Employees

Health insurance plan agreement

For members insured under their company's health insurance policy and whose policy year starts on or between 01 January 2025 and 31 December 2025.

William Russell

Platinum Trusted Service Award 2024 feefo

Welcome to William Russell

We want to provide **you** with health insurance **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.

Your plan is insured under the **master policy** issued by the **William Russell Association for Health, Financial Protection and Well-Being (WRA)**, and **you** are eligible for cover under the **WRA's** contract of insurance with **us**.

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 describe **your** cover under the contract of insurance between the **WRA** 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 Europe SRL, on behalf of the **insurer**
- '**You**, **your**' – means **you** and all **members** 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**.

We are, of course, always at the end of a telephone to answer queries or deal with y**our claim**. **You** can find **our** contact details below.

William Russell

William Russell Europe SRL is the administrator of **your employer's policy**. William Russell Europe SRL is registered in Belgium with the Financial Services and Markets Authority as a mandated underwriter, acting on behalf of AWP Health & Life SA.

Allianz

The **insurer** of **your employer's policy** is AWP Health & Life SA, an insurance company in the Allianz group. AWP Health & Life SA has its registered address at Eurosquare 2, 7 rue Dora Maar, 93400 Saint Ouen, France, and is regulated by the French Prudential Supervisory Authority ("Autorite de Controle Prudentiel et de Resolution"). AWP Health & Life SA is authorised to carry out insurance activities in accordance with the provisions of the Insurance Code in France.

Contact details

If you have an enquiry about your plan or insurance Available from 9:00am to 5:00pm (UK time), Monday to Friday	**Phone** +44 1276 486 455 **Email** contact@william-russell.com
If you need to make a claim Available from 6:00am to 6:00pm (UK time), Monday to Friday	**Phone** +44 1276 486 460 **Email** claims@william-russell.com **Web** william-russell.com/claims
If you need to contact our 24-hour emergency medical Assistance Service	**For emergency medical assistance please call the following number:** +44 1243 621 155 **For non-emergencies, please contact us by email:** **Email** william.russell@cegagroup.com **Web** william-russell.com/contact
If you'd like to write to us	**William Russell Europe SRL** Place Marcel Broodthaers, 8 1060 Saint-Gilles Brussels, Belgium

Your plan agreement

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

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

When **you** join **your employer's plan**, **our medical underwriting** requirements depend on that **plan's medical underwriting** type and **your** age or the age of **your eligible dependant** at the time of joining. Please ask **your employer** for full details of the requirements that apply to the **plan**.

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** costs of **medically necessary treatment** of medical conditions covered by **your plan** provided **your employer** has kept up to date with **your premium** payments. **We** will only pay for such **treatment** if it is received during **your policy year**, and—in the case of medication—only for medication prescribed for **your** use during **your policy year**.

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**.

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 eligible 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**.

Your obligation to provide information relating to you and your dependants' medical history

The information we require relating to **you** and **your eligible dependant's** medical history depends on the **medical underwriting** type of **your employer's plan**.

If we require **you** to complete an **application form**, **we** rely on the information **you** supply to **us** in that **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**.

Pre-existing medical conditions and related conditions

Your cover for **pre-existing medical conditions** and **related conditions** depends on the **medical underwriting** type of **your employer's plan**.

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

Start of your cover

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

Your coverage zone

The cover provided by **your** policy is limited to within the **coverage zone** stated on **your certificate of insurance**.

When **we** use the term '**emergency treatment**' throughout this **agreement**, **we** mean **treatment**:

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

Please also note that even if **your** policy gives **you** cover in the USA, **we** do not cover emergency medical evacuations to, from, or within the USA.

Zone 1

Worldwide cover, with restricted cover in the USA.

You have cover in the USA during **temporary trips** of up to 45 days' duration from the date on which **you** enter the USA.

While in the USA, **you** have cover for **emergency treatment** only up to US$50,000 or £33,000 or €37,500 per **policy year**.

There's no limit to the number of **temporary trips you** can make to the USA.

Zone 2

Worldwide cover (excluding the USA), but with restricted cover in the following countries and regions:

*United Kingdom, all countries in the European Economic Area, Andorra, the Channel Islands, Gibraltar, Greenland, Monaco, San Marino, Switzerland, the UAE, Singapore, Thailand (here, **your** cover is restricted only for **treatment you** receive at the Bumrungrad Hospital, Bangkok Hospital Group, and Samitivej Hosptial facilities), China, Hong Kong, Macau, Taiwan, Japan, Australia, New Zealand, Canada, and the **Caribbean countries and islands**.*

While in any of the above countries or regions **you** have cover for **emergency treatment** only, up to US$100,000 or £66,000 or €75,000 per **policy year**.

You have no cover at all in the USA.

Zone 3

Worldwide cover (excluding the USA), but with restricted cover in the following countries and regions:

*China, Hong Kong, Macau, Taiwan, Japan, Singapore, Switzerland, and the **London area**.*

While in any of the above countries or regions **you** have the following cover:

- 80% cover for elective, eligible **treatment** costs; and
- 100% cover for **emergency treatment** that **you** receive while on a **temporary trip** of up to 90 days' duration, up to US$100,000 or £66,000 or €75,000 per **policy year**.

Zone 3 is only available if **your country of residence** is Indonesia.

Zone 4

Full cover in **Africa** and the **Indian Subcontinent**.

While outside of **Africa** and the **Indian Subcontinent you** have cover for **emergency treatment** only, up to US$100,000 or £66,000 or €75,000 per **policy year**.

You have no cover at all in the USA.

