL COVER**
COVER FOR EVERYDAY MEDICAL CARE		
Annual out-patient treatment benefit limit The overall maximum limit to the amount that each **insured person** can claim for all **out-patient treatment** during any one **period of cover**.	US$2,500	US$10,000
Emergency ward treatment **Emergency treatment** that **you** have received at a **hospital**.	**NOT COVERED**	**FULL COVER**
Out-patient surgical procedures	**FULL COVER**	**FULL COVER**
Other medical care **GP and specialist consultations**, prescribed drugs and dressings, pathology, scans, radiology and **diagnostic tests** received as an **out-patient**.	Cover for **post-hospital treatment**	**FULL COVER**
Advanced diagnostic tests MRI and CAT (CT) scans performed on the advice of a **medical doctor**. PET scans performed on the advice of a **specialist**. Y**our medical referral letter** will be required. **We** will pay for one consultation only to obtain the results of the **diagnostic test**.	Cover for **post-hospital treatment**	**FULL COVER**
Physiotherapy Physiotherapy performed on the advice of a **medical doctor**. **Your medical referral letter** will be required. After the 10th **session**, if **you** need more **sessions**, **you** must contact **us** for pre-authorisation and **we** will require a further **medical referral letter**. If **your** condition becomes a **chronic condition** and ongoing **treatment** is aimed at maintaining it rather than curing it, no further payments will be made.	Cover up to US$250 for **post-hospital treatment per period of cover**	Cover up to US$1,000 **per period of cover**
IF YOU NEED TREATMENT FOR HIV AND/OR AIDS IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT		
(24-month waiting period) **Treatment** arising from or related to Human Immunodeficiency Virus (HIV) and/or HIV-related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC) for a maximum period of 5 years, provided the HIV virus was contracted after **your date of entry**. **We** do not provide cover if the virus was contracted before **your date of entry**.	US$1,000 **per period of cover**	US$2,500 **per period of cover**

KEY FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT | PARTIAL OR LIMITED COVER | NOT COVERED

IF YOU NEED HOSPICE & PALLIATIVE CARE
IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT

The palliative care of a medical condition covered by **your plan**.	**Lifetime limit** of US$25,000	**Lifetime limit** of US$50,000

IF YOU NEED PROSTHETIC IMPLANTS AND APPLIANCES

Surgically-implanted, artificial body parts necessary to replace a joint or ligament, a heart valve, the aorta or an arterial blood vessel, a sphincter muscle, the lens or cornea of the eye, or to control urinary incontinence, or to act as a heart pacemaker, or to remove excess fluid from the brain. **We** will also pay for a knee brace if it is an essential part of a surgical operation for the repair to a knee ligament, and for a spinal support if it is an essential part of a surgical operation to the spine.	**FULL COVER**	**FULL COVER**

IF YOU NEED TREATMENT FOR COMPLICATIONS OF PREGNANCY
IMPORTANT NOTE: DEPENDENT CHILDREN INCLUDED IN **YOUR PLAN** ARE NOT ELIGIBLE FOR THIS BENEFIT

(10-month waiting period) **In-patient** or **day-patient treatment** necessary as a direct result of a **complication of pregnancy**. **We** do not provide cover under this benefit for childbirth (which includes planned or **emergency caesarean section**). **We** do not provide cover under this benefit if **you** act as a surrogate or have anyone else acting as a surrogate for **you**. **We** do not provide cover under this benefit for a pregnancy established through **assisted reproduction** (e.g. IVF) until after the 12-week scan, irrespective of how long **you** have been covered by the **plan**. **We** do not cover termination of pregnancy or any **treatment** or investigations that arise as a result of complications relating to termination of pregnancy.	**NOT COVERED**	Cover up to US$5,000 **per period of cover**

IF YOU NEED EMERGENCY EVACUATION
IMPORTANT NOTES: ALL COSTS MUST BE PRE-AUTHORISED AND ARRANGED BY THE **ASSISTANCE SERVICE**
- In a potential emergency evacuation situation, the **Assistance Service** retains the absolute right to decide whether **your** medical condition is life threatening, whether or not the **treatment** could be adequately provided locally, where **you** are evacuated to and the means and method of the evacuation.
- **We** do not cover emergency evacuation to the USA.

Emergency evacuation If **you**, (or any child covered by the newborn benefit within its first 90 days of life), have a **life-threatening condition** covered by **your plan** which requires immediate **in-patient treatment** that cannot be adequately provided locally, the **Assistance Service** will arrange for **you** to be moved by air and/or by surface transportation, to the nearest **hospital** within **your area of cover** where appropriate medical **treatment** is available. **We** do not cover any other costs under this benefit such as hotel accommodation charges.	**FULL COVER**	**FULL COVER**

KEY FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT | PARTIAL OR LIMITED COVER | NOT COVERED

CONTINUED: IF YOU NEED EMERGENCY EVACUATION

Return airfare Following an emergency evacuation covered by **your plan, we** will pay for **your** economy return airfare to **your country of residence**.	**FULL COVER**	**FULL COVER**
Travelling expenses of a companion The transportation costs of another person to accompany **you** on **your** emergency evacuation, and their economy class ticket back. If it is not possible for them to accompany **you** on **your** medical evacuation flight, **we** will pay for their economy class airfare on a scheduled flight.	**FULL COVER**	**FULL COVER**
Repatriation of mortal remains If **you** die as the result of a condition that is covered by **your plan** whilst **you** are outside **your home country**, **we** will pay for **your** body or ashes to be transported to **your home country** or **country of residence**. This benefit is not available if a claim is made for Burial or cremation at the place where **you** died. **We** do not provide cover under this benefit if the cause of death is suicide.	Cover up to US$5,000	Cover up to US$10,000
Burial or cremation If **you** die as the result of a condition that is covered by **your plan** whilst **you** are outside **your home country**, **we** will pay for **you** to be buried or cremated at the place where **you** died. This benefit is not available if a claim is made under the Repatriation of mortal remains benefit. **We** do not provide cover under this benefit if the cause of death is suicide. **We** do not provide cover under this benefit if **you** die in **your home country**. **We** do not provide cover under this benefit for the costs of a religious practitioner.	Cover for up to US$1,600	Cover for up to US$1,600

