



**Elite Health  
Plan Agreement  
for Employees**

For employees with an Elite Health plan  
whose period of cover starts on or after  
**01 January 2018**

**William Russell<sup>o</sup>**

Welcome to William Russell	3
Your plan agreement	4
Your area of cover	5
What you are covered for	6
What you are not covered for	20
If you need to make a claim	24
Other information about your plan	27
How to make a complaint	29
How we process your information	30
Definitions	32

# Welcome to William Russell

We want to provide **you** with an insurance policy **you** can rely on, so it is important that **you** fully understand the scope of the cover **we** provide. This **agreement** explains what is and what is not covered by **your plan**, and how **your claims** will be administered.

Please take time to read this **agreement** along with **your employer's master certificate of insurance**, **your own certificate of insurance**, and **your application form**. Together, these documents form the contract between **your employee, you and us**.

Certain words **we** use within this **agreement** have a special meaning to which **we** would like to draw **your** attention. For example:

- **'We, us, our'** – means William Russell Ltd., on behalf of the **insurer**
- **'You, your'** – means **you** and all **insured persons** on this **plan**, as shown on **your certificate of insurance**
- **'Policyholder'** – means **your** company or **employer** who has the insurance contract with **us**
- **'Assistance Service'** – means the company **we** have appointed to provide **you** with 24-hour medical assistance

These words appear in **bold** type, and we provide their precise meanings in the 'Definitions' section of this **agreement**.

All web addresses in this **agreement** are live. Simply click on a link and **you** will be taken directly to **our** website. **We** are, of course, always at the end of a telephone to answer queries or deal with **your claim**. **You** can find **our** contact details below.

## William Russell Ltd.

William Russell Ltd. is the administrator of **your plan**. William Russell Ltd. is authorised and regulated by the UK Financial Conduct Authority under reference number 309314.

## Allianz

Allianz (AWP Health & Life S.A., registered address at Eurosquare 2, 7 rue Dora Maar, 93400 Saint Ouen, France) is the **insurer** of **your plan**.

## Contact details

If you have an enquiry about your plan or insurance	Tel +44 1276 486 455 Fax +44 1276 486 466 Email <a href="mailto:enquiries@william-russell.com">enquiries@william-russell.com</a>
If you need to make a claim	Tel +44 1276 486 460 Fax +44 1276 486 476 Email <a href="mailto:claims@william-russell.com">claims@william-russell.com</a> Web <a href="http://william-russell.com/making-a-claim">william-russell.com/making-a-claim</a>
If you need to contact our 24-hour emergency medical Assistance Service	Tel +44 1232 621 155 Email <a href="mailto:william.russell@cegagroup.com">william.russell@cegagroup.com</a> Web <a href="http://william-russell.com/emergency-contact">william-russell.com/emergency-contact</a>
If you'd like to write to us	William Russell Ltd. William Russell House The Square, Lightwater Surrey, GU18 5SS, UK

# Your plan agreement

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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 **your employer's 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 treatment** of 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 you and your 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**.

## 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 the USA is or becomes your country of residence

Under the terms of this **agreement** cover is not available to **you** if the USA is or becomes **your country of residence**, irrespective of **your** nationality. If the USA becomes **your country of residence** **you** must tell **us**. **Your** cover will automatically terminate from the date on which **you** take up residence in the USA.

# Your area of cover

The cover provided by **your plan** is restricted to the **area of cover** stated on **your certificate of insurance**. The available areas of cover and their corresponding territorial limits are stated below.

## Standard area of cover

The standard **area of cover** is worldwide, excluding the United States of America. No cover is provided for any medical **treatment** in, or emergency medical evacuations to, within or from, the United States of America.

## Enhanced areas of cover

There are two **areas of cover** that provide worldwide cover, with limited cover in the United States of America. If **you** have one of these **areas of cover**, it will be stated on **your certificate of insurance**.

### Worldwide cover, with USA cover for trips up to 45 days

We will cover **you** in the United States of America for temporary trips of up to 45 days' duration from the date on which **you** enter the United States of America. Any trip of longer than 45 days will not be covered but there is no limit to the number of temporary trips **you** can make to the United States of America during any **period of cover**. The maximum amount **we** will pay in respect of **treatment you** receive in the United States of America is US\$100,000 per **period of cover**, unless the payment is in respect of **emergency treatment**, in which case the maximum **we** will pay is US\$250,000 per **period of cover**.

### Worldwide cover, with USA cover for trips up to 90 days

We will cover **you** in the United States of America for temporary trips of up to 90 days' duration from the date on which **you** enter the United States of America. Any trip of longer than 90 days will not be covered, but there is no limit to the number of temporary trips **you** can make to the United States of America during any **period of cover**. The maximum amount **we** will pay in respect of **treatment you** receive in the United States of America is US\$250,000 per **period of cover**.

## Restricted areas of cover

There are three **areas of cover** that provide regional or otherwise restricted cover. If **you** have one of these **areas of cover**, it will be stated on **your certificate of insurance**.

### Africa & Indian Subcontinent (AIS)

This **area of cover** is only available to residents of **Africa & the Indian Subcontinent**. If **you** have this **area of cover** **you** will be eligible for cover in all countries within **Africa & the Indian Subcontinent**.

We will cover **you** for **emergency treatment** in any location outside of **Africa & the Indian Subcontinent** that is not the United States of America, Canada, any **Caribbean country or island**, or within the **London area**, whilst **you** are on a temporary trip of up to 90 days' duration from the date on which **you** departed from **Africa & the Indian Subcontinent**. Any trip of longer than 90 days will not be covered, but there is no limit to the number of temporary trips **you** can make during any **period of cover**.

We will not pay for cover if **you** have travelled knowing that **you** may require **medical treatment**, and the maximum benefit **we** will pay in respect of all **emergency treatment you** receive outside **Africa & the Indian Subcontinent** is US\$100,000 or £62,500 or €120,000 per **period of cover**.

No cover at all is provided in the United States of America, Canada, any **Caribbean country or island**, and anywhere within the **London area**.

### Lotus

This **area of cover** is only available to residents of Indonesia. If **you** have this **area of cover** **you** will be eligible for cover in the **Lotus countries** (listed below):

Indonesia, Thailand, Vietnam, Malaysia, Laos, Cambodia, Brunei, Philippines, South Korea, Kazakhstan, Kyrgyzstan, Mongolia, Papua New Guinea, Tajikistan, Turkmenistan, Uzbekistan, and all countries within **Africa & the Indian Subcontinent**.

We will cover **you** for **emergency treatment** only in any location outside of the **Lotus countries** that is not the United States of America, Canada, any **Caribbean country or island**, or within the **London area**, whilst **you** are on a temporary trip of up to 90 days' duration from the date on which **you** departed from a **Lotus country**. Any trip of longer than 90 days will not be covered, but there is no limit to the number of temporary trips **you** can make during any **period of cover**.

We will not pay for cover if **you** have travelled knowing that **you** may require **medical treatment**, and the maximum benefit **we** will pay in respect of all **emergency treatment you** receive outside the **Lotus countries** is US\$100,000 or £62,500 or €120,000 per **period of cover**.

No cover at all is provided in the United States of America, Canada, any **Caribbean country or island**, and anywhere within the **London area**.

### Worldwide excluding the USA, with 20% co-insurance in certain countries

This **area of cover** is only available to residents of Indonesia. If **you** have this **area of cover** **you** will be eligible for cover worldwide. However, there will be a 20% **co-insurance** when **you** travel to certain locations for medical **treatment**.

These locations are Singapore, Hong Kong, China, Japan, Macau, Taiwan, Switzerland, and the **London area**. In these locations, **we** will only cover **you** up to 80% of your eligible **treatment** costs.

However, in these locations **we** will reimburse **you** 100% up to US\$100,000 or £62,500 or €120,000 per **period of cover** for **emergency treatment** whilst **you** are on a temporary trip of up to 90 days' duration. There is no limit to the number of temporary trips **you** can make during any **period of cover**, but for trips longer than 90 days the 20% **co-insurance** will apply to **emergency treatment**.

# What you are covered for

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 your **plan**.

Each benefit limit in the **table of benefits** is expressed in US Dollars, Sterling, and Euros. The currency of the benefit limits that we will apply to your **plan** is shown on your **certificate of insurance**.

The limits shown in the **table of benefits** are the maximum amounts we will pay after the application of any **excess** and **co-insurance**, and will be subject to the annual benefit limit and any other specified applicable benefit limits.

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**.

Wherever the term 'Full cover' appears in the **table of benefits**,

this means full refund of **reasonable and customary** charges, less any **excess** or **co-insurance** applicable to your **plan**, and subject to any limits that are specified anywhere else in the **table of benefits** for the type of **treatment** or care you receive.

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** are optional. You are only eligible for these benefits if your **employer** has selected them and they are stated on your **certificate of insurance**.

There are certain benefits in the **table of benefits** for which you must obtain pre-authorisation.

The **table of benefits** should be read in conjunction with the 'What you are not covered for' section of this **agreement**.