Zone 5

Full cover in **Africa** (except South Africa) and the **Indian Subcontinent**.

While outside of **Africa** or the **Indian Subcontinent** (or while in South Africa) **you** have cover for **emergency treatment** only, up to US$100,000 or £66,000 or €75,000 per **policy year**.

You have no cover at all in the USA.

Zone 6

This **coverage zone** is not available with **your** policy.

Zone 7

You have full cover in Brunei, Cambodia, Timor Leste, Indonesia, Laos, Malaysia, Myanmar, Papua New Guinea, the Philippines, and Vietnam, but no cover anywhere else.

Additional cover in the USA

If **you** have a USA cover option, **you** will see it stated on **your certificate of insurance**.

USA-45

You have cover in the USA for **temporary trips** of up to 45 days' duration from the date on which **you** enter the country. **Your** cover ends when a trip exceeds 45 days' duration.

While in the USA, **you** have cover for eligible **treatment** and care up to US$250,000 per **policy year**. Within this amount, **you** have the following cover:

- up to US$100,000 for elective, eligible **treatment** and care costs
- up to US$250,000 for **emergency treatment**

There's no limit to the number of **temporary trips you** can make to the USA.

USA-90

You have cover in the USA for **temporary trips** of up to 90 days' duration from the date on which **you** enter the country. **Your** cover ends when a trip exceeds 90 days' duration.

While in the USA, **you** have cover for eligible **treatment** and care up to US$250,000 per **policy year**. This amount includes elective **treatment**, **care** and **emergency treatment** that **you** receive.

There's no limit to the number of **temporary trips you** can make to the USA.

This option is only available to existing **members** who already have it on their policy.

What you are covered for

The following **table of benefits** sets out the cover provided by each **plan**. The **plan 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 policy**, 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. If **you** do not obtain pre-authorisation for these benefits, **we** will only pay 80% of the **reasonable and customary** cost of **treatment**.

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

Key ✓ Full cover within annual benefit limit | ✎ Partial or limited cover | ✕ No cover | ⊕ Optional cover

	Bronze	Silver*Lite*	Silver	Gold
Annual benefit limit The overall maximum limit that each **member** can **claim** during any one **policy year**.	US$1,500,000 or £1,000,000 or €1,125,000	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
Hospital costs Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
Hospital accommodation With cover for a private hospital room, **we** will pay the cost of a standard single room with an en-suite bath or shower room when **you** are an **inpatient** or **daypatient**. With cover for a semi-private hospital room, **we** will pay the cost of a standard shared room with an en-suite bath or shower room when **you** are an **inpatient** or **daypatient**. Accommodation in a private hospital room is only available under the Bronze and Silver*Lite* plans if **your employer** has selected this option.	✓ Semi-private hospital room ⊕ Private hospital room	✓ Semi-private hospital room ⊕ Private hospital room	✓ Private hospital room	✓ Private hospital room
Hospital treatment **Treatment you** receive while **you** are an **inpatient** or **daypatient**, including surgeons' and anaesthetists' and **doctors'** fees, nursing care, drugs and surgical dressings, operating theatre charges and intensive care, pathology, X-rays, scans, **imaging tests** and physiotherapy. **We** will also pay for **pre-admission tests** that **you** undergo on an **outpatient** basis for **hospital treatment you** are scheduled to receive that is covered by **your plan**. **We** will also pay for the **inpatient** surgical removal of impacted, buried or unerupted wisdom teeth. This is subject to a 12-month **waiting period** and covered only when the surgery is performed by a **doctor** (not a dentist) in a **hospital** (not a dental surgery) and under general anaesthetic.	✓ Full cover	✓ Full cover	✓ Full cover	✓ Full cover

Key	✓ Full cover within annual benefit limit	⁄ Partial or limited cover	✗ No cover	+ Optional cover	
	Bronze	**Silver*Lite***	**Silver**	**Gold**
Hospital costs (continued) Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
Parent accommodation The cost of one parent staying in **hospital** with a child under 18 years of age while the child is receiving eligible **treatment** covered by their **plan**.	✓ Full cover	✓ Full cover	✓ Full cover	✓ Full cover
Local ambulance The cost of a local road or air ambulance if **you** need **medically necessary hospital treatment** covered by **your plan**. Transport must be to the nearest available and appropriate **hospital** and an air ambulance is only covered if there is no viable alternative.	✓ Full cover	⁄ Up to US$1,600 or £1,065 or €1,200 per **policy year**	✓ Full cover	✓ Full cover
Hospital cash benefit Payable for each night spent in a **hospital** when **you** receive **treatment** eligible for cover by **your plan** for which no charge is made by the **hospital** to **us**. Benefit is paid for up to a maximum of 60 nights per **policy year**. If **you** have an **excess**, **we** will not apply it to this benefit.	⁄ US$150 or £100 or €113 per night	⁄ US$200 or £132 or €150 per night	⁄ US$200 or £132 or €150 per night	⁄ US$350 or £231 or €263 per night
Advanced imaging tests MRI and CAT (CT) scans performed on the advice of a **doctor** and PET scans performed on the advice of a **specialist**. **Your medical referral letter** will be required. **We** will pay for one consultation only to obtain the results of the **imaging test**.	✓ Full cover	✓ Full cover	✓ Full cover	✓ Full cover
Cancer treatment Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
Cancer treatment Cancer **treatment**, including chemotherapy, radiotherapy, immunotherapy, consultations, tests, scans, and drugs. **We** will also pay for restorative **dental treatment** following chemotherapy or radiotherapy.	✓ Full cover	✓ Full cover	✓ Full cover	✓ Full cover
Cancer genome tests The cost of tests to sequence the genes of cancer cells.	✓ Full cover	✓ Full cover	✓ Full cover	✓ Full cover