IF YOU NEED TREATMENT FOR A CONGENITAL ABNORMALITY
IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT

Treatment aimed to cure a congenital abnormality (whether diagnosed as a **chronic condition** or not), palliative **treatment** and care for a congenital abnormality which is diagnosed as terminal, and **treatment** for any related medical condition, provided **you** did not have signs or symptoms of the congenital abnormality prior to **your date of entry** and the congenital abnormality was diagnosed after **your date of entry**. This benefit covers **medical practitioners**' and **specialists**' fees, surgical procedures including prostheses surgically implanted to form permanent parts of **your** body, physiotherapy, prescribed drugs and dressings, MRI, PET and CT scans, X-rays, pathology and other **diagnostic tests** and procedures. This benefit does not extend to psychiatric **treatment** or psychotherapy, complementary medicine, traditional Chinese medicine, acupuncture or homeopathic **treatment**. **We** do not cover congenital abnormalities if either they were diagnosed or **you** were showing signs or symptoms of the abnormality before **your date of entry**.	Cover for **in-patient** and **day-patient treatment**, and for **post-hospital treatment** within the Annual out-patient treatment benefit limit, up to a **lifetime limit** of US$20,000	Cover for **in-patient** and **day-patient treatment**, and for **post-hospital treatment** within the Annual out-patient treatment benefit limit, up to a **lifetime limit** of US$40,000

KEY FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT | PARTIAL OR LIMITED COVER | NOT COVERED

IF YOU HAVE A CHRONIC CONDITION		
Acute flare ups Cover for an acute exacerbation of a **chronic condition**.	Cover for **in-patient** and **day-patient treatment**, and for **post-hospital treatment** within the Annual out-patient treatment benefit limit	Cover for **in-patient** and **day-patient treatment**, and for **post-hospital treatment** within the Annual out-patient treatment benefit limit
Monitoring and maintenance Regular consultations, tests and prescribed medication required to monitor and maintain the stability of a **chronic condition** that is not a pre-existing condition. This benefit is limited to the above **treatments** and does not include other medical **treatments**, e.g. physiotherapy aimed at maintaining stability.	**NOT COVERED**	Cover subject to an overall maximum limit (regardless of the number of **chronic conditions**) of US$1,000 **per period of cover** within the Annual out-patient treatment benefit limit

4. COSTS NOT COVERED BY YOUR PLAN

The following are not covered by **your plan**, as well as any specific exclusions on **your certificate of insurance**, and other exclusions given within the **table of benefits**. Other benefits, as given within the **table of benefits**, may also be restricted or excluded depending on **your plan type**.

All conditions, tests, **treatments** or increased **treatment** costs **you** incur because of complications that occur directly or indirectly as a consequence or **treatment** of any excluded condition will also not be covered.

As well as the exclusions stated below, **we** also do not cover the following fees:
- fees for the completion of claim forms
- bank charges incurred as a result of **us** transferring money
- losses **you** may incur due to fluctuations in exchange rates
- charges incurred as the result of payment errors that arise as the result of **you** having provided **us** with incorrect information
- administration, registration, or cancellation fees charged by **hospitals**, **doctors**, or other providers of medical services
- any charges made by **your** bank or credit card company

Addictive conditions/disorders and alcohol, drug and solvent abuse

Treatment related to:
- addictions (such as alcohol or drug addiction) or substance abuse (such as alcohol, drug or solvent abuse)
- any illness or injury needed directly or indirectly as a result of any such abuse or addiction
- any illness or injury needed directly or indirectly as a result of being under the influence of any substance (such as alcohol, drugs or solvents)

Allergy testing and/or desensitisation

Treatment related to:
- allergy testing by hair analysis
- allergy desensitisation or food neutralising injections

• **We** will only pay for patch testing if **you** have been referred by a **medical doctor** and this is limited to one patch testing investigation over the lifetime of **your plan**. **Your medical referral letter** will be required.

Alternative treatment and therapies
Alternative **treatments** and therapies including but not limited to: aqua physiotherapy, bone-setting, colonic irrigation, hydrotherapy, Intervertebral Differential Dynamics (IDD), kinesiology, naturotherapy, Pilates, Reiki, and yoga.

Birth control, sexual problems and gender reassignment
Treatment directly or indirectly arising from or connected with:
- contraception or sterilisation
- sexual problems (including impotence and decreased libido)
- gender reassignment

Chemical exposure and contamination
Treatment costs directly or indirectly related to **treatment** for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material whatsoever, including the combustion of nuclear fuel.

Circumcision
Unless it is required for **treatment** of an **acute medical condition** covered by **your plan**.

Complementary medicine
Consultations or **treatment** performed by a chiropractor, osteopath, homeopath acupuncturist, a therapist using acupressure or traditional Chinese **medical practitioners**.

Convalescence, rehabilitation, nursing homes and health spas/hydros
- **hospital** accommodation if the reason **you** are hospitalised is for the purpose of convalescence, **rehabilitation** or supervision
- relaxation or rest **treatments**, or **treatments** in nature cure clinics, health spas and health hydros
- private beds registered as nursing homes attached to such establishments or a **hospital** where the **hospital** has effectively become **your** home or permanent abode
- home nursing

Cosmetic surgery and treatment
Investigations or **treatment** related to:
- cosmetic or aesthetic **treatment** to enhance **your** appearance, even when medically prescribed
- the removal of fat or surplus tissue
- breast enlargement or reduction
- sclerotherapy for spider veins, **treatment** of superficial varicose veins
- Botox, dermal fillers, or **treatment** of vitiligo or any skin pigmentation disorder

Criminal activity
Treatment arising from or related to injuries sustained whilst engaged in a criminal, illegal or unlawful act.

Dental treatment
Dental, gum, oral or orthodontic consultations or **treatment** of any kind, unless covered under the In-patient emergency restorative dental treatment benefit.

Developmental problems, learning difficulties, speech disorders and behavioural problems
Consultations, tests required to diagnose, or **treatment** of or related to:
- developmental delays
- learning difficulties, including, but not limited to dyslexia and speech disorders
- behavioural problems, including but not limited to Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), and Tourette's syndrome
- physical development problems of any kind

Dietician
Treatment or advice by a dietician or nutritionist.

Experimental drugs and treatments
Treatment which is experimental, or has not been proven to be effective. This includes but is not limited to:

- **treatment** that is provided as part of a clinical trial
- **treatment** that has not been approved by the National Institute for Clinical Excellence (NICE)
- any drug or medicine that is prescribed for a purpose for which it has not been licensed for or approved by NICE
- any combination of drugs or medicines prescribed for the purpose for which they have not been licensed for, or approved by NICE

Eyesight
- **treatment** to correct **your** eyesight, such as laser **treatment**, refractive keratotomy and photorefractive keratotomy
- spectacles, and other visual aids, **treatment** of strabismus (squint) or amblyopia (lazy eye)
- sight tests

Failure to follow medical advice
- **treatment** arising from or related to **your** unreasonable failure to seek or follow medical advice and/or prescribed **treatment**, or **your** unreasonable delay in seeking or following such medical advice and/or prescribed **treatment**
- complications arising from ignoring such advice

Foetal surgery
Surgery undertaken on a child whilst it is in its mother's womb.

Foot care
Podiatry, chiropody, orthotics and gait scans.