**Key** ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Bronze	Silver	Gold
<b>Annual benefit limit</b>			
The overall maximum limit that each <b>insured person</b> can <b>claim</b> during any one <b>period of cover</b> .	US\$1,500,000 or £1,000,000 or €1,125,000	US\$2,500,000 or £1,666,000 or €1,875,000	US\$5,000,000 or £3,333,000 or €3,750,000
<b>Hospital costs</b> Important notes: • You must obtain pre-authorisation for all benefits included in this section.			
<b>Hospital accommodation</b> The cost of a standard single room with an en-suite bath or shower room, when you are an <b>in-patient</b> or <b>day-patient</b> .	○ Full cover	○ Full cover	○ Full cover
<b>Hospital treatment</b> <b>Treatment</b> you receive while you are an <b>in-patient</b> or <b>day-patient</b> , including surgeons' and anaesthetists' and <b>doctors'</b> fees, nursing care, drugs and surgical dressings, operating theatre charges and intensive care, pathology, X-rays, scans, <b>diagnostic tests</b> and physiotherapy. <b>We</b> will also pay for <b>pre-admission tests</b> that you undergo on an <b>out-patient</b> basis for <b>hospital treatment</b> you are scheduled to receive that is covered by your <b>plan</b> . <b>We</b> will also pay for <b>in-patient</b> surgical removal of impacted, buried or unerupted wisdom teeth. This is subject to a 12-month <b>waiting period</b> and covered only when the surgery is performed by a <b>medical doctor</b> (not a <b>dentist</b> ) in a <b>hospital</b> (not a dental surgery) and under general anaesthetic.	○ Full cover	○ Full cover	○ Full cover

**Key** ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Bronze	Silver	Gold
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### Hospital costs (continued)

Important notes:

- **You** must obtain pre-authorisation for all benefits included in this section.

<p><b>Parent accommodation</b></p> <p>The cost of one parent staying in <b>hospital</b> with a child under 18 years of age while the child is receiving eligible <b>treatment</b> covered by their <b>plan</b>.</p>	○ Full cover	○ Full cover	○ Full cover
<p><b>Road ambulance</b></p> <p>The cost of a private road ambulance if <b>you</b> need <b>hospital treatment</b> covered by <b>your plan</b> and if it is <b>medically necessary</b> for <b>you</b> to travel to <b>hospital</b> by ambulance.</p>	○ Full cover	○ Full cover	○ Full cover
<p><b>Hospital cash benefit</b></p> <p>Payable for each night spent in a <b>hospital</b> when <b>you</b> receive <b>treatment</b> eligible for cover by <b>your plan</b> for which no charge is made by the <b>hospital</b>. Benefit is paid for up to a maximum of 60 nights per <b>period of cover</b>.</p>	US\$40 or £27 or €30 per night	US\$80 or £53 or €60 per night	US\$250 or £167 or €188 per night

### Cancer treatment

Important notes:

- **You** must obtain pre-authorisation for all benefits included in this section.

<p><b>Cancer treatment</b></p> <p>Cancer <b>treatment</b>, including chemotherapy, radiotherapy, immunotherapy, consultations, tests, scans, and drugs. <b>We</b> will also pay for restorative <b>dental treatment</b> following chemotherapy or radiotherapy.</p>	○ Full cover	○ Full cover	○ Full cover
<p><b>Cancer genome tests</b></p> <p>The cost of tests to sequence the genes of cancer cells.</p>	○ Cover up to US\$6,000 or £4,000 or €4,500 per <b>period of cover</b>	○ Cover up to US\$6,000 or £4,000 or €4,500 per <b>period of cover</b>	○ Cover up to US\$6,000 or £4,000 or €4,500 per <b>period of cover</b>
<p><b>Cash benefit upon diagnosis of cancer (6-month waiting period)</b></p> <p>Payable if <b>you</b> are diagnosed with cancer.</p> <p>By ‘cancer’ <b>we</b> mean the presence of tumours that consist of cells that are malignant, due to characteristics which can be shown microscopically. These cells can multiply and spread to other parts of the body uncontrollably– cancers such as breast cancer, lung cancer, bowel cancer, and cancers of the blood (also known as leukaemia).</p> <p>The following are not covered:</p> <ul style="list-style-type: none"> <li>• non-melanoma skin cancer unless it has spread to lymph nodes or organs</li> <li>• prostate cancer unless it has spread to other glands or organs</li> </ul> <p>This benefit will not be paid if <b>you</b> were first diagnosed with any cancer before <b>you</b> were covered under the Gold <b>plan</b> for a period of six consecutive months.</p>	○ No cover	○ No cover	US\$5,000 or £3,330 or €3,750 with a lifetime limit of one <b>claim per insured person</b>
<p><b>Wigs</b></p> <p>Help towards the cost of a wig following chemotherapy, covered by <b>your plan</b>.</p>	○ Lifetime limit of US\$150 or £100 or €113	○ Lifetime limit of US\$150 or £100 or €113	○ Lifetime limit of US\$150 or £100 or €113



**Key** Full cover within annual benefit limit Partial or limited cover No cover Optional cover

Cover	Bronze	Silver	Gold
<p><b>Cancer treatment (continued)</b> Important notes:</p> <ul style="list-style-type: none"> <li><b>You</b> must obtain pre-authorisation for all benefits included in this section.</li> </ul>			
<p><b>Counselling</b> Consultations with a registered psychologist/counsellor when <b>you</b> have received cancer <b>treatment</b> covered by <b>your plan</b>, up to a lifetime limit of 10 consultations. <b>We</b> do not cover any drugs prescribed under this benefit.</p>	Lifetime limit of US\$500 or £330 or €375	Lifetime limit of US\$500 or £330 or €375	Lifetime limit of US\$500 or £330 or €375
<p><b>Dietitian</b> Consultation with a registered dietitian when <b>you</b> have received cancer <b>treatment</b> covered by <b>your plan</b>, up to a lifetime limit of 2 consultations.</p>	Lifetime limit of US\$100 or £67 or €75	Lifetime limit of US\$100 or £67 or €75	Lifetime limit of US\$100 or £67 or €75
<p><b>Organ, bone marrow or tissue transplants</b> Important notes:</p> <ul style="list-style-type: none"> <li><b>You</b> must obtain pre-authorisation for all benefits included in this section.</li> <li><b>We</b> 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.</li> <li><b>We</b> do not cover any costs associated with the acquisition of the organ.</li> </ul>			
<p><b>Transplant and related treatment</b> Costs incurred while hospitalised, including anti-rejection drugs, and all related <b>out-patient treatment</b> required prior to and after the transplant.</p>	Full cover	Full cover	Full cover
<p><b>Donor costs</b> Medical costs associated with the donor as an <b>in-patient</b> or <b>day-patient</b>.</p>	Cover up to US\$25,000 or £16,600 or €18,750 per transplant	Cover up to US\$25,000 or £16,600 or €18,750 per transplant	Cover up to US\$25,000 or £16,600 or €18,750 per transplant
<p><b>Kidney dialysis</b> Important notes:</p> <ul style="list-style-type: none"> <li><b>You</b> must obtain pre-authorisation for this benefit.</li> </ul>			
<p><b>Treatment</b> for kidney dialysis while <b>you</b> are an <b>in-patient</b>, <b>day-patient</b> or <b>out-patient</b>.</p>	Full cover	Full cover	Full cover
<p><b>Reconstructive surgery</b> Important notes:</p> <ul style="list-style-type: none"> <li><b>You</b> must obtain pre-authorisation for this benefit.</li> </ul>			
<p>A maximum of two surgeries to restore <b>your</b> appearance after an <b>accident</b> or after surgery for cancer, provided the original <b>treatment</b> for the <b>accident</b> or cancer was paid for by <b>us</b>, and provided the reconstructive surgery takes place within two years of the <b>accident</b> or the original cancer surgery.</p>	Cover for <b>in-patient</b> , <b>day-patient</b> and <b>post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b>	Full cover	Full cover



**Key** ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Bronze	Silver	Gold
<p><b>Congenital conditions or hereditary conditions</b> Important notes:</p> <ul style="list-style-type: none"> <li>You must obtain pre-authorisation for this benefit.</li> </ul>			
<p><b>Treatment</b> for a <b>congenital condition</b> or hereditary condition (whether diagnosed as a <b>chronic condition</b> or not) and <b>treatment</b> for any <b>related condition</b>. This benefit does not extend to psychiatric <b>treatment</b> or psychotherapy, complementary medicine, traditional Chinese medicine, acupuncture or homeopathic <b>treatment</b>. There is no cover for <b>congenital conditions</b> or hereditary conditions if, prior to commencement of <b>your</b> cover, <b>you</b> have had any abnormal signs, symptoms or test results related to the <b>congenital condition</b> or hereditary condition (whether or not a specific diagnosis has been made). However, there may be some cover for newborn babies under the newborn babies benefit. <b>Your</b> lifetime limit for this benefit will be reduced by any payments <b>we</b> have made under the newborn babies benefit with respect to birth defects, <b>congenital conditions</b> or hereditary conditions. The lifetime limit shown applies irrespective of the number of <b>congenital conditions</b> and hereditary conditions.</p>	<p>○ Cover for <b>in-patient, day-patient and post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b> only, up to a lifetime limit of US\$20,000 or £13,300 or €15,000</p>	<p>○ Lifetime limit of US\$40,000 or £26,600 or €30,000</p>	<p>○ Lifetime limit of US\$80,000 or £53,300 or €60,000</p>
<p><b>Psychiatric &amp; psychotherapy treatment</b> Important notes:</p> <ul style="list-style-type: none"> <li>You must obtain pre-authorisation for all benefits included in this section.</li> <li>All <b>treatment</b> must be administered under the direct control of a registered psychiatrist or psychologist.</li> <li>We do not cover investigations or <b>treatment</b> related to psycho-geriatric conditions including Alzheimer's disease or dementia, phobias, hypnotherapy, postnatal depression or marriage counselling.</li> </ul>			
<p><b>Lifetime psychiatric and psychotherapy treatment limit</b> The overall maximum limit to the amount that <b>you</b> can <b>claim</b> for all psychiatric and psychotherapy <b>treatment</b> covered by <b>your plan</b> during <b>your</b> lifetime.</p>	<p>Lifetime limit of US\$50,000 or £33,300 or €37,500</p>	<p>Lifetime limit of US\$75,000 or £50,000 or €56,250</p>	<p>Lifetime limit of US\$100,000 or £66,600 or €75,000</p>
<p><b>In-patient and day-patient psychiatric and psychotherapy treatment (24-month waiting period)</b> <b>In-patient and day-patient treatment</b> received in a recognised psychiatric or psychotherapy unit of a <b>hospital</b>.</p>	<p>○ Cover for up to 30 days per <b>period of cover</b></p>	<p>○ Cover for up to 30 days per <b>period of cover</b></p>	<p>○ Cover for up to 30 days per <b>period of cover</b></p>
<p><b>Out-patient psychiatric and psychotherapy treatment (24-month waiting period)</b> <b>Specialist</b> psychiatric consultations with a registered psychiatrist or psychologist when <b>you</b> have been referred by a <b>medical doctor</b>. We do not pay for drugs prescribed for <b>out-patient</b> psychiatric and psychotherapy <b>treatment</b>.</p>	<p>○ Cover for up to 10 consultations for <b>post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b> per <b>period of cover</b></p>	<p>○ Cover for up to 10 consultations per <b>period of cover</b></p>	<p>○ Cover for up to 10 consultations per <b>period of cover</b></p>