Key	✓ Full cover within annual benefit limit	◐ Partial or limited cover	✗ No cover	⊕ Optional cover

	Bronze	Silver*Lite*	Silver	Gold
Cancer treatment (continued) Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
Genetic testing for cancer (12-month waiting period) **We** will pay for genetic tests (and any associated genetic counselling) for BRCA1 and BRCA2 genes (for breast, ovarian, prostate, and pancreatic cancer) and familial adenomatous polyposis (FAP) (for colorectal cancer). **We** will only pay for such genetic tests if: • **your doctor** has referred **you**; or • **you** have a parent, sibling, or child with breast cancer or FAP, or their genetic testing has established the presence of a hereditary cancer syndrome; or • tests take place outside of the USA. **We** won't pay for genetic tests when similar tests are available free of charge in the public healthcare system of the country where **you're** receiving oncology **treatment**.	✗ No cover	✗ No cover	◐ Lifetime limit of US$2,000 or £1,320 or €1,500	◐ Lifetime limit of US$4,000 or £2,640 or €3,000
Preventive cancer treatment (12-month waiting period) **We** will only pay for mastectomy (surgery to remove breasts), oophorectomy (surgery to remove ovaries), and colectomy (surgery to remove all or part of the bowel). **We** will only pay for these surgeries if: • **your doctor** has referred **you**; or • **you** have a parent, sibling, or child with a disease that's part of a hereditary cancer syndrome (e.g., breast cancer, ovarian cancer), or their genetic testing has established the presence of a hereditary cancer syndrome; or • **treatment** takes place outside of the USA. **We** won't pay for such surgeries when they are available free of charge in the public healthcare system of the country where **you're** receiving oncology **treatment**.	✗ No cover	✗ No cover	◐ Lifetime limit of US$25,000 or £16,600 or €18,750, subject to a 20% **co-insurance**	◐ Lifetime limit of US$40,000 or £26,600 or €30,000
Cash benefit upon diagnosis of cancer (6-month waiting period) Payable if **you** are diagnosed with cancer. By cancer we 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 (e.g., cancers such as breast cancer, lung cancer, bowel cancer, and cancers of the blood [also known as leukaemia]). The following are not covered: • non-melanoma skin cancer unless it has spread to lymph nodes or organs • prostate cancer unless it has spread to other glands or organs This benefit will not be paid if **you** were first diagnosed with any cancer before **you** were covered under the Gold **plan** for a period of six consecutive months.	✗ No cover	✗ No cover	✗ No cover	◐ US$5,000 or £3,330 or €3,750 with a lifetime limit of one claim per **member**
Wigs Help towards the cost of a wig following chemotherapy, covered by **your plan**.	◐ 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	◐ Lifetime limit of US$250 or £165 or €188

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

	Bronze	Silver*Lite*	Silver	Gold
Cancer treatment (continued) Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
Counselling Consultations with a registered psychologist/counsellor when **you** have received cancer **treatment** covered by **your plan**, up to a lifetime limit of 10 consultations. Drugs prescribed by a **doctor** for **outpatient** mental health **treatment** are covered under this benefit.	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	Lifetime limit of US$750 or £500 or €563
Dietitian Consultation with a registered dietitian when **you** have received cancer **treatment** covered by **your plan**, up to a lifetime limit of 2 consultations.	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	Lifetime limit of US$250 or £165 or €188
Organ, bone marrow or tissue transplants Important notes: • **You** must obtain pre-authorisation for all benefits in this section. • **We** only cover transplants carried out in internationally accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO (World Health Organisation) guidelines. • **We** do not cover any costs associated with the acquisition of the organ.				
Transplant and related treatment Costs incurred while hospitalised, including anti-rejection drugs, and all related **outpatient treatment** required prior to and after the transplant.	Full cover	Full cover	Full cover	Full cover
Donor costs Medical costs associated with the donor as an **inpatient** or **daypatient**.	Up to US$25,000 or £16,600 or €18,750 per transplant	Up to US$25,000 or £16,600 or €18,750 per transplant	Up to US$25,000 or £16,600 or €18,750 per transplant	Up to US$25,000 or £16,600 or €18,750 per transplant
Kidney dialysis Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
Treatment for kidney dialysis while **you** are an **inpatient**, **daypatient** or **outpatient**.	Full cover	Full cover	Full cover	Full cover