Genetic testing and/or genetic engineering
Please note however that genome testing may be covered under the Cancer genome tests benefit within the IF YOU ARE DIAGNOSED WITH CANCER section.

Hearing
- **treatment** for or arising from deafness caused by maturing or ageing
- **treatment** for or arising from deafness caused by a congenital abnormality if either the abnormality was diagnosed or **you** were showing signs or symptoms of the abnormality before **your date of entry**
- hearing aids
- hearing tests

Infertility, IVF and assisted reproduction
- testing or diagnosis related to infertility
- infertility **treatment**, **assisted reproduction** (e.g. IVF **treatment**), including establishing pregnancy

Menopause and puberty
- **treatment** to relieve the symptoms commonly associated with physiological or natural changes as a result of ageing e.g. menopause or puberty
- bone densitometry
- reproductive hormone testing, reproductive hormone therapy or hormone replacement therapy (HRT)

Nasal septum deviation
Treatment related to nasal septum deviation. In the event that **treatment** of nasal septum deviation takes place concurrently with **treatment** of other conditions, **we** will only pay for a proportion of the **treatment** on a pro-rata basis, e.g. if **you** receive **treatment** for nasal septum deviation, plus one covered condition, **we** will pay half of the cost of the **treatment**. If **you** receive **treatment** for nasal septum deviation, plus two covered conditions, **we** will pay two thirds of the cost of the **treatment**.

Pre-existing medical conditions or related conditions
Treatment related to:
- any **pre-existing** and **related conditions** which **you** have had during the five years before **your date of entry**, unless **we** have agreed otherwise; and
- any **pre-existing medical conditions** of the following types and any **related conditions**, if **you** have ever had them at any time before **your date of entry**, unless **we** have agreed otherwise:
    - brain or nervous system conditions
    - cancer, tumours or growths
    - heart or circulatory conditions
    - psychiatric or psychological conditions, drug and alcohol issues or sleep disorders

Pregnancy and childbirth
Any investigations or **treatment** related to pregnancy and childbirth, unless covered under the IF YOU NEED TREATMENT FOR COMPLICATIONS OF PREGNANCY benefit.

Preventive surgery
Surgery when no physical signs or symptoms are shown, or diagnosis has been made.

Professional sports and motorised racing as an amateur or a professional
Treatment for an illness or injury related to:
- participation, to include training for or practising for, in any kind of professional sport or professional racing (by professional **we** mean sport where **you** are being paid to participate)
- participation, to include training for or practising for, in any kind of racing (whether amateur or professional) which involves the use of a motorised vehicle

Psychiatric conditions
Any investigations or **treatment** or of any psychiatric condition, or investigations or **treatment** of any condition caused by or relating to any psychiatric condition. This includes, but is not limited to, eating disorders, psycho-geriatric conditions, phobias, hypnotherapy, marriage counselling and postnatal depression.

Scalp conditions
- **treatment** specifically related to scalp conditions including but not limited to alopecia
- wigs

Search and/or rescue
- search and/or rescue operations including, but not limited to, mountain rescue or rescue from ski slopes or pistes
- evacuations from offshore installations such as oil rigs, or from any type of sea going vessel such as a ship, ferry or yacht

Second opinions or duplicate tests
Second or subsequent opinions from a **medical doctor, medical practitioner** or **specialist** or for duplicate tests for the same condition.

Self-inflicted injuries
Treatment of self-inflicted injuries or **treatment** of any injury or illness directly or indirectly caused by self-inflicted injuries.

Sexually transmitted diseases
Treatment related to sexually transmitted diseases including genital/anal warts.

Sleep disorders
Diagnostic tests for or **treatment** of any sleep related disorder including but not limited to insomnia, snoring and sleep apnoea.

Stem cell harvesting
Stem cell harvesting other than prior to a stem cell transplant, or any **treatment** undertaken in anticipation of, prior to, or following such harvesting.

Surgical or medical appliances and prostheses
- supplying, fitting or hiring physical aids and devices (for example crutches, splints, walking sticks and wheelchairs)
- unprescribed aids such as gym equipment, even if **you** have been advised to use such an aid
- preparation for, or the fitting of artificial limbs
- hot and cold packs and support bandages

Travel costs
Travel costs including airfares and hotel accommodation, unless specifically covered under the IF YOU NEED EMERGENCY EVACUATION section.

Treatment by a family member
Treatment provided by and/or under the control of and/or on referral from any family member including, but not limited to, a spouse, partner, parent, brother, sister, child, grand-parent, grand-child, uncle or aunt.

Vitamins, dietary supplements and natural substances
Naturally available substances that can be purchased without prescription including, but not limited to, vitamins, minerals and organic substances.

War and terrorism

Treatment arising directly or indirectly from war, foreign enemy hostility, terrorism, rebellion, civil war, revolution, military coup, riot, strike, martial law, state of siege, or attempted overthrow of government unless **you** are an **innocent bystander** who is not in a country or region within a country that the British Foreign and Commonwealth Office has advised its citizens to leave.

Weight-related conditions and eating disorders

Investigations or **treatment** related to:

- obesity, or which is necessary because of obesity
- weight monitoring or control, such as slimming classes, aids and drugs
- bariatric surgery, or complications resulting from bariatric surgery
- eating disorders of any kind, such as anorexia nervosa or bulimia

Wilful exposure to needless danger

Treatment of any conditions arising directly or indirectly from **your** gross negligence and/or **your** wilful exposure to needless danger except in an attempt to save a human life.

5. MAKING A CLAIM

As stated in the **table of benefits**, there are certain benefits and **treatments** for which **you** must obtain pre-authorisation.

If **you** need to claim for a benefit or **treatment** for which **you** must obtain pre-authorisation, **you** must contact **us** in advance of starting **your treatment** and give **us** all the information **we** require to assess if **your** proposed **treatment** will be eligible for cover under **your plan**. If **your** proposed **treatment** is eligible for cover, **we** will pre-authorise all eligible expenses. **We** will not pay for any **treatment** costs or expenses that have not been pre-authorised by **us** in advance.

Eligible medical services providers

You have the freedom to choose when and where **you** receive **your** medical **treatment** within **your area of cover**. **We** do not have **hospital** lists which restrict where **you** can have **your treatment**.

If you are admitted to hospital

All **in-patient** and **day-patient hospital treatment** must be pre-authorised by **us** or by the **Assistance Service**.

Please contact **us** as soon as **you** know **you** need to have **in-patient** or **day-patient treatment** so **we** can contact the **hospital** to obtain the necessary medical information.

We will ask **you** to complete a pre-authorisation form and a consent form for the **hospital** to release details to **us**. Once **we** have received all information required from the **hospital** and **yourself** (to include any additional information **we** may request) **we** will advise **you** if the proposed **treatment** will be covered by **your plan**.