**Key** ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Bronze	Silver	Gold
<p><b>HIV/AIDS treatment</b> Important notes:</p> <ul style="list-style-type: none"> <li>• <b>You</b> must obtain pre-authorisation for this benefit.</li> </ul>			
<p><b>(24-month waiting period)</b> <b>Treatment</b> 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. <b>We do not provide cover if the virus was contracted before your date of entry.</b></p>	<p>○ Cover for <b>in-patient and day-patient treatment</b> only, up to US\$5,000 or £3,300 or €3,750 per <b>period of cover</b></p>	<p>○ Cover up to US\$75,000 or £50,000 or €56,250 per <b>period of cover</b></p>	<p>○ Cover up to US\$100,000 or £66,600 or €75,000 per <b>period of cover</b></p>
<p><b>Medical appliances</b></p>			
<p><b>Medical aids</b> Supplying, fitting or hiring instruments, apparatuses or devices which are medically prescribed as a medical aid to <b>you</b> (for example crutches, wheelchairs, orthopaedic supports/braces, orthotics, stoma supplies, compression stockings) when it immediately follows <b>in-patient, day-patient</b> or emergency ward <b>treatment</b> covered by <b>your plan</b>. <b>We do not cover medical aids that form part of the care of a chronic condition.</b> <b>We do not cover unprescribed medical aids such as gym equipment, even if you have been advised to use such an aid.</b></p>	<p>○ Cover up to US\$250 or £160 or €188 per medical condition per <b>period of cover</b></p>	<p>○ Cover up to US\$500 or £330 or €375 per medical condition per <b>period of cover</b></p>	<p>○ Cover up to US\$1,000 or £660 or €750 per medical condition per <b>period of cover</b></p>
<p><b>Prosthetic implants</b> 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. As part of this benefit, <b>we</b> 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.</p>	<p>○ Full cover</p>	<p>○ Full cover</p>	<p>○ Full cover</p>
<p><b>Prosthetic devices</b> External prosthetic body parts, such as prosthetic limbs, fitted at the time of a surgical operation covered by <b>your plan</b>.</p>	<p>○ Cover up to US\$500 or £330 or €375 per device</p>	<p>○ Cover up to US\$1,000 or £660 or €750 per device</p>	<p>○ Cover up to US\$1,500 or £1,000 or €1,125 per device</p>
<p><b>Everyday medical costs</b></p>			
<p><b>Primary medical care</b> Visits to a GP or <b>doctor, specialist</b> consultations, prescribed drugs and dressings, pathology, scans, radiology and <b>diagnostic tests</b> received as an <b>out-patient</b>.</p>	<p>○ Cover for <b>post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b></p>	<p>○ Full cover</p>	<p>○ Full cover</p>

**Key** Full cover within annual benefit limit Partial or limited cover No cover Optional cover

Cover	Bronze	Silver	Gold
<b>Everyday medical costs (continued)</b>			
<b>Emergency ward treatment</b> <b>Emergency treatment that you have received at a hospital</b>	Cover for essential and immediate <b>treatment</b> necessary as the result of an <b>accident</b> , plus one follow-up appointment with a <b>medical doctor</b>	Full cover	Full cover
<b>Out-patient surgical procedures</b> Surgical procedures that do not require <b>in-patient</b> or <b>day-patient treatment</b> .	Full cover	Full cover	Full cover
<b>Advanced diagnostic tests</b> MRI and CAT (CT) scans performed on the advice of a <b>medical doctor</b> and PET scans performed on the advice of a <b>specialist</b> . <b>Your medical referral letter</b> will be required. We will pay for one consultation only to obtain the results of the <b>diagnostic test</b> .	Full cover	Full cover	Full cover
<b>Complementary treatments</b> <b>Treatment</b> by a chiropractor, osteopath, chiropodist, podiatrist, homeopath or acupuncturist on the advice of a <b>medical doctor</b> . <b>Your medical referral letter</b> will be required for any treatment by a chiropractor, osteopath, chiropodist or podiatrist. If <b>your</b> condition is (or becomes) a <b>chronic condition</b> and ongoing <b>treatment</b> is aimed at maintaining it rather than curing it, no further payments will be made. Cover is limited to the maximum number of <b>sessions</b> shown per <b>period of cover</b> in respect of all <b>treatment</b> types. <b>Treatment</b> must be performed by a <b>medical practitioner</b> .	Cover for up to <b>10 sessions</b> for <b>post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b> per <b>period of cover</b>	Cover for up to <b>10 sessions</b> per <b>period of cover</b>	Cover for up to <b>15 sessions</b> per <b>period of cover</b>
<b>Hormone replacement therapy</b> When prescribed by a <b>medical doctor</b> following <b>your</b> diagnosis with premature ovarian failure (i.e. loss of ovarian function before the age of 40).	No cover	Cover for a maximum period of 12 months from the date of diagnosis	Cover for a maximum period of 18 months from the date of diagnosis
<b>Traditional Chinese medicine</b> Cover is limited to the maximum number of <b>sessions</b> shown per <b>period of cover</b> . <b>Treatment</b> must be performed by a <b>medical practitioner</b> .	No cover	Cover up to US\$50 or £33 or €38 per <b>session</b> , up to a maximum of <b>15 sessions</b>	Cover up to US\$50 or £33 or €38 per <b>session</b> , up to a maximum of <b>20 sessions</b>

**Key** ● Full cover within annual benefit limit ● Partial or limited cover ● No cover ● Optional cover

Cover	Bronze	Silver	Gold
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**Everyday medical costs (continued)**

<p><b>Physiotherapy</b>  <b>Medically necessary</b> physiotherapy when <b>you</b> have been referred on the advice of your <b>medical doctor</b> to a physiotherapist who is registered to practice physiotherapy in the country where the <b>treatment</b> is administered. <b>You</b> must send <b>us your medical referral letter</b> in support of <b>your claim</b>.          If <b>you</b> need more <b>sessions</b> after <b>your</b> first 6 <b>sessions</b> of physiotherapy, <b>you</b> must contact <b>us</b>. <b>We</b> will write to your <b>doctor</b> for a medical report in order to assess your <b>claim</b> further. <b>We</b> will not pay for any physiotherapy that <b>we</b> have not pre-authorised.          If <b>your</b> condition is (or becomes) a <b>chronic condition</b> and ongoing <b>treatment</b> is aimed at maintaining it rather than curing it, no further payments will be made.</p>	<p><span style="color: orange;">●</span> Cover for <b>post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b> only, up to US\$1,000 or £660 or €750 per <b>period of cover</b></p>	<p><span style="color: green;">●</span> Full cover</p>	<p><span style="color: green;">●</span> Full cover</p>
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**Well-being benefits**

Important notes:

- You** are eligible for certain benefits in this section only if they have been selected by **your employer**.

<p><b>Preventive health and well-being (6-month waiting period)</b>  <b>Preventive health checks</b> and tests for adults, including:</p> <ul style="list-style-type: none"> <li>health screens (e.g. tests for cholesterol, high blood pressure, diabetes, anaemia, lung/kidney/liver function, cardiac risk)</li> <li>Papanicolaou (PAP) test</li> <li>mammogram, prostate cancer, and colon cancer screens</li> <li>flu jabs</li> <li>hearing test</li> <li>eye examination</li> </ul> <p>If <b>your employer</b> has selected the enhanced preventive health and well-being option, <b>you</b> are eligible for the higher benefit limit on <b>your plan</b>.</p>	<p><span style="color: red;">●</span> No cover</p>	<p><span style="color: orange;">●</span> Cover up to US\$300 or £200 or €225 per <b>period of cover</b></p> <p>—</p> <p><span style="color: blue;">●</span> Cover up to US\$500 or £330 or €375 per <b>period of cover</b> (only if selected by <b>your employer</b>)</p>	<p><span style="color: orange;">●</span> Cover up to US\$750 or £500 or €563 per <b>period of cover</b></p> <p>—</p> <p><span style="color: blue;">●</span> Cover up to US\$1,300 or £860 or €975 per <b>period of cover</b> (only if selected by <b>your employer</b>)</p>
<p><b>Vaccinations for adults</b>          Immunisations and booster injections required under regulation of the country in which <b>treatment</b> is being given, and any <b>medically necessary</b> travel vaccinations and malaria prophylaxis.</p>	<p><span style="color: red;">●</span> No cover</p>	<p><span style="color: orange;">●</span> Cover up to US\$150 or £100 or €113 per <b>period of cover</b></p>	<p><span style="color: orange;">●</span> Cover up to US\$250 or £167 or €188 per <b>period of cover</b></p>
<p><b>Well-child benefit (12-month waiting period)</b>          Routine vaccinations and developmental check-ups for children.</p>	<p><span style="color: red;">●</span> No cover</p>	<p><span style="color: orange;">●</span> Cover up to US\$200 or £133 or €150 per <b>period of cover</b></p>	<p><span style="color: orange;">●</span> Cover up to US\$400 or £260 or €300 per <b>period of cover</b></p>