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

	Bronze	Silver*Lite*	Silver	Gold
Reconstructive surgery Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
A maximum of two surgeries per lifetime to restore **your** appearance after an **accident** or after surgery for cancer, provided the original **treatment** for the **accident** or cancer was paid for by **us**, and provided the reconstructive surgery takes place within two years of the **accident** or the original cancer surgery.	**Inpatient**, **daypatient** and **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital** following reconstructive surgery	Full cover	Full cover	Full cover
Congenital conditions or hereditary conditions Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
Treatment for a **congenital condition** or hereditary condition (whether diagnosed as a **chronic condition** or not) and **treatment** for any **related condition**. This benefit does not extend to mental health treatment, complementary medicine or traditional Chinese medicine. There is no cover for **congenital conditions** or hereditary conditions if, prior to **your date of entry**, **you** have had any abnormal signs, symptoms or test results related to the **congenital condition** or hereditary condition (whether or not a specific diagnosis has been made). The lifetime limit shown applies irrespective of the number of **congenital conditions** and hereditary conditions. Newborn babies may be eligible for this benefit once the **congenital conditions** or hereditary conditions limits have been exhausted under the *maternity costs* section of the **table of benefits**.	**Inpatient**, **daypatient** and **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**, up to a lifetime limit of US$50,000 or £33,300 or €37,500	Lifetime limit of US$60,000 or £40,000 or €45,000	Lifetime limit of US$80,000 or £53,300 or €60,000	Lifetime limit of US$100,000 or £66,600 or €75,000
HIV/AIDS treatment Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
(24-month waiting period) **Treatment** arising from or related to Human Immunodeficiency Virus (HIV) and/or HIV-related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC) for a maximum period of 5 years. **We** do not provide cover if the virus was contracted before **your date of entry**.	**Inpatient** and **daypatient treatment** only, up to US$5,000 or £3,300 or €3,750 per **policy year**	Up to US$5,000 or £3,300 or €3,750 per **policy year**	Up to US$75,000 or £50,000 or €56,250 per **policy year**	Up to US$100,000 or £66,600 or €75,000 per **policy year**

Key ✓ Full cover within annual benefit limit | ⚠ Partial or limited cover | ✗ No cover | ⊕ Optional cover

	Bronze	Silver*Lite*	Silver	Gold
Mental health treatment Important notes: • **You** must obtain pre-authorisation for all benefits in this section. • All **treatment** must be administered under the direct control of a registered psychiatrist, psychologist or counsellor. • **We** do not cover investigations or **treatment** related to phobias, hypnotherapy, postnatal depression or marriage/relationship counselling, or psycho-geriatric conditions including Alzheimer's disease or dementia.				
Lifetime mental health treatment limit The overall maximum limit to the amount that **you** can **claim** for all benefits in the *mental health treatment* section that are covered by **your plan** during **your** lifetime.	US$50,000 or £33,300 or €37,500	No cover	US$75,000 or £50,000 or €56,250	US$100,000 or £66,600 or €75,000
Inpatient and daypatient mental health treatment (12-month waiting period) **Inpatient** and **daypatient treatment** received in a recognised mental health unit of a **hospital**. **Your** cover under this benefit is subject to the lifetime mental health **treatment** limit above.	⚠ Up to 30 days per **policy year**	✗ No cover	⚠ Cover up to the lifetime limit for mental health treatment	⚠ Cover up to the lifetime limit for mental health treatment
Outpatient mental health treatment (12-month waiting period) **Specialist** mental health consultations with a registered psychiatrist or psychologist or mental health consultations with a registered counsellor when **you** have been referred by a **doctor**. **Your** cover under this benefit is subject to the lifetime mental health **treatment** limit above.	⚠ Up to 10 consultations per **policy year** for **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital** following **inpatient** or **daypatient** mental health **treatment**	✗ No cover	⚠ Up to 10 consultations per **policy year**	⚠ Up to 10 consultations per **policy year**
Outpatient mental health medication (12-month waiting period) Medication prescribed by a **doctor** or registered psychiatrist to treat a mental health condition**. Your** cover under this benefit is subject to the lifetime mental health **treatment** limit above.	⚠ Up to US$500 or £333 or €375 per **policy year** for **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital** following **inpatient** or **daypatient** mental health **treatment**, subject to a 20% **co-insurance**	✗ No cover	⚠ Up to US$500 or £333 or €375 per **policy year**, subject to a 20% **co-insurance**	⚠ Up to US$500 or £333 or €375 per **policy year**, subject to a 20% **co-insurance**

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

	Bronze	Silver*Lite*	Silver	Gold
Medical appliances				
Medical aids Supplying, fitting or hiring instruments, apparatuses or devices which are medically prescribed as a medical aid to **you** (e.g., crutches, wheelchairs, orthopaedic supports/ braces, orthotics, stoma supplies, compression stockings) when it immediately follows **inpatient**, **daypatient** or emergency ward **treatment** covered by **your plan**. **We** do not cover medical aids that form part of the care of a **chronic condition**. **We** do not cover unprescribed medical aids such as gym equipment, even if **you** have been advised to use such an aid.	Partial: Up to US$250 or £160 or €188 per medical condition per **policy year**	No cover	Partial: Up to US$500 or £330 or €375 per medical condition per **policy year**	Partial: Up to US$1,000 or £660 or €750 per medical condition per **policy year**
Prosthetic implants 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, **we** will also pay for a knee brace if it is an essential part of a surgical operation for the repair to a knee ligament, and for a spinal support if it is an essential part of a surgical operation to the spine.	Full cover	Full cover	Full cover	Full cover
Prosthetic devices External prosthetic body parts, such as prosthetic limbs, fitted after the healing of an amputation covered by **your plan**.	Partial: Up to US$500 or £330 or €375 per device	Partial: Up to US$1,000 or £660 or €750 per device	Partial: Up to US$1,000 or £660 or €750 per device	Partial: Up to US$1,500 or £1,000 or €1,125 per device
Outpatient treatment				
Annual limit for outpatient treatment The overall maximum limit to the amount **you** can **claim** for **treatment you** receive as an **outpatient** during any one **policy year**. For **members** with a Silver*Lite* **plan**: • If **your employer** has selected Option A, **your** annual limit for **outpatient treatment** increases to the limit shown. **Your** limit for the primary medical care benefit (below) also increases to the limit shown for Option A. • If **your employer** has selected Option B, **your** annual limit for **outpatient treatment** increases to the limit shown. **Your** limit for the primary medical care benefit (below) also increases to the limit shown for Option B. **You** are not eligible for the higher limits if **your employer** has not selected Option A or Option B.	Full cover up to your annual plan limit	Partial: Up to US$5,000 or £3,300 or €3,750 **per policy year** Optional: **Option A** Up to US$7,500 or £5,000 or €5,625 **per policy year** Optional: **Option B** Up to US$10,000 or £6,600 or €7,500 **per policy year**	Full cover up to your annual plan limit	Full cover up to your annual plan limit