Please note, if **you** contact **us** less than 48 hours in advance of **your** admission **we** may be unable to authorise **your treatment** in time and **you** may be required to pay for the **treatment yourself** and submit a claim for reimbursement.

If **you** are admitted to **hospital** in an emergency and it is not reasonably possible for **you** to contact **us** in advance of **your** admission, **we** will consider **your** claim, provided **you** contact **us** within 72 hours of **your** admission. If **you** do not contact **us** within 72 hours, **we** may decline **your** claim, or subject **your** claim to 20% **co-insurance**.

If you have out-patient treatment

Although most **outpatient treatment** does not need to be pre-authorised in advance by **us**, **we** recommend that **you** do contact **us** or the **Assistance Service**, even in the event of an emergency, before undergoing any **treatment** to ensure that the **treatment** is covered by **your plan**.

How to claim back your eligible treatment costs

If **you** are claiming for a medical condition, **you** will need to download a claim form from **our** website.

Please complete section A of the claim form. If the total amount of **your** claim is likely to exceed US$500 (or the foreign currency equivalent), please take the claim form with **you** when **you** visit **your doctor** and ask him or her to complete and sign section B of the claim form.

Scan the completed claim form and the fully itemised invoices for the **treatment you** have received, and send to claims@william-russell.com.

Even if **your** claim is less than US$500 **we** may in some cases require **your doctor** to complete and sign section B of **your** claim form before **we** can settle **your** claim.

We can only reimburse **your** claim when **we** have fully itemised invoices which give a breakdown of the **treatment** and medical services **you** have received, and any drugs **you** have been prescribed.

Please retain **your** original invoices for up to 12 months. **We** may require **your** original claim form and invoices for auditing purposes.

Claims for which a medical referral letter is required

If **you** are claiming for **out-patient** physiotherapy, or an MRI or CAT (CT) scan **you** must also send **us your medical referral letter**. If **you** are claiming for a PET scan, **you** must also send **us your specialist's medical referral letter**.

Supplying the information required to process your claim

We can accept the information required to process **your** claim via email. Simply, scan in PDF format **your** itemised invoices, receipts, **medical referral letter** (when required) and **your** fully completed claim form and email them all to claims@william-russell.com. Please always retain the original copies of everything for a period of 12 months as **we** reserve the right to receive these documents before **we** assess **your** claim. **We** may also require them at any time for auditing purposes. Or, **you** can send the information required to process **your** claim by post.

You must submit **your** claim within 6 months of **your treatment** date, unless it was not reasonably possible for **you** to submit the claim within this time.

We will not pay fees charged by a **medical practitioner**, or anyone else, for completing a claim form.

Paying your claim

Where possible **we** will settle invoices for **in-patient** or **day-patient treatment** direct with the **hospital** or **medical services provider**. **We** will deduct any **excess** or **co-insurance** amount, as well as any other ineligible items, and **you** will be responsible for paying the shortfall direct to the **hospital** or **medical services provider**.

If **we** are paying **you** direct, **our** preferred method of payment is bank transfer.

We will only make payment to **you** or to the **medical services provider** that provided **your treatment**.

If **we** or the **Assistance Service** pre-authorise costs which subsequently turn out to have been related to a condition which is not covered by **your plan**, **you** will be responsible for all the costs incurred, and if **we** have made any settlement on **your** behalf, **you** will be responsible for repaying to **us** the amount **we** have paid.

Exchange rates

We will settle **your** claim in US dollars unless **you** instruct **us** otherwise. If **we** have to make a currency conversion, **we** will use the historic exchange rate (provided by oanda.com) applicable on the date of each separate invoice **you** submit.

Exchange rates are imported into **our** computer system overnight, each night, using the live exchange rate at the time of the import. This may vary slightly from the historic exchange rates shown on oanda.com for the relevant day, which are based on the average exchange rate for the day.

If **we** have placed a Guarantee of Payment **we** will use the exchange rate applicable on the date **we** placed the guarantee.

Excesses, co-insurance and benefit limits

The **excess** shown on **your certificate of insurance** is the amount **you** will have to pay towards the cost of **your treatment**.

If **your plan** has an **excess** and the benefit **you** are claiming for has **co-insurance** and/or limits, **we** will apply the **co-insurance** first, then the **excess**, then the limit.

If **you** have a **plan** which has an **excess** per claim, this is the amount **you** will have to pay each time **you** make a new claim for **treatment** covered by **your plan**. New claims are those that are for a condition which is not related to an existing claim.

If **your** claim is for the **treatment** of a **chronic condition**, AIDS/HIV, or for **out-patient** follow up consultations and/or tests for cancer and the **treatment** continues into a new **period of cover**, **we** will treat it as a new claim. In these circumstances **we** will re-apply the **excess** at **your plan renewal date** and each subsequent **plan** renewal until the claim is finished.

If **your excess** is per annum it will be applied once per **period of cover**. For example, if **your excess** is US$250 per annum, **we** will not pay for the first US$250 of eligible expenses **you** incur during **your period of cover**. **We** will apply one **excess** per **period of cover** irrespective of the number of claims **you** make. **You** must submit all eligible claims to **us** - even claims within **your** annual **excess**, as **we** will only be able to reimburse **you** when the value of the eligible expenses **you** incur exceeds the amount of **your** annual **excess**. When **you** renew the **plan**, the annual **excess** will apply again in respect of **your** new **period of cover**.

Our right to request additional information

We may need to ask for additional information to enable **us** to assess **your** claim, such as further medical reports or tests, or an independent medical examination. If **you** do not agree to supply **us** with any reasonable additional medical information **we** ask for, **we** will not be able to assess **your** claim.

If **you** require ongoing **treatment we** may ask for further medical information and if **we** do, the cost of providing this information must be borne by **you**. **We** are unable to return original documents such as invoices or medical letters, but **we** will send **you** copies upon request.

Our right to request a treatment review

We will not pay for **treatment** which in **our** opinion is inappropriate based on established medical and clinical practice and **we** are entitled to conduct a review of **your treatment** when it is reasonable for **us** to do so.

Illness or injury caused by a third party

If **you** are claiming for an illness or injury that was caused by some other person or organisation (a third party) **you** must let **us** know in writing straight away, or tell **us** on **your** claim form. **We** will then pay benefit in accordance with the terms of this **agreement** provided that **you** take all necessary steps **we** ask **you** to take to assist **us** in recovering **our** costs from the person or organisation at fault (such as through their insurance company) the cost of the **treatment** paid for by **us**, plus interest, at **your** own expense.

If **you** pursue a personal claim for damages against the third party, **you** must provide **us** with the full name and address of the solicitor handling the action. **We** will then contact the solicitor to register **our** interest and seek to recover **our** own costs, plus interest, in addition to any damages that **you** may recover or be awarded. **We** reserve the right to appoint **our** own solicitor to act on **your** behalf in this matter and to take over the conduct of the action.