**Key** ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Bronze	Silver	Gold
<b>Chronic conditions</b>			
<b>Acute flare-ups</b> Short-term <b>treatment</b> to treat acute flare-ups of a <b>chronic condition</b> covered by <b>your plan</b> .	○ Cover for <b>in-patient, day-patient and post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b> .	○ Full cover	○ Full cover
<b>Monitoring and maintenance</b> Regular consultations, tests, and prescribed medication required to monitor and maintain the stability of a <b>chronic condition</b> .	○ No cover	○ Full cover	○ Full cover
<b>Rehabilitation treatment</b>			
Important notes:			
• <b>You</b> must obtain pre-authorisation for this benefit.			
<b>Rehabilitation treatment you</b> receive as an <b>in-patient</b> , carried out under the control and supervision of a <b>specialist</b> in a recognised <b>rehabilitation hospital or unit</b> , and only when it immediately follows <b>in-patient treatment</b> for illness or injury covered by <b>your plan</b> .  This benefit is payable only when the admission takes place on the written recommendation of <b>your treating specialist</b> and the admission must take place immediately following <b>your</b> discharge from <b>hospital</b> .	○ Cover for up to 7 days per medical condition	○ Cover for up to 15 days per medical condition	○ Cover for up to 30 days per medical condition
<b>Home nursing costs</b>			
Important notes:			
• <b>You</b> must obtain pre-authorisation for this benefit.			
The medical services of a <b>qualified nurse</b> to treat <b>you</b> in <b>your</b> own home when it is <b>medically necessary</b> and relates directly to an illness or injury covered by <b>your plan</b> .	○ Cover for up to 12 weeks per medical condition	○ Cover for up to 12 weeks per medical condition	○ Cover for up to 12 weeks per medical condition
<b>Lifetime care</b>			
Important notes:			
• <b>You</b> must obtain pre-authorisation for all benefits included in this section.			
<b>Lifetime limit for all lifetime care</b> The overall maximum limit to the amount <b>you</b> can <b>claim</b> during <b>your</b> lifetime for all benefits within the lifetime care benefit section.	US\$25,000 or £16,600 or €18,750	US\$50,000 or £33,300 or €37,500	US\$100,000 or £66,600 or €75,000
<b>Hospice and palliative care</b> On diagnosis of a <b>terminal medical condition</b> covered by <b>your plan</b> , all costs for <b>treatment</b> received on the advice of a <b>medical practitioner</b> or <b>specialist</b> for the purpose of offering relief of symptoms. This includes all <b>hospital</b> or hospice accommodation, and nursing care by a <b>qualified nurse</b> .	○ Cover up to the lifetime limit for lifetime care	○ Cover up to the lifetime limit for lifetime care	○ Cover up to the lifetime limit for lifetime care







**Key**  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Bronze	Silver	Gold
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**Lifetime care (continued)**

Important notes:




- **You** must obtain pre-authorisation for all benefits included in this section.

<p><b>Artificial life maintenance</b>  <b>Treatment you</b> require after <b>you</b> have already been on <b>artificial life maintenance</b> for 8 weeks.</p>	 Cover up to the lifetime limit for lifetime care	 Cover up to the lifetime limit for lifetime care	 Cover up to the lifetime limit for lifetime care
<p><b>Persistent vegetative state and neurological damage</b>  <b>Treatment you</b> require after <b>you</b> have been in <b>hospital</b> for 8 weeks for permanent neurological damage or if <b>you</b> are in a persistent <b>vegetative state</b>.</p>	 Cover up to the lifetime limit for lifetime care	 Cover up to the lifetime limit for lifetime care	 Cover up to the lifetime limit for lifetime care

**Optical care**

Important notes:

- **You** are eligible for the benefits in this section only if they have been selected by **your employer**.

<p>We will pay up to US\$200 or £133 or €150 per <b>period of cover</b> for an annual optical test. Within this benefit, we will pay for lenses and contact lenses only upon a change of prescription.</p> <p>We do not pay for LASIK eye surgery or any other surgical correction of short-sightedness (myopia), long-sightedness (hyperopia) or irregular-shaped cornea (astigmatism).</p> <p><b>You</b> are eligible for the optical care benefit only if it has been selected by <b>your employer</b>.</p>	 Covered up to US\$200 or £133 or €150 per <b>period of cover</b> (only if selected by <b>your employer</b> )	 Covered up to US\$200 or £133 or €150 per <b>period of cover</b> (only if selected by <b>your employer</b> )	 Covered up to US\$200 or £133 or €150 per <b>period of cover</b> (only if selected by <b>your employer</b> )
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**Dental costs**

Important notes:

- **You** are eligible for certain benefits in this section only if they have been selected by **your employer**.
- All **dental treatment** must be carried out by a **dentist** in a **hospital** emergency room or dental surgery.
- **Treatment** for damaged crowns, dentures, bridge work or false teeth is only covered under the Dental Plus benefit.
- We do not cover orthodontic consultations or **treatment** of any kind.

<p><b>Emergency restorative treatment you receive as an in-patient</b>  <b>In-patient treatment</b> required to restore sound and natural teeth following an <b>accident</b> covered by <b>your plan</b>, provided that <b>treatment</b> is received within 15 days of the <b>accident</b>.</p>	 Full cover	 Full cover	 Full cover
<p><b>Emergency restorative treatment you receive as an out-patient</b>  <b>Out-patient treatment</b> required to treat or replace sound and natural teeth which are lost or damaged following an <b>accident</b>, provided that <b>treatment</b> is received within 72 hours of the <b>accident</b>.</p>	 No cover	 Cover up to US\$500 or £330 or €375 per <b>period of cover</b>	 Cover up to US\$1,000 or £660 or €750 per <b>period of cover</b>








**Key**  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Bronze	Silver	Gold
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**Dental costs (continued)**

Important notes:

- **You** are eligible for certain benefits in this section only if they have been selected by **your employer**.
- All **dental treatment** must be carried out by a **dentist** in a **hospital** emergency room or dental surgery.
- **Treatment** for damaged crowns, dentures, bridge work or false teeth is only covered under the Dental Plus benefit.
- **We** do not cover orthodontic consultations or **treatment** of any kind.

<p><b>Dental Basic (6-month waiting period)</b>            We will pay for the following basic dental costs:</p> <ul style="list-style-type: none"> <li>• screening (e.g. the checking for or the assessment of any diseased, missing, and filled teeth, including X-rays where necessary) twice per year</li> <li>• scaling, polishing, and sealing twice per year</li> <li>• fillings (both composite and amalgam)</li> <li>• simple extractions</li> <li>• root canal <b>treatment</b></li> </ul> <p>The Dental Basic benefit on the Silver <b>plan</b> is limited to US\$1,000 or £660 or €750, or US\$1,500 or £1,000 or €1,125, depending on which option <b>your employer</b> has selected. <b>You</b> are not eligible for cover if neither option is selected.</p>	<p> No cover</p>	<p> Cover up to US\$1,000 or £660 or €750 per <b>period of cover</b>, subject to 10% <b>co-insurance</b> (only if selected by <b>your employer</b>)</p> <hr/> <p> Cover up to US\$1,500 or £1,000 or €1,125 per <b>period of cover</b>, subject to 10% <b>co-insurance</b> (only if selected by <b>your employer</b>)</p>	<p> Cover up to US\$1,500 or £1,000 or €1,125 per <b>period of cover</b></p>
<p><b>Dental Plus (12-month waiting period)</b>            We will pay for the following advanced dental costs:</p> <ul style="list-style-type: none"> <li>• denture repair</li> <li>• full/partial dentures</li> <li>• dental bridges</li> <li>• crowns, inlays, and onlays</li> <li>• dental implants</li> </ul> <p>This benefit is optional on the Silver and Gold <b>plans</b>. <b>You</b> are not eligible for cover if neither option is selected by <b>your employer</b>.</p>	<p> No cover</p>	<p> Cover up to US\$1,500 or £1,000 or €1,125 per <b>period of cover</b>, subject to 10% <b>co-insurance</b> (only if selected by <b>your employer</b>)</p>	<p> Cover up to US\$2,000 or £1,330 or €1,500 per <b>period of cover</b>, subject to 10% <b>co-insurance</b> (only if selected by <b>your employer</b>)</p>


