Key	✓ Full cover within annual benefit limit	⚠ Partial or limited cover	✗ No cover	⊕ Optional cover	
	Bronze	**Silver*Lite***	**Silver**	**Gold**
Outpatient treatment (continued)				
Primary medical care Consultations with a GP, **doctor**, or **specialist**. Consultations can be in-person or via technology (e.g., video or phone call). **We** do not cover home visits. **We** will also pay for the following primary medical care costs: • Prescription drugs and other pharmacy costs (must be prescribed by a GP, **doctor**, or **specialist**) • Pathology • Scans • Radiology • **Imaging tests** **We** cover COVID-19 PCR and Antigen testing when **you** have symptoms such as cough or fever or have been in close contact with someone who has tested positive for COVID-19. Tests must be prescribed by a **doctor** and undertaken under medical supervision in a recognised medical facility. **We** don't cover home testing kits. If you have a Silver*Lite* **plan** and **your employer** has selected Option A or Option B, **your** annual limit for primary medical care increases to the limit shown.	⚠ **Post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**	⚠ Up to US$1,500 or £1,000 or €1,125 **per policy year** (up to the annual limit for **outpatient treatment**) ⊕ **Option A** Up to US$2,500 or £1,665 or €1,875 **per policy year** (up to the annual limit for **outpatient treatment**) ⊕ **Option B** Up to US$3,500 or £2,310 or €2,625 **per policy year** (up to the annual limit for **outpatient treatment**)	✓ Full cover	✓ Full cover
Emergency ward treatment **Emergency treatment** that **you** have received at a **hospital**.	⚠ Essential and immediate **treatment** necessary as the result of an **accident**, plus one follow-up appointment with a **doctor**	⚠ Up to the annual limit for **outpatient treatment**	✓ Full cover	✓ Full cover
Outpatient surgical procedures Surgical procedures where it is not **medically necessary** for **you** to be admitted to **hospital** as an **inpatient** or **daypatient**.	✓ Full cover	⚠ Up to the annual limit for **outpatient treatment**	✓ Full cover	✓ Full cover
Complementary treatments **Treatment** by a chiropractor, osteopath, chiropodist, podiatrist, homeopath or acupuncturist on the advice of a **doctor**. **Your medical referral letter** will be required for any **treatment** by a chiropractor, osteopath, chiropodist or podiatrist. If **your** condition is (or becomes) a **chronic condition** and ongoing **treatment** is aimed at maintaining it rather than curing it, no further payments will be made. Cover is limited to the maximum number of **sessions** shown per **policy year** in respect of all **treatment** types. **Treatment** must be performed by a **medical practitioner**. Medication provided by complementary therapists is not covered under this benefit.	⚠ Up to 10 **sessions** per **policy year** for **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**	✗ No cover	⚠ Up to 10 **sessions** per **policy year**	⚠ Up to 15 **sessions** per **policy year**

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

	Bronze	Silver*Lite*	Silver	Gold
Outpatient treatment (continued)				
Hormone replacement therapy When prescribed by a **doctor** following **your** diagnosis with premature ovarian failure (i.e., loss of ovarian function before the age of 40).	✗ No cover	✗ No cover	✓ Maximum period of 12 months from the date of diagnosis	✓ Maximum period of 18 months from the date of diagnosis
Traditional Chinese medicine Cover is limited to the maximum number of **sessions** shown per **policy year**. **Treatment** must be performed by a **medical practitioner**.	✗ No cover	✗ No cover	✓ Up to US$50 or £33 or €38 per **session**, up to a maximum of 15 **sessions**	✓ Up to US$50 or £33 or €38 per **session**, up to a maximum of 20 **sessions**
Physiotherapy **Medically necessary** physiotherapy when **you** have been referred on the advice of **your doctor** to a physiotherapist who is registered to practice physiotherapy in the country where the **treatment** is administered. **You** must send **us your medical referral letter** in support of **your claim**. After **your** first 6 **sessions** of physiotherapy, if **you** need more **sessions you** must contact **us** for pre-authorisation. **We** will write to **your doctor** for a medical report in order to assess **your claim** further. After **your** first 6 **sessions**, **we** will not pay for any physiotherapy that **we** have not pre-authorised. If **your** condition is (or becomes) a **chronic condition** and ongoing **treatment** is aimed at maintaining rather than curing it, no further payments will be made.	✓ **Post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**, up to US$1,000 or £660 or €750 per **policy year**	✓ Up to US$250 or £165 or €188 per **policy year** up to the annual limit for **outpatient treatment**	✓ Full cover	✓ Full cover
Chronic conditions				
Acute flare-ups Short-term **treatment** to treat acute flare-ups of a **chronic condition** covered by **your plan**.	✓ **Inpatient**, **daypatient**, and **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**	✓ **Inpatient** and **daypatient treatment**, with cover for **outpatient treatment** up to the benefit limit for primary medical care	✓ Full cover	✓ Full cover
Monitoring and maintenance Regular consultations, tests, and prescribed medication required to monitor and maintain the stability of a **chronic condition**.	✗ No cover	✓ Up to the benefit limit for primary medical care	✓ Full cover	✓ Full cover