If **you**, or any **insured person**, are able to recover from the third party (whether or not through legal action) compensation that includes **any treatment** costs **we** have paid, **you** must repay that amount to **us**. Any interest that **you** or any **insured person** may also have been awarded that relates to the recovered **treatment** costs **we** have paid for must also be repaid to **us**. If **you** only receive a proportion of **your** claim for damages then **you** must repay to **us** the same proportion of **our** costs.

If you are covered by another insurance plan

If **you** have any other insurance that covers the same costs as **we** do, **we** will only pay **our** proportionate share of the claim. In this event, **you** must provide **us** with full details of the other insurance, including the name and address of the other insurer, their policy and claim number and any other relevant information, when **you** first submit **your** claim. **We** will then contact the other insurance company to ensure that **we** only pay **our** proportion of the claim. This may involve **us** sending **your** personal information regarding **your** claim to the other insurer.

We will also allow sums paid by another insurer to be offset against **the excess** payable under **your plan** with **us**, subject to receiving confirmation from the other insurer of any amounts already paid by them, and subject to the **treatment** costs being eligible for cover under **your plan** with **us**.

6. GENERAL INFORMATION ABOUT YOUR PLAN

PREMIUMS

Plan premiums

Your employer is responsible for paying the **premium**. **We** must be in receipt of the **premium** before **we** will commence **your** cover.

Your plan will only remain in force whilst **you** are employed by **your employer**. **We** will not pay for any **treatment** expenses incurred after **your** cover has ended, even it was previously authorised.

Unpaid or late premiums

We will automatically cancel **your** cover if **your employer** fails to pay **your premium** on or before the **premium due date**.

We may allow **your** cover to continue without **you** having to complete a new **application form** and health declaration if **your employer** pays the outstanding **premium** within 30 days of the **premium due date**. During this 30 day period **we** will not accept any claims for **treatment** incurred on or after the **premium due date** until **your employer** has paid the **premium** due. This also applies to **treatment** that **we** have already pre-authorised.

If **your employer** does not pay the **premium** within 30 days of the **premium due date**, **we** will cancel **your plan** from midnight on the day before **your premium due date**. Once **we** have cancelled the **plan**, **your employer** will have to reapply for cover and **you** will have to complete a new **application form** which will be subject to **medical underwriting**.

MAKING CHANGES

Adding dependants to your plan

If the **plan** includes cover for **employees'** dependants **you** must apply for cover on behalf of **your** spouse or partner, if they are under 70 years of age on their **date of entry**.

You must also apply for cover for **your eligible dependant** children, if they are under 18 years old, or under 25 years old if they are in continuous full-time education. **We** reserve the right to request proof of a child being in full-time education.

We will not commence cover for a new **eligible dependant** until **we** have accepted their **application** and **we** have received payment of their **premium** from **your employer**.

Adding newborn babies to your plan

If the **plan** includes cover for **employees'** dependants **you** may add **your** newborn child to **your plan**, without any **medical underwriting**, provided **you** notify **us** of their full name and date of birth, and **your employer** pays the additional **premium** required, within 30 days of their date of birth. The child's cover will be restricted to the cover provided by **your employer's plan type**.

If **you** do not inform **us** about the birth of **your** child within 30 days of their birth, and/or **your employer** does not pay the additional **premium** within 30 days of their date of birth, **you** will have to make a new **application** for **your** child to be added to **your plan**, and this **application** will be subject to **medical underwriting**.

Newborn children who have been born as a result of **assisted reproduction treatment** and born within 36 weeks of conception are always subject to **medical underwriting**.

In the event of the death of an insured person

If **you** (the **employee**) die and have **eligible dependants** insured under the **plan**, they will no longer be entitled to be insured on the **plan** and will be removed from the date of **your** death. However, they may apply to be insured on their own individual **plan**, provided they are over the age of 18 years.

To enable **us** to do this **we** will require a new **application form** which must be completed and returned to **us** within 30 days of **your** date of death. Provided **we** receive the new **application form**, and provided **premiums** continue to be paid up to date, **we** will continue their cover as before, but subject to **our** individual **premium** rates.

If **your eligible dependants** want to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

If **your eligible dependants** are under the age of 18, their legal guardian will have to sign the **application form** on their behalf.

If an insured **eligible dependant** dies, please inform **us** as soon as possible.

Divorce and separation

If **you** have **your** spouse or partner included under **your plan** and **you** become separated or divorced, **we** will have to transfer **your** insured spouse or partner on to their own **plan** as they will no longer be entitled to be covered on **your employer's plan**. To enable **us** to do this **we** will require **your** spouse or partner to complete a new **application form** which must be completed and returned to **us** within 30 days of **your** date of divorce or separation.

Provided **we** receive the new **application form**, and provided **premiums** are paid by the new **plan holder**, **we** will continue to cover **your** insured ex-spouse or partner as before, but subject to **our** individual **premium** rates. If **your** ex-spouse or partner want to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

When a child dependant is no longer eligible to be covered under your plan

If one of **your** children has married, or has reached the age of 18 (or the age of 25 if they are in full time education) they will no longer be able to be included on the **plan** from the **renewal date** following their marriage/birthday. However, they may apply to be insured on their own individual **plan**.

To enable **us** to continue their cover as before **we** will require a new **application form** which must be completed and returned to **us** within 30 days of **your renewal date** along with the appropriate **premium** due, which will be subject to **our** individual **premium** rates.

If **your** child wants to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

If **we** do not receive **your** child's **application form** and **premium** within 30 days of **your renewal date**, their cover will automatically cease from midnight on the day before **your renewal date**. If they subsequently wish to apply for cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

Changing your address, country of residence or nationality

You must inform **us** if **you** change **your** address and provide **us** with the new details.

If **you** change **your country of residence** or **you** change **your home country**, **you** must tell **us** straight away.

If you take up residence in an excluded or restricted country and/or region

Under the terms of this **agreement** cover is not available to **you** if **you** take up residence in an excluded or restricted country and/or region, irrespective of **your** nationality.

These countries and/or regions are as follows: USA, Canada, any **Caribbean country or island**, all countries within the European Union, Andorra, Channel Islands, Gibraltar, Greenland, Iceland, Liechtenstein, Monaco, Norway, San Marino, Switzerland, Australia, Bali, China, Hong Kong, Japan, Macau, New Zealand, Singapore and Taiwan.

If **you** take up residence in an excluded or restricted country and/or region **you** must tell **us**. **Your** cover will automatically terminate from the date on which **you** take up residence in the excluded or restricted country and/or region.