**Key** ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Bronze	Silver	Gold
<p><b>Maternity costs</b> Important notes:</p> <ul style="list-style-type: none"> <li>• <b>You</b> are eligible for certain benefits in this section only if they have been selected by <b>your employer</b>.</li> <li>• Dependant children included in <b>your plan</b> are not eligible for these benefits.</li> <li>• <b>We</b> do not cover the <b>treatment</b> of any newborn child born following <b>assisted reproduction</b> (e.g. IVF) in the event of the birth occurring within 36 weeks of conception.</li> <li>• Any charges incurred during normal childbirth (including a <b>planned caesarean section</b>) will be paid from the routine maternity care and childbirth benefit.</li> <li>• <b>We</b> do not cover pregnancy testing, or pre-natal classes and doulas.</li> <li>• <b>We</b> do not cover termination of pregnancy or any <b>treatment</b> or investigations that arise as a result of complications relating to termination of pregnancy.</li> </ul>			
<p><b>Routine maternity care and childbirth (10-month waiting period)</b> <b>We</b> will pay for the following routine maternity costs:</p> <ul style="list-style-type: none"> <li>• pre-natal tests and examinations</li> <li>• post-natal <b>treatments</b> and examinations</li> <li>• natural childbirth</li> <li>• childbirth by <b>planned caesarean section</b></li> <li>• home birth, where a midwife is present</li> <li>• supplements and vitamins as recommended by a <b>medical doctor</b></li> </ul> <p>The limits shown for this benefit apply to each pregnancy, regardless of the number of children born. Any <b>hospital</b> or birthing centre accommodation costs will be limited to the cost of a standard room. The routine maternity care and childbirth benefit on the Silver <b>plan</b> is limited to US\$5,000 or £3,330 or €3,750, or US\$7,500 or £5,000 or €5,625, or US\$10,000 or £6,660 or €7,500, depending on which option <b>your employer</b> has selected. <b>You</b> are not eligible for cover if no option is selected.</p>	<span style="color: red;">○</span> No cover	<ul style="list-style-type: none"> <li><span style="color: blue;">○</span> Cover up to US\$5,000 or £3,330 or €3,750 per pregnancy, subject to 20% <b>co-insurance</b> (only if selected by <b>your employer</b>)</li> <li><span style="color: blue;">○</span> Cover up to US\$7,500 or £5,000 or €5,625 per pregnancy, subject to 20% <b>co-insurance</b> (only if selected by <b>your employer</b>)</li> <li><span style="color: blue;">○</span> Cover up to US\$10,000 or £6,660 or €7,500 per pregnancy, subject to 20% <b>co-insurance</b> (only if selected by <b>your employer</b>)</li> </ul>	<ul style="list-style-type: none"> <li><span style="color: orange;">○</span> Cover up to US\$15,000 or £10,000 or €11,250 per pregnancy</li> </ul>
<p><b>Complications of pregnancy (10-month waiting period)</b> <b>In-patient</b> or <b>day-patient treatment</b> necessary as a direct result of a <b>complication of pregnancy</b>.</p> <p><b>We</b> do not provide cover under this benefit arising from a pregnancy established through <b>assisted reproduction</b> (e.g. IVF) until after the standard 12-week scan, irrespective of how long <b>you</b> have been covered by the <b>plan</b>.</p> <p>The benefit limit on the Silver <b>plan</b> is extended to full cover if the complex maternity option is selected by <b>your employer</b>.</p>	<ul style="list-style-type: none"> <li><span style="color: orange;">○</span> Cover up to US\$4,800 or £3,200 or €3,600 per <b>period of cover</b></li> </ul>	<ul style="list-style-type: none"> <li><span style="color: orange;">○</span> Cover up to US\$15,000 or £10,000 or €11,250 per <b>period of cover</b></li> <li><span style="color: blue;">○</span> Full cover (only if selected by <b>your employer</b>)</li> </ul>	<span style="color: green;">○</span> Full cover






**Key** ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Bronze	Silver	Gold
<p><b>Maternity costs (continued)</b> Important notes:</p> <ul style="list-style-type: none"> <li>• <b>You</b> are eligible for certain benefits in this section only if they have been selected by <b>your employer</b>.</li> <li>• Dependant children included in <b>your plan</b> are not eligible for these benefits.</li> <li>• <b>We</b> do not cover the <b>treatment</b> of any newborn child born following <b>assisted reproduction</b> (e.g. IVF) in the event of the birth occurring within 36 weeks of conception.</li> <li>• Any charges incurred during normal childbirth (including a <b>planned caesarean section</b>) will be paid from the routine maternity care and childbirth benefit.</li> <li>• <b>We</b> do not cover pregnancy testing, or pre-natal classes and doulas.</li> <li>• <b>We</b> do not cover termination of pregnancy or any <b>treatment</b> or investigations that arise as a result of complications relating to termination of pregnancy.</li> </ul>			
<p><b>Childbirth necessitating an emergency surgical procedure (10-month waiting period)</b> Surgeons', anaesthetists' and theatre fees for childbirth that necessitates an emergency surgical procedure and any additional accommodation charges incurred as the result of the surgical procedure. This includes childbirth by <b>emergency caesarean section</b>. Cover on the Silver <b>plan</b> is only available if the complex maternity option is selected by <b>your employer</b>.</p>	<span style="color: red;">○</span> No cover	<span style="color: blue;">○</span> Cover up to US\$20,000 or £13,330 or €15,000 per pregnancy (only if selected by <b>your employer</b> )	<span style="color: green;">○</span> Full cover
<p><b>Cover for newborn babies (10-month waiting period)</b> <b>We</b> will pay the following costs during <b>your</b> baby's first 90 days of life provided <b>you</b> have been insured by the Silver or Gold <b>plan</b> for a period of 10 continuous months at the baby's date of birth:</p> <ul style="list-style-type: none"> <li>• <b>treatment your</b> newborn baby receives as an <b>in-patient</b> or <b>day-patient</b> (including <b>treatment</b> of birth defects and congenital or hereditary conditions)</li> <li>• accommodation costs for one parent to stay with the newborn baby if the baby is hospitalised</li> <li>• any <b>hospital</b> accommodation costs for the newborn baby</li> <li>• basic newborn healthcare (physical examination, Vitamin K, hepatitis B vaccine, BCG vaccine, one hearing test, and blood tests for PKU, congenital hypothyroidism and G6PD)</li> </ul> <p>The limits shown apply to each pregnancy, regardless of the number of children born. The benefit limit on the Silver <b>plan</b> is extended if the complex maternity option is selected by <b>your employer</b>.</p>	<span style="color: red;">○</span> No cover	<span style="color: orange;">○</span> Cover up to US\$10,000 or £6,600 or €7,500 per pregnancy  <span style="color: blue;">○</span> Cover up to US\$50,000 or £33,300 or €37,500 per pregnancy (only if selected by <b>your employer</b> )	<span style="color: orange;">○</span> Cover up to US\$100,000 or £66,600 or €75,000 per pregnancy

**Key**  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Bronze	Silver	Gold
<p><b>Expat benefits</b> Important notes:</p> <ul style="list-style-type: none"> <li>• <b>You</b> are eligible for certain benefits in this section only if they have been selected by <b>your employer</b>.</li> <li>• <b>You</b> must obtain pre-authorisation for all benefits included in this section.</li> </ul>			
<p><b>24-hour medical assistance helpline</b> If <b>you</b> have a medical emergency which requires immediate medical assistance, <b>you</b> must contact <b>our</b> 24-hour helpline (provided by CEGA) at +44 (0) 1243 621155 or <a href="mailto:william.russell@cegagroup.com">william.russell@cegagroup.com</a>.</p>	 Full cover	 Full cover	 Full cover
<p><b>Medevac Basic</b> If <b>you</b> (or any child covered by the newborn benefit within its first 90 days of life) have a life-threatening or limb-threatening condition covered by <b>your plan</b> which requires immediate <b>in-patient treatment</b> that cannot be adequately provided locally, the <b>Assistance Service</b> will arrange for <b>you</b> to be moved by air and/or by surface transportation, to the nearest <b>hospital</b> within <b>your area of cover</b> where appropriate medical <b>treatment</b> is available. <b>We</b> do not cover any other costs under this benefit such as hotel accommodation charges. <b>We</b> do not cover emergency evacuation to, from or within the USA. The <b>Assistance Service</b> retains the absolute right to decide whether <b>your</b> medical condition is eligible for evacuation, where <b>you</b> are evacuated to and the means and method of the evacuation.</p>	 Full cover	 Full cover	 Full cover
<p><b>Return airfare</b> Following an emergency evacuation covered by <b>your plan</b>, <b>we</b> will pay for <b>your</b> economy return airfare to <b>your country of residence</b>.</p>	 Full cover	 Full cover	 Full cover
<p><b>Expenses of a companion</b> The transportation costs of another person to accompany <b>you</b> on <b>your</b> emergency evacuation, and their economy class ticket back. If it is not possible for them to accompany <b>you</b> on <b>your</b> medical evacuation because of the method of evacuation, <b>we</b> will pay either for their economy class round-trip airfare on a scheduled flight, or their suitable round-trip surface transportation, whichever is the most appropriate. If <b>your</b> companion is then staying with <b>you</b> while <b>you</b> are hospitalised following <b>your</b> evacuation, <b>we</b> will pay towards the costs of their hotel accommodation up to US\$72 per night on the Bronze <b>plan</b>, US\$96 per night on the Silver <b>plan</b>, and US\$250 per night on the Gold <b>plan</b> (limited to a maximum of 15 nights per <b>period of cover</b>).</p>	 Full cover	 Full cover	 Full cover
<p><b>Compassionate home visit (12-month waiting period)</b> If a <b>close family member</b> dies during <b>your period of cover</b> and after <b>you</b> have been insured by <b>your plan</b> for a continuous period of 12 months, <b>we</b> will pay for <b>your</b> round-trip economy airfare to attend the funeral. <b>Your</b> travel must take place within 28 days of the date of death.</p>	 Lifetime limit of one claim per insured person	 Lifetime limit of one claim per insured person	 Lifetime limit of one claim per insured person