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

	Bronze	SilverLite	Silver	Gold
Well-being benefits Important notes: • **You** are eligible for certain benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**.				
Preventive health and well-being (6-month waiting period) **Preventive health checks** and tests for adults, as follows: • Blood tests (cholesterol, liver function, kidney function, high blood pressure, anaemia, diabetes testing/screening) • Lung function test • Cardiac risk testing • Bone densitometry testing (every five years for women aged 50+) • Neurological examination (physical examination) • Hearing test • Allergy patch testing (lifetime limit of one test per member) • Smoking cessation aids prescribed by a doctor (up to US$100 or £67 or €75 per **policy year**) • Eye examination (limited to one test per **policy year**) Cancer screening for adults, as follows: • Annual Papanicolaou test (PAP/smear test) • Mammogram (one every two years for members aged 45+) • Annual prostate cancer test (only for members aged 45+) • Colonoscopy (one every five years for members aged 50+) The benefit limit on the Silver or Gold **plan** is extended if the enhanced well-being option is selected by **your employer**.	No cover	No cover	Up to US$400 or £260 or €300 per **policy year** Up to US$750 or £500 or €563 per **policy year** (only if selected by **your employer**)	Up to US$1,200 or £780 or €900 per **policy year** Up to US$2,000 or £1,330 or €1,500 per **policy year** (only if selected by **your employer**)
Vaccinations for adults Vaccinations for adults as follows: • Immunisation and booster injections required under regulation of the country in which **treatment** is being given • **Medically necessary** travel vaccinations • Malaria prophylaxis • Flu jabs • Approved COVID-19 vaccinations (where not available free of charge in **your country of residence**)	No cover	No cover	Up to US$300 or £200 or €225 per **policy year**	Up to US$500 or £330 or €375 per **policy year**
Well-child benefit (6-month waiting period) Immunisations and booster injections that form part of government-recommended programmes within the child's **country of residence**, allergy patch testing, and routine developmental check-ups (including vision and hearing). **We** will waive the **waiting period** if either parent has been insured on the **policy** for at least 6 months and children are covered as **eligible dependants** on the **policy**.	No cover	No cover	Up to US$400 or £260 or €300 per **policy year**	Up to US$800 or £520 or €600 per **policy year**

Key ✓ Full cover within annual benefit limit | ◐ Partial or limited cover | ✗ No cover | ⊕ Optional cover

	Bronze	Silver*Lite*	Silver	Gold
Rehabilitation treatment Important notes: **You** must obtain pre-authorisation for all benefits in this section.				
Rehabilitation treatment you receive when carried out under the control and supervision of a **specialist** in a recognised **rehabilitation hospital or unit**, and only when it immediately follows **inpatient treatment** for illness or injury covered by **your plan**. **Rehabilitation treatment** in the form of a therapy or a combination of therapies (e.g., physical therapy, occupational therapy, speech therapy) after an acute event like a stroke. This benefit is payable only on the written recommendation of **your** treating **specialist** and when **treatment** begins within 30 days of **your** discharge from **hospital**.	◐ Up to US$2,000 or £1,330 or €1,500 per **policy year**	◐ Up to US$2,000 or £1,330 or €1,500 per **policy year**	◐ Up to US$4,000 or £2,660 or €3,000 per **policy year**	◐ Up to US$6,000 or £4,000 or €4,500 per **policy year**
Home nursing costs Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
The medical services of a **qualified nurse** to treat **you** in **your** own home when it is **medically necessary** and relates directly to an illness or injury covered by **your plan**.	◐ Up to US$5,000 or £3,330 or €3,750 per medical condition per **policy year**	◐ Up to US$8,000 or £5,300 or €6,000 per medical condition per **policy year**	◐ Up to US$10,000 or £6,660 or €7,500 per medical condition per **policy year**	◐ Up to US$15,000 or £10,000 or €11,250 per medical condition per **policy year**
Lifetime care Important notes: • **You** must obtain pre-authorisation for all benefits in this section.				
Lifetime limit for all lifetime care The overall maximum limit to the amount that **you** can **claim** for all benefits in the *lifetime care* section that are covered by **your plan** during **your** lifetime.	US$25,000 or £16,600 or €18,750	US$50,000 or £33,300 or €37,500	US$50,000 or £33,300 or €37,500	US$100,000 or £66,600 or €75,000
Hospice and palliative care On diagnosis of a **terminal medical condition** covered by **your plan**, all costs for **treatment** received on the advice of a **medical practitioner** or **specialist** for the purpose of offering relief of symptoms. This includes all **hospital** or hospice accommodation, and nursing care by a **qualified nurse**.	◐ Up to the lifetime limit for all lifetime care	◐ Up to the lifetime limit for all lifetime care	◐ Up to the lifetime limit for all lifetime care	◐ Up to the lifetime limit for all lifetime care
Artificial life maintenance **Treatment you** require after **you** have already been on **artificial life maintenance** for 8 weeks.	◐ Up to the lifetime limit for all lifetime care	◐ Up to the lifetime limit for all lifetime care	◐ Up to the lifetime limit for all lifetime care	◐ Up to the lifetime limit for all lifetime care
Persistent vegetative state and neurological damage **Treatment you** require after **you** have been in **hospital** for 8 weeks for permanent neurological damage or if **you** are in a persistent **vegetative state**.	◐ Up to the lifetime limit for all lifetime care	◐ Up to the lifetime limit for all lifetime care	◐ Up to the lifetime limit for all lifetime care	◐ Up to the lifetime limit for all lifetime care