If you leave your employement

If **you** leave **your** employment **you** are no longer eligible to be included on **your employer's plan** and **you** will be removed on the date **your** employment ceases. In some circumstances **you** may be allowed to continue cover with **us** on an individual **plan** with no additional **medical underwriting**, but subject to **our** individual premium rates. If **you** would like more information about this then please contact **us**.

OTHER INFORMATION

When we can cancel your plan

We have the right to cancel **your plan** if:

- **your employer** does not pay **your premium** and other charges such as insurance premium tax within 30 days of any **premium due date**
- **your** employment with the **employer** ceases (and **you** have not submitted an **application form** and paid the required **premium** within 30 days of the date in which it ceased)
- **you** are no longer eligible to be included in the **plan** or **you** move to a country where **we** are unable to offer health cover
- **you** have not provided **us** with medical information **we** have requested to enable **us** to assess a claim or any potential claim that may arise in the future
- **you** have not repaid to **us** fully any ineligible claim payments **we** have invoiced **you** with
- **we** reasonably suspect that any **insured person** has misled **us** or attempted to mislead **us**, whether intentionally or carelessly, either at the time of joining or when making a claim, by:

- providing **us** with incomplete or false information; or
- working with another party to provide false information to **us**; or
- changing original documents.

When we may apply special terms to your plan

We have the right to apply **special terms** to **your plan** if **you** give **us** inaccurate or incomplete information. Such **special terms** will be applied from **your date of entry**.

Arbitration/applicable law

All disputes arising out of or in connection with the present contract shall be finally settled under the Rules of Arbitration of the International Chamber of Commerce of Paris by one or more arbitrators appointed in accordance with the said rules, and shall take place in Paris. The arbitration shall be conducted in English and English law shall apply. A sole arbitrator shall be appointed by the International Chamber of Commerce of Paris unless the parties to the dispute agree otherwise.

Our liability under this plan

Our liability under this **plan** is limited to paying for **treatment** or services in respect of eligible claims under this **plan**. The choice of provider of the **treatment** or services for which **you** are claiming under this **plan** is **your** responsibility. **We** make no representations or recommendations regarding the availability and standard of any **treatment** or services offered or provided by any **hospital** or **medical services provider**. **We** will not be held liable to **you** or any **insured person** for any loss, harm or damage of any description resulting from lack of availability or from a defect in the quality of any **treatment** or service offered or provided by any **hospital** or **medical services provider**. This **plan** represents the whole and only **agreement** between **your employer** and the **insurer** relating to the provision of **your** private medical insurance.

Your responsibilities as an employee

It is **your** responsibility to:

- inform **us** if **your** personal details, or the personal details of any **insured person**, change
- keep **us** advised of **your** current email address
- inform **us** if **you** change **your** address, country of residency or **home country**

Complaints procedure

We want to provide **you** with a first class standard of service at all times. If **you** feel that **our** service has been poor or **you** feel that any decision **we** make about a claim is unfair and not in accordance with the terms of this **agreement**, please let **us** know. **You** may telephone or write to **us** at:

William Russell Limited

William Russell House,

The Square, Lightwater, Surrey GU18 5SS, UK

T: +44 1276 486455

F: +44 1276 486466

E: enquiries@william-russell.com

The time it takes **us** to resolve **your** complaint will depend on how complex it is and how much investigation **we** have to do. **We** will always try to resolve **your** complaint as quickly as possible, keeping **you** informed of **our** progress. **We** will acknowledge **your** complaint promptly, and tell **you** who is dealing with **your** complaint so contacting **us** is easier.

We will then fully investigate **your** complaint and send **you** a detailed written report about **our** findings.

We will clearly explain the reasons behind **our** decision and what action **we** will take to put things right, if appropriate.

We want to resolve complaints to **your** satisfaction whenever possible. If **we** cannot reach agreement with **you**, **you** may refer **your** complaint to the **insurer**.

Allianz Benelux N.V.

Coolsingel 139, Postbus 64,

NL-3000 AB Rotterdam,

Netherlands

If **you** are dissatisfied with the response **you** receive from the **insurer you** may submit a complaint to the Netherlands Financial Services Complaints Institute:

Klachteninstituut Financiële Dienstverlening (Kifid)

Postbus 93257,

2509 AG Den Haag,

Netherlands

If **your** complaint relates to a service provided to **you** by William Russell Limited, for example a delay in providing **you** with information or documents, or a complaint about any aspect of **our** sales process, and more than 8 weeks from the date of **your** complaint **you** haven't received **our** final response, or **you** are dissatisfied with **our** final response **you** may write to The Financial Ombudsman Service.

The Financial Ombudsman Service
South Quay Plaza, 183 Marsh Wall,
London, E14 9SR
T (inside the UK): 0800 023 4567
T (outside the UK): +44 207 9640 500
F: 020 7964 1001
E: complaint.info@financialombudsman.org.uk

The Financial Ombudsman Service is an impartial adjudicator and provides a free, independent service for resolving disputes with financial services firms. If **you** are going to ask the Financial Ombudsman to review **your** case, **you** should do so within 6 months of **us** giving **you our** final decision on **your** complaint.

If **you** contact the Financial Ombudsman Service, this does not affect **your** right to take legal action if **you** are dissatisfied with, and do not accept the outcome of their review.

Data protection notice

We think it is important for all **our** customers to be made aware of what information **we** hold about them and to have the reassurance of knowing that **we** comply with the Data Protection Act. 1988 and the EU Data Protection Directive 95/46/EC.

We will use **your** information (including information provided about **your eligible dependants**) for underwriting and administration purposes. By taking out a **plan** with **us**, **you** agree to **us** processing **your** personal information and sensitive personal information (e.g. health information). **We** will also use **your** information for statistical data analysis, management information and fraud prevention purposes.

If **you** wish to make a claim on **your plan**, this will invariably mean that **you** will have to provide **us** with information regarding **your** medical condition which **we** will then process in order to administer **your** claim.

Please note calls to William Russell Limited may be recorded and may be monitored and used for training purposes.

Who we may give personal data to

We may disclose **your** personal information to **our** business associates, agents and service providers for the purposes above. **Your** information may be processed by service providers in a country outside the European Economic Area, which may not have the same standard of data protection as in the UK.

We will ensure appropriate safeguards are in place to protect **your** information. **We** will pass **your** information to any legal or regulatory body if **we** are required to do so.

We may also use **your** information or give it to others, for research, statistical purposes or to improve **our** services, but **we** will remove **your** name and address from this first.

As **you** belong to a corporate **plan you** may want to ask **your employer** whether an insurance adviser has been appointed, so that **you** know who may have access to **your** personal information. **We** may disclose information about a claim to the administrator of a corporate **plan**, but no medical information will be provided without **your** consent. Correspondence about any claim, (including when made by **your eligible dependants**) will be restricted to that needed to handle the claim, and will be addressed to the **employee**.

Your information may be disclosed to other parties (for example other insurance companies) with a view to preventing fraudulent or improper claims.