Key  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Bronze	Silver	Gold
<b>Expat benefits (continued)</b>			
Important notes:			
<ul style="list-style-type: none"> <li><b>You</b> are eligible for certain benefits in this section only if they have been selected by <b>your employer</b>.</li> <li><b>You</b> must obtain pre-authorisation for all benefits included in this section.</li> </ul>			
<p><b>Repatriation of mortal remains</b></p> <p>If <b>you</b> die as the result of a condition that is covered by <b>your plan</b> while <b>you</b> are outside <b>your country of nationality</b>, we will pay for <b>your</b> body or ashes to be transported to <b>your country of nationality</b> or <b>country of residence</b>.</p> <p>This benefit is not available if a <b>claim</b> is made for the burial or cremation benefit at the place where <b>you</b> died.</p>	 Full cover	 Full cover	 Full cover
<p><b>Burial or cremation</b></p> <p>If <b>you</b> die as the result of a condition that is covered by <b>your plan</b> while <b>you</b> are outside <b>your country of nationality</b>, we will pay for <b>you</b> to be buried or cremated at the place where <b>you</b> died.</p> <p>This benefit is not available if a <b>claim</b> is made under the repatriation of mortal remains benefit.</p> <p><b>We</b> do not provide cover under this benefit if <b>you</b> die in <b>your country of nationality</b>.</p> <p><b>We</b> do not provide cover under this benefit for the costs of a religious practitioner.</p>	 Cover up to US\$1,600 or £1,060 or €1,200	 Cover up to US\$1,600 or £1,060 or €1,200	 Cover up to US\$1,600 or £1,060 or €1,200
<p><b>Medevac Plus</b></p> <p>The following benefits apply in addition to those under the Medevac Basic benefit.</p> <p>Evacuation if <b>you</b> (or any child covered by the newborn benefit within its first 90 days of life) need <b>advanced imaging</b> or cancer <b>treatment</b> such as radiotherapy or chemotherapy that cannot be adequately provided locally.</p> <p>All eligible evacuations will include repatriation to <b>your country of nationality</b> if it is within <b>your area of cover</b>, or to <b>your country of residence</b>. <b>We</b> do not cover emergency evacuation or repatriation to, from or within the USA.</p> <p>If <b>you</b> request repatriation to <b>your country of nationality</b> or to <b>your country of residence</b>, it may, in some cases, not be appropriate immediately due to <b>your</b> medical condition. In such cases, <b>we</b> will first evacuate <b>you</b> to the nearest place within <b>your area of cover</b> where appropriate <b>treatment</b> is available. Once <b>you</b> have been stabilised, <b>we</b> will then repatriate <b>you</b> to <b>your country of nationality</b> if it is within <b>your area of cover</b>, or <b>your country of residence</b>.</p> <p>If <b>you</b> are evacuated to a country which is not <b>your country of residence</b> and not <b>your country of nationality</b>, and <b>you</b> do not have anyone to accompany <b>you</b>, <b>we</b> will pay the economy class round-trip airfare to have one companion flown from anywhere in the world to be with <b>you</b> while <b>you</b> receive <b>your treatment</b>. <b>We</b> will also pay up to US\$150 per day (for a maximum of 30 days per <b>period of cover</b>) towards their hotel accommodation expenses whilst <b>you</b> have <b>your treatment</b>, or until the date on which <b>you</b> return to your <b>country of nationality</b> or your <b>country of residence</b> (whichever is the sooner).</p> <p>Cover is only available if the Medevac Plus option is selected by <b>your employer</b>.</p>	 Full cover (only if selected by <b>your employer</b> )	 Full cover (only if selected by <b>your employer</b> )	 Full cover (only if selected by <b>your employer</b> )

# What you are not covered for

The following are not covered by **your plan**, as well as any specific exclusions stated on **your certificate of insurance**, and other exclusions stated within the **table of benefits**. Other benefits, as stated 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 of **treatment** of any excluded condition will also not be covered.

**We** will also not pay for the fees and charges listed below. **You** will be responsible for them.

- fees for the completion, or providing of, claim forms or any other medical reports or forms such as **medical referral letters**, even if **we** have requested them
- 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 or disorders, and alcohol, drug, and solvent abuse

**You** are not covered for **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

**You** are not covered for **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

**You** are not covered for alternative **treatment** and therapies, including, but not limited to, aqua physiotherapy, bone-setting, colonic irrigation, hydrotherapy, Intervertebral Differential Dynamics (IDD), kinesiology, naturotherapy, Ayurveda and massage therapy.

## Artificial life maintenance

**You** are not covered for **artificial life maintenance**, other than any benefit **you** are eligible for under the lifetime care benefit.

## Birth control, sexual problems and gender reassignment

**You** are not covered for **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

**You** are not covered for **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

**You** are not covered for **treatment** related to circumcision, unless it is required for **treatment** of an **acute medical condition** covered by **your plan**.

## Convalescence, rehabilitation, nursing homes, and health spas or hydros

**You** are not covered for:

- **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

Other than treatment **you** are eligible for under the rehabilitation **treatment** benefit.

## Cosmetic surgery and treatment

**You** are not covered for 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

**You** are not covered for **treatment** arising from or related to injuries sustained while **you** are engaged in a criminal, illegal or unlawful act.

## Development, learning difficulties, speech disorders, and behavioural problems

**You** are not covered for consultations, tests required to diagnose, or **treatment** of or related to:

- developmental delays
- learning and education 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 of any kind
- teething

## Dietitian

**You** are not covered for **treatment** or advice by a dietitian or nutritionist. Please note however this may be covered following a diagnosis of cancer. Please see the dietitian benefit within the cancer **treatment** section of the **table of benefits**.

## Experimental drugs and treatments

**You** are not covered for **treatment** or medicine which in **our** reasonable opinion is experimental or unproven based on generally acceptable current clinical evidence and generally accepted medical practice.

## Eyesight

**You** are not covered for:

- **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); however, lenses and contact lenses may be covered under the optional optical care benefit
- sight tests. Please note, however, that sight tests may be covered under the wellness benefit or the optional optical care benefit

## Failure to follow medical advice

**You** are not covered for:

- **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

**You** are not covered for surgery undertaken on a child while it is in its mother's womb.

## Genetic testing or genetic engineering

**You** are not covered for genetic testing or genetic engineering, other than **treatment you** are eligible for under the cancer genome

tests benefit within the cancer **treatment** benefit section of the **table of benefits**.

## Hearing

**You** are not covered for:

- **treatment** for or arising from deafness caused by maturing or ageing
- **treatment** for or arising from deafness caused by a **congenital condition** if either the abnormality was diagnosed, or **you** were showing signs or symptoms of the abnormality, before **your date of entry**. Please note, however, that this may be covered for newborn children during their first 90 days of life under the cover for newborn babies benefit
- hearing aids
- hearing tests (unless covered under **your plan** in the well-being benefit section of the **table of benefits**)

## Learning and educational difficulties

**You** are not covered for learning and educational difficulties, including, but not limited to, dyslexia and speech disorders.

## Infertility, IVF, and assisted reproduction

**You** are not covered for:

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

## Menopause and puberty

**You** are not covered for:

- **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). Please note however this may be covered under the hormone replacement therapy benefit within the everyday medical costs section of the **table of benefits** if **you** suffer loss of ovarian function before the age of 40

## Nasal septum deviation

**You** are not covered for **treatment** related to nasal septum deviation and nasal concha resection.

## Palliative care

**You** are not covered for palliative care other than cover available to **you** for the palliative care of a **terminal medical condition** under the lifetime care benefits section of the **table of benefits**.

## Persistent vegetative state and neurological damage

**You** are not covered for **treatment** received after:

- **you** have been in a **vegetative state** for a period of eight weeks
- **you** have sustained permanent neurological damage and remained in **hospital** for a period of eight weeks

Except for any **treatment you** are eligible for under the lifetime care benefit.



## Pre-existing medical conditions or related conditions

**You** are not covered for **treatment** related to:

- any **pre-existing medical conditions** and **related conditions** which **you** have had during the five years before **your date of entry**, unless **we** have agreed otherwise
- 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
  - joint replacements

## Preventive surgery

**You** are not covered for 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

**You** are not covered for **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

## Scalp conditions

**You** are not covered for:

- **treatment** specifically related to scalp conditions, including, but not limited to, alopecia
- wigs (please note however this may be covered following chemotherapy – see the wigs benefit of the **table of benefits**)

## Search and/or rescue

**You** are not covered for:

- 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

**You** are not covered for second or subsequent opinions from a **medical doctor**, **medical practitioner** or **specialist** or for duplicate tests for the same condition.

## Self-inflicted injuries

**You** are not covered for **treatment** of self-inflicted injuries or **treatment** of any injury or illness directly or indirectly caused by self-inflicted injuries.

## Sexually transmitted diseases

**You** are not covered for **treatment** related to sexually transmitted diseases including genital/anal warts.

## Sleep disorders

**You** are not covered for **diagnostic tests** for or **treatment** of any sleep related disorder, including, but not limited to, insomnia, snoring and sleep apnoea.

## Stem-cell harvesting

**You** are not covered for stem cell harvesting other than prior to a stem cell transplant, or any **treatment** undertaken in anticipation of, prior to, or following such harvesting.

## Sundry medical supplies

**You** are not covered for non-prescribed items such as hot and cold packs and support bandages, unless these are required as a result of **treatment** received during a medical emergency.

## Travel costs

**You** are not covered for travel costs including airfares and hotel accommodation, unless specifically covered under the expat benefits section of the **table of benefits**.