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

	Bronze	Silver*Lite*	Silver	Gold
Optical care Important notes: • **You** are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**.				
We will pay for an annual optical test and for lenses, frames and contact lenses upon a change of prescription within this benefit. **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). **You** are eligible for the optical care benefit only if it has been selected by **your employer**.	No cover	No cover	Up to US$200 or £133 or €150 (only if selected by **your employer**)	Up to US$200 or £133 or €150 (only if selected by **your employer**)
Dental costs Important notes: • **You** are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**. • 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 or periodontic consultations or **treatment** of any kind.				
Emergency restorative treatment you receive as an inpatient **Inpatient treatment** required to restore sound and natural teeth following an **accident** covered by **your plan**, provided that **treatment** is received within 15 days of the **accident**.	Full cover	Up to US$5,000 or £3,330 or €3,750 per **policy year**	Full cover	Full cover
Emergency restorative treatment you receive as an outpatient **Outpatient treatment** required to treat or replace sound and natural teeth which are lost or damaged following an **accident**, provided that **treatment** is received within 72 hours of the **accident**.	No cover	No cover	Up to US$500 or £330 or €375 per **policy year**	Up to US$1,000 or £660 or €750 per **policy year**

Key: ✓ Full cover within annual benefit limit | ◐ Partial or limited cover | ✗ No cover | + Optional cover

	Bronze	Silver*Lite*	Silver	Gold
Dental costs (continued) Important notes: • **You** are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**. • 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 or periodontic consultations or **treatment** of any kind.				
Dental Basic (6-month waiting period) **We** will pay for the following basic dental costs: • screening (e.g., the checking for and/or the assessment of any diseased, missing and filled teeth including X-rays where necessary) twice per year • scaling and polishing and sealing (twice per year) • fillings (both composite and amalgam) • simple extractions • root canal **treatment** The benefit is optional on the Silver*Lite* and Silver **plans**. **You** are not eligible for cover if **your employer** does not select a Dental Basic option. It's included as standard on the Gold **plan**.	✗ No cover	+ Up to US$500 or £330 or €375 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**)	+ **Option A** Up to US$1,000 or £660 or €750 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**) + **Option B** Up to US$1,500 or £1,000 or €1,125 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**)	◐ Up to US$1,500 or £1,000 or €1,125 per **policy year**
Dental Plus (10-month waiting period) **We** will pay for the following advanced dental costs: • denture repair • full/partial dentures • dental bridges • crowns, inlays, and onlays • dental implants This benefit is optional on the Silver and Gold **plans**. **You** are not eligible for cover if neither option is selected by **your employer**.	✗ No cover	✗ No cover	+ Up to US$1,500 or £1,000 or €1,125 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**)	+ Up to US$2,000 or £1,330 or €1,500 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**)

Key	✓ Full cover within annual benefit limit	⁄ Partial or limited cover	✗ No cover	+ Optional cover

	Bronze	Silver*Lite*	Silver	Gold
Maternity costs Important notes: • **You** are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**. • Dependant children included on **your policy** are not eligible for these benefits. • **You** must obtain pre-authorisation for all benefits in this section. • **Treatment** of any newborn born following assisted reproduction (e.g., IVF) and within 36 weeks of conception is limited to the complications of childbirth benefit. • Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and routine care of newborns benefit. • **We** do not cover pregnancy testing, or pre-natal classes and doulas. • **We** do not cover termination of pregnancy or any **treatment** or investigations that arise as a result of complications relating to termination of pregnancy (unless there is a threat to the mother's health and **treatment** is provided in a recognised medical facility). • **We** do not cover breast pumps.				
Routine maternity care and routine care of newborns (12-month waiting period) **We** will pay for the following routine maternity costs: • pre-natal tests and examinations • post-natal **treatments** and examinations • natural childbirth • childbirth by caesarean section (whether planned, medically necessary, or emergency) • any **hospital** accommodation costs for the newborn • basic newborn healthcare (physical examination, vitamin K, hepatitis B vaccine, BCG vaccine, one hearing test, blood tests for PKU, congenital hypothyroidism and G6PD, prior to discharge from the **hospital**) • home birth, where a midwife is present • supplements and vitamins as recommended by a **doctor** The limits shown for this benefit apply to each pregnancy, regardless of the number of children born. Any **hospital** or birthing centre accommodation costs will be limited to the cost of a standard **hospital** room. This benefit is optional on the Silver*Lite* and Silver **plans**. **You** are not eligible for cover if an option is not selected by **your employer**.	✗ No cover	+ Up to US$5,000 or £3,330 or €3,750 per pregnancy, subject to a 20% **co-insurance**	+ **Option A** Up to US$5,000 or £3,330 or €3,750 per pregnancy, subject to a 20% **co-insurance** + **Option B** Up to US$7,500 or £5,000 or €5,625 per pregnancy, subject to a 20% **co-insurance** + **Option C** Up to US$10,000 or £6,660 or €7,500 per pregnancy, subject to a 20% **co-insurance** + **Option D** Up to US$15,000 or £10,000 or €11,250 per pregnancy, subject to a 20% **co-insurance**	⁄ Up to US$18,500 or £12,200 or €13,875 per pregnancy

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

Maternity costs (continued)

Important notes:

- **You** are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**.
- Dependant children included on **your policy** are not eligible for these benefits.
- **You** must obtain pre-authorisation for all benefits in this section.
- **Treatment** of any newborn born following assisted reproduction (e.g., IVF) and within 36 weeks of conception is limited to the complications of childbirth benefit.
- Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and routine care of newborns benefit.
- **We** do not cover pregnancy testing, or pre-natal classes and doulas.
- **We** do not cover termination of pregnancy or any **treatment** or investigations that arise as a result of complications relating to termination of pregnancy (unless there is a threat to the mother's health and **treatment** is provided in a recognised medical facility).
- **We** do not cover breast pumps.