Processing claims

In the event of a claim **we** may have to give some information to those involved in **your treatment** or care, and/or **your** representative (if **you** have chosen one), this will be done confidentially.

An **insured person** over the age of 16 has the right to confidentiality in relation to their claims and information.

In order for them to exercise this right please contact customer services. If **you** have another insurance **plan** that covers the same costs that **you** are claiming from **us**, then **we** may also disclose **your** relevant personal information to that other **insurer** so that **we** can ensure **we** only pay **our** proportion of the claim.

Obtaining a copy of the information we hold about you

You have the right to request a copy of the information **we** hold about **you** (for which **we** may charge a fee) and to have any inaccurate information corrected by writing to **us** at the below address. Where information has been supplied by a **medical practitioner**, **you** should be aware that **we** need their consent before **we** can supply this to **you**, or alternatively **you** can request such information direct from the practitioner.

Data Protection Officer
William Russell Limited
William Russell House,
The Square, Lightwater,
Surrey, GU18 5SS, UK

Disposal of information

We will continue to hold information about **your plan** for a reasonable period of time after it has ended. **We** will then dispose of **your** personal information in a responsible way to maintain **your** confidentiality.

7. DEFINITIONS

This section explains what **we** mean by certain words and phrases bolded in this **agreement**.

Accident
A sudden, unexpected, unusual, specific, violent, external event which occurs at a single identifiable time and place independently of all other causes, which results directly, immediately and solely in physical bodily injury which results in a loss. In no event shall the contracting of any disease and/or illness (including, but not limited to heart attack, stroke or cancer), nor the injection or ingestion of any substance, be considered an **accident**. An event which directly or indirectly exacerbates a previously existing physical bodily injury shall not be considered an **accident**.

Acute medical condition
A disease, injury or illness that is likely to respond quickly to **treatment** which aims to return **you** to the state of health **you** were in immediately before suffering the disease, illness or injury, or which leads to **your** full recovery.

Agreement
This booklet. The **agreement** should be read in conjunction with the **master certificate of insurance** issued to **your employer**, **your** completed and signed **application form** and **your certificate of insurance**.

Application/Application form
The **application form you** have completed and signed on behalf of **yourself** and on behalf of any **eligible dependants** for whom cover is requested. Please note that on some occasions an alternative form such as a health declaration or an upgrade form may be required to be completed instead of a full **application form**. **We** will advise **you** when this is the case. The alternative form will then be classed as the **application/application form** for the purpose of this **agreement**. Information on previously completed **application forms**, if applicable, may also be used by **us** for underwriting and claims assessment reasons.

Area of cover
The territorial limits of **your plan**.

Assistance Service
The emergency assistance company contracted by **us** to provide **assistance services** to Corporate Global Health **plan** members at the time of **your** claim. The contact details for the **Assistance Service** can be found in the Contact Details section at the front of this **agreement**.

Assisted Reproduction
The use of medical techniques, including but not limited to in-vitro fertilisation (IVF) with or without intra-cytoblastic sperm injection (ICSI), gamete intrafallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), egg donation and intra-uterine insemination (IUI) with ovulation induction, received during the 3 month period prior to conception.

Caribbean country and island
All countries in the Caribbean region including the West Indies and all islands surrounded by or bordering the Caribbean Sea.

Certificate of insurance
The confirmation of **your** insurance cover issued by **us**. It confirms the **plan type your employer** has chosen, **your area of cover**, **period of cover**, **date of entry**, **renewal date**, **excess** amount, **special terms**, **your country of residence**, **your home country**, and the schedule of **insured persons**. The schedule of **insured persons** lists the persons insured by **us** under **your employer's agreement** with **us**. If there are any changes to the details on **your certificate of insurance we** will issue **you** with a new one confirming the changes.

Chronic Condition
A disease, illness or injury that has one or more of the following characteristics:
- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- **you** need to be **rehabilitated** or specially trained to cope with it
- It continues indefinitely
- it has no known cure
- it comes back or is likely to come back

Co-insurance
A contribution that **you** must make towards the eligible costs of **your** claim.

Complications of pregnancy
Treatment received for a medical condition which arises because of the antenatal or postnatal stages of pregnancy.

Congenital condition
Whether hereditary or not, any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not, or any deformity arising during the antenatal stages of pregnancy, or caused during childbirth.

Country of residence
The country in which **you** are habitually resident as specified on **your application form** or subsequently advised to **us** in writing.

Date of entry
The date on which cover for **you**, and each of **your** dependants, first commenced. **Your date of entry** is as stated on **your certificate of insurance**.

Day-patient
A patient admitted to a **hospital** or **day-patient** unit for a medical procedure which for medical reasons could not have been performed on an **out-patient** basis and which requires them to occupy a **hospital** bed for a period of medically supervised recovery, but it is not **medically necessary** for them to occupy a bed overnight.

Dental Treatment
Dental procedures undertaken by **your dental practitioner** which are clinically necessary for the maintenance and/or restoration of oral health, and are provided in accordance with accepted standards of dental practice.

Dentist/Dental Practitioner
A qualified person legally carrying out this profession in the country in which he or she is located.

Diagnostic tests
Investigations, such as x-rays or blood tests to diagnose the cause of **your** symptoms.

Doctor
See **Medical doctor**.

Eligible dependants
Your spouse or partner, provided they are under age 70 at their **date of entry**, and **your** unmarried children (i.e. **your** son, daughter, step-son, step-daughter, adopted children and children subject to legal guardianship) provided the unmarried children are aged less than 18 years old, or less than 25 years old if in continuous full-time education. If a child is adopted or the subject of legal guardianship **we** may require proof. **We** may also require proof of a dependent child being in full time education.

Emergency caesarean section
A caesarean section, which has been scheduled to take place less than 24 hours in advance.

Emergency treatment
Essential **treatment**, covered by **your plan**, and required if **you** suffer an **accident** or a sudden and unforeseen illness **you** have never suffered from before, which is not a **pre-existing condition**, or a **related condition**, or a condition for which **you** have a **personal medical exclusion**.

Employee
You, the member of the Corporate Global Health **plan** provided by **your employer**.

Employer
The **plan holder** specified as **your** company/**employer** on **your certificate of insurance**.

Excess
The amount stated as the **excess** in **your certificate of insurance**, being the amount **you** must contribute to each claim. If **your excess** is per annum, the **excess** stated on **your certificate of insurance** is the amount **you** must contribute towards the cost of eligible **treatment** covered by **your plan** and received within the same **period of cover**.

Home country
Your country of origin, for which **you** hold a passport. If **you** hold more than one passport **your home country** will be the country **you** have declared on **your application form**.

Hospice
A facility that provides palliative care and attends to the needs of terminally ill patients.