## Treatment by a related party

**You** are not covered for **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
- any **medical services provider**, **medical practitioner** or **specialist** where the **insured person** has a financial interest and/or a professional interest, including, but not limited to, **employees**, **employers**, consultants and owners

## Vitamins, dietary supplements, natural substances, and creams

**You** are not covered for commercially available substances that can be purchased without prescription, including, but not limited to, vitamins, minerals, organic substances, moisturisers, oils, creams, or other pharmaceutical products, other than any **treatment** available to **you** under the routine maternity care and childbirth benefit within the maternity costs benefits section of the **table of benefits**.

## War and terrorism

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

## Weight-related conditions and eating disorders

**You** are not covered for 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**

**You** are not covered for **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.

# If you need to make 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**.

## If you have cover for temporary trips to the USA and you seek treatment there

All **treatment** **you** receive in the USA must be pre-authorised in advance by **us** or by the **Assistance Service**. **We** will not pay for any **treatment** in the USA that has not been pre-authorised, other than the first consultation.

If **we** instruct a local agent to arrange the billing and/or cost adjustment of **your** medical **treatment** expenses in the USA, any fees charged by the local agent will be deducted from the USA benefit limit available under **your plan**, as stated in the '**Your area of cover**' section of this **agreement**.

## 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** more than 48 hours in advance.

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**.

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 24 hours of **your** admission. If **you** do not contact **us** within 24 hours, **we** may decline **your claim**, or subject **your claim** to 20% **co-insurance**.

## If you have out-patient treatment

Although most **out-patient 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 and receipts for the **treatment** **you** have received, and send to [claims@william-russell.com](mailto: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 and receipts 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, receipts and claim forms for 12 months. **We** may require these for auditing purposes.

Claim forms are not required however when **you** are claiming for the following benefits:

**Well-being and dental claims:** If **you** are claiming for the well-being benefit, or dental benefit please send **us** the fully itemised invoices and receipts for which **you** are claiming reimbursement, together with **your** bank account details.

**Compassionate home visit claims:** If **you** are claiming for the compassionate home visit benefit please send **us** a copy of the death certificate of **your close family member**, together with a copy of the invoice for **your** round-trip airfare, stating the class of travel, and **your** bank account details.

## Claims for which a medical referral letter is required

If **you** are claiming for **out-patient** physiotherapy, any **treatment** by a chiropractor, osteopath or podiatrist, **out-patient** psychiatric or psychotherapy **treatment**, a dietitian consultation 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](mailto: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 any invoices received by **us** more than 12 months after the **treatment** date.

**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, and 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. If **you** provide **us** with incorrect payment details and **we** cannot recover the payment, **we** will not make the payment again to **you**.

**We** will only make payment to **you** or to the **medical services provider** that provided **your treatment**. Payment will not be made for **treatment** that has not been received yet.

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.

## Using the direct billing service

To be eligible to receive the direct billing service, **your employer** must have completed an application for this service on **your** behalf and paid any additional **premium** invoiced by **us**.

If you are eligible for the direct billing service this will be stated on **your certificate of insurance**, and **you** will be issued with a membership card which bears the letters 'DB'. This card, together with photographic identification, will enable **you** to receive eligible **treatment** at **direct billing medical services providers** within **our medical network**. The **direct billing medical services provider** will bill **us** directly for **your treatment**.

If the cost of **your treatment** is greater than US\$500, the **direct billing medical services provider** will contact **us** for pre-authorization of the **treatment**. To avoid delays, **we** recommend that **you** contact **us** in advance of **your treatment**. Once **we** have verified that the **treatment** is eligible for cover, **we** will let the **direct billing medical services provider** know.

It is important to note that the **direct billing medical services provider** is not aware of the terms and benefits provided by **your plan**. They will provide **treatment** in accordance with a separate agreement between **us** and them.

This means that, for **claims** of less than US\$500 where the **direct billing medical services provider** is not obliged to contact **us** for pre-authorization, it is **your** responsibility to claim only for **treatment** that is eligible for cover under **your plan**.

**We** have an obligation to settle all bills for **treatment** received from **direct billing medical services providers** within **our medical network**, provided that they fall within the terms of the contract between **us** and them.

If **you** receive **treatment** for a medical condition that is not covered by **your plan**, **we** will invoice **you** for the ineligible expenses **you** have claimed. If **you** do not repay to **us** these ineligible expenses within 30 days, **we** will withdraw the direct billing service from **you** and **we** will not renew **your plan**.

If **you** cancel **your plan**, **you** must return **your** membership card

to **us**. **We** will cancel **your** cover with effect from the date **we** receive **your** membership card. **We** can accept a photograph of a cut card.

The membership cards are **our** property and **we** can ask **you** to return the cards to **us** at any time.

## Exchange rates

**We** will settle **your claim** in the currency in which **your employer** pays **your premium** unless **you** instruct **us** otherwise. If **we** have to make a currency conversion, **we** will use the historic exchange rate (provided by [anda.com](http://anda.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 [anda.com](http://anda.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 claim** is in respect of the well-being benefits, **your excess** will be applied once per **period of cover**.

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 request additional medical information to enable **us** to assess **your claim**, such as medical reports or tests. These must be provided at **your** own expense. **We** may also request an independent medical examination. If **you** do not agree to supply **us** with additional medical information that **we** reasonably request, **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**.

# Other information about your plan

## 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 while **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 **your 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**.

## Changing your cover

Any changes to **your** cover must be requested by **your employer**, and may be subject to further requirements such as requiring **you** to complete a new **application form** which will be subject to **medical underwriting**. We cannot accept requests from **you** to change cover for **you** or **your** dependants.

## 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. If **you** have been insured with **us** for a continuous period of ten months or more at the date of birth, the **date of entry** can be backdated to 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**.

If **your** newborn child is not added to **your plan** they may still have some cover under **your plan** for their first 90 days of life. Please see the newborn babies benefit for full details.

## In the event of the death of an insured person

If **you** (the **employee**) die and have **eligible dependants** insured under **your 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 the required **premium**, 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 anyway 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 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**.



## When a child dependant is no longer eligible to be covered under the 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 country of 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 country of nationality**, **you** must tell **us** straight away.

If **you** have a restricted **area of cover** and **you** move to a country outside **your area of cover**, **your employer** must apply to change **your area of cover**. **Your** application will be subject to **medical underwriting**.

## If the USA is or becomes your country of residence

Under the terms of this **agreement** cover is not available to **you** if the USA is or becomes **your country of residence**, irrespective of **your** nationality. If the USA becomes **your country of residence** **you** must tell **us**. **Your** cover will automatically terminate from the date on which **you** take up residence in the USA.

## If you leave your employment

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**.

## When we can cancel your plan

**We** have the right to cancel **your plan** immediately 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 on 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
- **you**, any **insured person** or any person acting on **your** behalf has made any threatening or abusive comment, or used any unacceptable language towards **us** or any member of **our** staff, or any service provider acting on **our** behalf, whether verbally (including any telephone conversation) or in writing (including any electronic communication)
- **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:
  - making a **claim** under this policy knowing it to be dishonest, intentionally exaggerated or fraudulent in any way
  - providing **us** with incomplete or false information
  - working with another party to provide false information to **us**
  - changing original documents

If **we** cancel **your plan** for any of the above reasons **we** may also report the matter to the relevant authorities, if appropriate.

## 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**.

## 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 **country of nationality**

# How to make a complaint

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At William Russell, each one of **our** customers is important to **us**. We believe that **you** have the right to professional customer service of the highest quality at all times. If you think **we** have fallen short of this standard, please follow the procedures outlined below.

If **you** are not happy with the service **you** have received, **you** may write to **us** at any time at the following address:

**William Russell Ltd.**  
William Russell House  
The Square, Lightwater  
Surrey, GU18 5SS, UK

**Tel** +44 1276 486455

**Fax** +44 1276 486466

**Email:** [enquiries@william-russell.com](mailto:enquiries@william-russell.com)

We will acknowledge receipt of **your** complaint within 2 working days. We will investigate **your** complaint and send a response to **you** within 4 weeks of the receipt of your complaint. If **we** are unable to provide **you** with a final response within this time period, **we** will write to **you** advising **you** of when **we** will be able to respond. We will endeavour to send a final response to **you** within 8 weeks of the receipt of **your** complaint. If **we** are unable to provide **you** with a final response within this time period, **we** will write to **you** again explaining why and advising **you** of when **you** may expect a final response.

William Russell Ltd. acts on behalf of the **insurer** of **your plan** in respect of policy administration and **claims** handling. If **your** complaint relates to a decision **we** have made on behalf of **our insurer** (e.g. a decision regarding a **claim** you have made), **you** can write to the **insurer** at any stage in the process.

## **AWP Health & Life S.A.**

Customer Relationships  
Eurosquare 2  
7 rue Dora Maar  
93400 Saint Ouen  
France

**Email** [client.care@allianzworldwidecare.com](mailto:client.care@allianzworldwidecare.com)

AWP Health & Life S.A. is a signatory to the French Insurance Mediation charter. In the event of a persistent and definitive disagreement, the **plan holder** has the option, after the exhaustion of all domestic remedies referred to above, to call for the French Insurance Mediator without prejudice to possibilities of legal action.

## **La Médiation de l'assurance**

TSA 50 110  
75441 Paris Cedex 09  
France

**Web** [mediation-assurance.org](http://mediation-assurance.org)

If **your** complaint relates to a service provided by William Russell Ltd. and **you** have not received a response from **us** within 8 weeks of **our** receipt of **your** initial complaint, or **you** are dissatisfied with the final response **you** have received from **us**, **you** may write to the UK Financial Ombudsman Service.

## **The Financial Ombudsman Service (FOS)**

Exchange Tower  
London E14 9SR

**Tel** +44 800 023 4 567

**Fax** +44 020 7964 1001

**Email** [complaint.info@financial-ombudsman.org.uk](mailto:complaint.info@financial-ombudsman.org.uk)

**Web** [financial-ombudsman.org.uk](http://financial-ombudsman.org.uk)

## **Arbitration and 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.



# How we process your information

We think it is important for all **our** customers to be made aware of what information **we**, as a data controller, hold about them and to have the reassurance of knowing that **we** will process their personal information fairly and securely. The following statements refer to the personal information of **yourself** and all other **insured persons on your plan**.

## The information we collect

We collect information **you** give **us** as part of **your application**, and in correspondence with **us** by phone, email, post or other means of communication. This information may include sensitive personal information, such as details of **your** physical and mental health.

In addition, **we** may receive information about **you** from third parties, such as those who provide services on **our** behalf. Failing to provide the personal information **we** require in order to underwrite and administer **your** plan, or to process **your claims**, could result in **your claims** being rejected or not being fully paid, or **your plan** being cancelled.

## How we use your personal information

We will only collect information that is necessary to provide **you** with the services **we** offer. These include:

- Underwriting and administration of **your plan**
- Processing **claims**
- **Our** business processes, such as auditing, business planning, and accounting
- Compliance with legal and regulatory obligations
- Research or statistical analysis to help **us** improve **our** services
- Communicating with **you**

By taking out a **plan** with **us**, you agree to **us** processing **your** personal information and sensitive personal information for the above purposes.

## Who we may share information with

We may disclose **your** personal information to selected third parties for the listed purposes above, including:

- Our providers of payment services
- Organisation (such as regulatory authorities) where **we** have a duty to disclose or share **your** personal information to comply with legal obligations
- Providers of research, marketing, and analysis services
- The **insurers** or reinsurers of your plan
- **Our** emergency Assistance Service providers
- **Your** insurance adviser (if **you** have appointed one)

**Your** information may be disclosed to other parties (such as 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, or to **your** representative (if **you** have chosen one). This will be done confidentially. Unless specifically instructed, correspondence about all **claims** (including those made by dependants) will be addressed to the **plan holder**. An insured dependant over the age of 16 has the right to confidentiality in relation to their **claims** and information. For them to exercise this right, they should 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 **we** can ensure that **we** only pay **our** proportion of the costs.

## How we keep, store, and dispose of your personal information

We hold **you** information in various forms, including electronic databases, computerised files, and paper files. Information may be held for a period after **your plan** ends with a view to preventing or detecting fraud, or as **we** are required to under UK law. When **we** dispose of **your** information, **we** will do so securely. **We** may continue to keep non-personally identifiable information for the purposes of research and statistical analysis to improve the services **we** offer.

## Where we store your personal information

The information **we** collect from **you** may be transferred to and stored at a destination outside the European Economic Area (EEA). It may also be processed by staff operating outside of the EEA who work for **us** or for one of **our** suppliers. By submitting **your** personal information, **you** agree to this transfer, storing, and processing. **We** will take all steps necessary to ensure that **your** information is treated securely and in accordance with this data protection notice.

## Marketing

**You** have the right to ask **us** not to process **your** information for marketing purposes. **We** will always inform **you** (before collecting **your** information) if **we** intend to use **your** information for such purposes. **You** can withdraw **your** consent for **us** to use **your** information in this way at anytime by sending **us** an email at [marketing@william-russell.com](mailto:marketing@william-russell.com).

## Obtaining a copy of the information we hold about you

**You** have a right to request a copy of the information **we** hold about **you**. **You** also have a right to restrict or object to how **we** use **your** information, or to request that any inaccurate information be corrected. To exercise any of these rights, please contact:

### Data Protection Officer

William Russell Ltd.  
William Russell House  
The Square, Lightwater  
Surrey, GU18 5SS, UK

Tel +44 1276 486455

Fax +44 1276 486466

Email: [enquiries@william-russell.com](mailto:enquiries@william-russell.com)

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 **medical practitioner**.  
If **you** believe **we** are not processing **your** personal data in accordance with the law, **you** can complain to the UK Information Commissioner's Office (ICO).

# 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.

## Africa & the Indian Subcontinent

Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde Islands, Central African Republic, Chad, Congo (Brazzaville), Djibouti, Egypt, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mayotte, Morocco, Mozambique, Namibia, Niger, Nigeria, Republic of Sudan, Rwanda, Sao Tome & Principe, Senegal, Sierra Leone, Somalia, South Africa, South Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, West Sahara, Zaire (Democratic Republic of Congo), Zambia, Zimbabwe, Ascension Island, St Helena, Equatorial Guinea and the Indian subcontinent countries of Afghanistan, Bangladesh, Bhutan, Myanmar, British Indian Ocean, Comoros, Heard Island, India, Maldives, Mauritius, Nepal, Pakistan, Seychelles and Sri Lanka.

## Agreement

The contents of this document, 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 or 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**.

## Artificial life maintenance

When you require medical equipment that assists or replaces important bodily functions, including mechanical ventilation, percutaneous endoscopic gastronomy (PEG), and nasal feeding.

## Assistance Service

The emergency assistance company contracted by **us** to provide assistance services to **plan** members at the time of **your claim**. The contact details for the **Assistance Service** can be found at the beginning of this **agreement**.

## Assisted reproduction

The use of medical techniques, including, but not limited to, in-vitro fertilisation (IVF) with or without intra-cytoplasmic sperm injection (ICSI), gamete intra-fallopian 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 or 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, the **plan** currency, **your area of cover**, **period of cover**, **date of entry**, **renewal date**, **excess** amount, **special terms**, **your country of residence**, **your country of nationality**, 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

## Claim

A course of **treatment** for a specific illness, injury, medical condition, dental condition or pregnancy, or the use of an expat benefit.

## Close family member

**Your** spouse, civil partner, a co-habiting partner, parent, brother, sister, child or grand-child.

## 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 post-natal 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.

## Direct billing medical services provider

A **hospital**, **out-patient** clinic or **medical doctor** with whom **we** hold a current direct billing agreement.

## 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**, that is immediately required if **you** suffer an **accident** or a sudden and unforeseen illness **you** have never suffered from before, which is not a **pre-existing medical condition**, or a **related condition**, or a condition for which **you** have a **personal medical exclusion**.

## Employee

**You**, the member the 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**.

## Country of nationality

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

## 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 (AWP Health & Life S.A.).

## 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.

## Lotus countries

Indonesia, Thailand, Vietnam, Malaysia, Laos, Cambodia, Brunei, Philippines, South Korea, Kazakhstan, Kyrgyzstan, Mongolia, Papua New Guinea, Tajikistan, Turkmenistan, Uzbekistan, and all countries within **Africa & the Indian Subcontinent**.

## 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 necessary and appropriate. The **treatment** must be:

- essential to diagnose or treat a patient's condition, illness or injury;
- consistent with the patient's symptoms, diagnosis or **treatment** of the underlying condition;
- in accordance with generally accepted medical practice and professional standards of medical care at the time;
- required for reasons other than the comfort or convenience of the patient or his or her physician
- proven and been demonstrated to have medical value, with international medical and scientific evidence of the effectiveness and safety of the **treatment**;
- considered to be the most appropriate type and level of **treatment** taking patient safety and cost effectiveness into

consideration;

- provided at an appropriate facility, in an appropriate setting, and at an appropriate level of care for the **treatment** of the patient's medical condition;
- provided only for an appropriate duration of time.

## 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, traditional Chinese 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 a fractured bone or dislocated joint by a **medical doctor**
- invasive surgical procedures
- invasive diagnostic procedures involving intra-arterial cannulation
- the use of endoscopic equipment

## Period of cover

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

## 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**.



## Plan or plan type

The Elite Bronze **plan**, or Silver **plan**, or Gold **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 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-admission tests

An **out-patient** assessment during which **your** health is assessed in order to confirm that **you** are medically fit to undergo the planned **treatment** and that **you** are sufficiently prepared for it. The assessment may include an electrocardiogram, blood and/or urine tests and a chest x-ray.

## 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, half-yearly, 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.

## Qualified nurse

A nurse whose name is currently on any official register of nurses maintained by a statutory nursing registration body within the country where **treatment** is provided.

## Reasonable and customary

The charge that would typically be made for **your treatment** by **medical services providers** in the country where **you** receive **your treatment**, and for the **medically necessary** length of stay required. 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. If the length of stay is not **reasonable**

**and customary**, we will only pay for the **medically necessary** length of stay required. In the event of a dispute, we will identify the amount typically charged for **your treatment** by obtaining comparable quotations from three other **medical services providers** in the country where **you** receive **your treatment**, 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.

## Rehabilitation hospital or unit

A medical facility licensed under the regulations of the country in which it operates and designed for patients who no longer need acute **hospital** care but who still require medical or nursing supervision and/or assistance with activities of daily living because of their medical disability.

## 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 medical 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 set beginning on page 6 which sets out the benefits covered by each **plan type**.

## Terminal medical condition

A condition that has become incurable and all the **treatments** given are to prolong life.

### 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 Ltd. on behalf of the **insurer**.

### Vegetative state

A state where there is no sign of awareness or any cognitive function, even if the person can open their eyes and/or breathe unaided. If the person is in a **vegetative state** for a continuous period of eight weeks, they will be considered to be in a persistent **vegetative state**.

### 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

Call us on +44 1276 486455  
or visit [william-russell.com](http://william-russell.com)