Hospital
An establishment which is legally licensed as a medical or surgical **hospital** under the laws of the country in which it is situated.

Innocent bystander
Someone who is not involved with, participating in or reporting on war, acts of foreign enemy hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, or attempted overthrow of government, or any acts of terrorism, or actively participating in operations countering any such activities.

In-patient
A patient who is admitted to **hospital** and who occupies a bed overnight or longer for medical reasons.

Insured person
You and any **eligible dependants** specified in **your certificate of insurance** as being included in the **plan**.

Insurer
The insurance company that provides the insurance cover for **your plan**. The **Insurer** is Allianz Benelux N.V.

Life-threatening condition
A critical medical condition covered by **your plan**, which in the opinion of the **Assistance Service** constitutes a life-threatening situation which requires immediate **in-patient treatment**.

London area
Any address in the United Kingdom within the E, EC, N, NW, SE, SW, W or WC postcode areas.

Master certificate of insurance
The certificate of insurance issued to **your employer** which together with this **agreement** and **your certificate of insurance** contains the terms, conditions and exclusions that apply to **you** and **your eligible dependants**.

Medical doctor
A person who is legally qualified in medical practice following attendance at a recognised medical school (as listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation), to provide medical **treatment** and who is licensed to practise medicine in the country where the **treatment** is received.

Medically necessary
Treatment that is medically appropriate and necessary to treat a condition and which is consistent with UK medical practice and guidelines regarding its type, frequency and duration. The UK guidelines used for the purpose will be those published by the National Institute for Health and Clinical Excellence (NICE) in the UK.

Medical practitioner
A person who has full registration under the Medical Acts of the country where they practice and who specialises in nursing, homeopathy, acupuncture, orthopaedic medicine, osteopathy, chiropractic, chiropody, podiatry, or physiotherapy **treatment**, and to whom **you** have been referred by a **medical doctor**.

Medical referral letter
A letter from **your medical doctor** or **specialist** which refers **you** to another **medical practitioner** for **treatment** covered by **your plan**. **We** will only pay for **treatment** when the start date of **your treatment** is within 3 months of the date of **your medical referral letter**.

Medical services provider(s)
A **hospital**, **out-patient** clinic, **medical practitioner**, **dental practitioner**, optician or pharmacy.

Medical underwriting
The process of **you** providing and **us** assessing the health and medical information **we** ask for to decide the terms under which **we** will accept **your application** for cover, or for enhanced cover. Based on the information **you** give **us**, **we** may decide to place **special terms** on **your** cover, such as **personal medical exclusions**, or **we** may decide not to offer **you** cover.

Out-patient
A patient who attends a **hospital** consulting room, emergency room or **out-patient** clinic, when it is not **medically necessary** for them to be admitted as a **day-patient** or an **in-patient**.

Out-patient surgical procedure
An **out-patient** procedure where one or more of the following is **medically necessary**:
- general or local anaesthesia or intravenous sedation
- manipulation or relocation of fractured bone or dislocated joint by a **medical doctor**
- invasive surgical procedures
- invasive diagnostic procedures involving intra-arterial cannulation
- the use of endoscopic equipment

Personal medical exclusions
A restriction on **your** cover that is stated on **your certificate of insurance** and specifically excludes **treatment** of a certain medical condition or conditions and any **related conditions**.

Period of cover
The period stated as the **period of cover** on **your certificate of insurance**.

Plan/Plan Type
The Corporate Global Health Essential Care **plan** or the Essential Care Plus **plan** on which **you** and **your eligible dependants** are covered.

Plan holder
The company or **employer** as stated on **your certificate of Insurance**.

Planned caesarean section
A caesarean section which has been scheduled to take place more than 24 hours in advance, whether this be for medical or elective reasons.

Post-hospital treatment
Medically necessary follow-up consultations, physiotherapy, **diagnostic tests** and/or **treatment** required on an **out-patient** basis following **in-patient** or **day-patient treatment** covered by **your plan** and received within the 90 day period following the date **you** are discharged from **hospital**.

Pre-existing medical conditions
Any disease, illness or injury, whether the condition has been diagnosed or not before **your date of entry**, for which:
- **you** have received medication, advice or **treatment**; or
- **you** have experienced symptoms

Premium
The amount(s) **your employer** is required to pay to **us** either annually, semi-annually, quarterly or monthly for **your** insurance **plan**.

Premium due date
The date on which **your premium** is due to be paid by **your employer**.

Preventive health checks
Health tests, screening and/ or clinical procedures specifically designed for disease prevention and early detection.

Reasonable and customary
The charge that would typically be made for **your treatment** by medical service providers in the country where **you** receive **your treatment**. If the cost of **your treatment** is not **reasonable and customary**, **we** will only pay up to the amount which is typically charged in that country. In the event of a dispute, **we** will identify the amount typically charged for **your treatment** by medical service providers in the country where **you** receive it, by obtaining three quotations and taking a mean average of these three quotations.

Rehabilitation
Treatment in the form of a combination of therapies such as physical, occupational and speech therapy aimed at restoring full function after an acute event such as a stroke.

Related condition
Any disease, illness or injury that is caused by a **pre-existing medical condition** or results from the same underlying cause as a **pre-existing condition**.

Renewal date
The **renewal date** of **your employer's plan** as shown on **your certificate of insurance**.

Session
A single continuous consultation during which time **you** may receive advice, **treatment** and/or prescribed medication.

Specialist
A **medical practitioner** who is fully registered by the regulatory body of the country in which he or she practices following attendance at a recognised medical school (as listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation). They must be on a **specialist** register appropriate for the condition for which **treatment** is sought. Where regulation demands, the **medical practitioner** must also have a licence to practice. **We** reserve the right to withhold or remove recognition of any **specialist** for reasons such as suspension of registration, fraud or unreasonable charges.

Special terms
Any **personal medical exclusions**, restrictions or **premium** adjustments **we** may apply to **your plan**. Any **special terms** relating to **your plan** will appear on **your certificate of insurance**.

Table of benefits
The table beginning on page 5 which sets out the benefits covered by each **plan type**.

Treatment
Surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

Us, we, our
William Russell Limited on behalf of the **insurer**.

Waiting period
When specified, the amount of time **you** must be covered by the same **plan** before **you** can claim for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**. When a **waiting period** is not specified there is no **waiting period** applicable.

You, your, yourself
Any and all persons named in the schedule of **insured persons** on **your certificate of insurance**.

We're here to help

William Russell is the leading independent provider of international health, life and income protection insurance. Over the last twenty-three years we have developed a range of world-class insurance products, each designed to provide protection for expatriate life and international living.

As a family-owned company, we are renowned for our fairness, honesty and outstanding personal service. We operate throughout the world, protecting expatriates and their families, international citizens, global corporations and SME businesses, and high-net-worth individuals.

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