	Bronze	SilverLite	Silver	Gold
Complications of childbirth (12-month waiting period) **We** will pay for complications experienced in childbirth, including post-partum haemorrhage, retained placental membrane, and childbirth by **emergency caesarean section**. **We** will also pay under this benefit for the **treatment** of any newborn born following assisted reproduction (e.g., IVF) if the birth occurs within 36 weeks of conception. If **you** have the Gold **plan**, this is subject to a maximum limit of US$30,000 or £20,000, or €22,500. If **you** have a Silver or Gold **plan**, and **your** childbirth necessitates an emergency surgical procedure, and **you** have already exhausted the benefit for routine maternity care and routine care of newborns, **you** may use this benefit as additional cover for surgeons', anaesthetists', and theatre fees for complex deliveries and additional accommodation charges incurred following a surgical procedure**.** Cover on the Silver **plan** is only available if the complex maternity option is selected by **your employer**.	No cover	No cover	Up to US$20,000 or £13,330 or €15,000 per pregnancy (only if selected by **your employer**)	Full cover
Complications of pregnancy affecting the mother (12-month waiting period) **Inpatient** or **daypatient treatment** necessary as a direct result of a complication experienced during pregnancy. **We** will pay only for the following complications (which arise only during pregnancy): ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth, and hydatidiform mole (also known as molar pregnancy). **We** do not provide cover for childbirth under this benefit. **We** do not provide cover under this benefit for complications arising from a pregnancy established through assisted reproduction (e.g., IVF) until after the standard 12-week scan, irrespective of how long **you've** been covered by **your policy**. **You** only have full cover on the Silver **plan** if **your employer** has selected the complex maternity option.	Up to US$4,800 or £3,200 or €3,600 per **policy year**	Up to US$10,000 or £6,600 or €7,500 per **policy year**	Up to US$15,000 or £10,000 or €11,250 per **policy year** Full cover (only if selected by **your employer**)	Full cover

Key	✓ Full cover within annual benefit limit	⁄ Partial or limited cover	✗ No cover	+ Optional cover		
	Bronze	**Silver*Lite***	**Silver**	**Gold**		
Maternity costs (continued)						
Important notes: • **You** are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**. • Dependant children included on **your policy** are not eligible for these benefits. • **You** must obtain pre-authorisation for all benefits in this section. • **Treatment** of any newborn born following assisted reproduction (e.g., IVF) and within 36 weeks of conception is limited to the complications of childbirth benefit. • Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and routine care of newborns benefit. • **We** do not cover pregnancy testing, or pre-natal classes and doulas. • **We** do not cover termination of pregnancy or any **treatment** or investigations that arise as a result of complications relating to termination of pregnancy (unless there is a threat to the mother's health and **treatment** is provided in a recognised medical facility). • **We** do not cover breast pumps.						
Treatment for congenital conditions or hereditary conditions for newborn babies **Treatment** that **your newborn** receives for a **congenital condition** or hereditary condition (whether diagnosed as a **chronic condition** or not) and **treatment** for any **related condition**. This benefit is subject to the following conditions: • **Your** newborn must be added to **your policy** within 30-days of birth and any additional **premium** paid • **Your** newborn must have the same **plan** as **you** • Either parent must have been insured on a Silver or Gold **plan** for a minimum of 12 months prior to the birth The limits shown apply to each pregnancy, regardless of the number of children born. The benefit limit on the Silver **plan** is extended if the complex maternity option is selected by **your employer**.	✗ No cover	✗ No cover	⁄ **Inpatient** or **daypatient treatment** received within the 90-day period following birth, up to US$10,000 or £6,600 or €7,500 per pregnancy + **Inpatient** or **daypatient treatment** received within the 90-day period following birth, up to US$50,000 or £33,300 or €37,500 per pregnancy (only if selected by **your employer**)	⁄ **Inpatient** or **daypatient treatment** received within the 90-day period following birth, up to US$100,000 or £66,600 or €75,000 per pregnancy		
Expat benefits						
Important notes: • **You** are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**. • **You** must obtain pre-authorisation for all benefits in this section.						
24-hour medical assistance helpline If **you** have a medical emergency which requires immediate medical assistance, **you** must contact **our** 24-hour helpline (provided by the Charles Taylor Group) at +44 (0) 1243 621 155 or william.russell@cegagroup.com.	✓ Full cover	✓ Full cover	✓ Full cover	✓ Full cover		

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

	Bronze	Silver*Lite*	Silver	Gold
Expat benefits (continued) Important notes: • **You** are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**. • **You** must obtain pre-authorisation for all benefits in this section.				
Medevac Basic If **you** have a life-threatening or limb-threatening condition covered by **your plan** which requires immediate **inpatient treatment** that cannot be adequately provided locally, the **Assistance Service** will arrange for **you** to be moved by air and/or by surface transportation to the nearest **hospital** within **your coverage zone** where appropriate medical **treatment** is available. **We** do not cover any other costs under this benefit such as hotel accommodation charges. **We** do not cover emergency evacuation to, from or within the United States of America. The **Assistance Service** retains the absolute right to decide whether **your** medical condition is eligible for evacuation, where **you** are evacuated to, and the means and method of the evacuation.	Full cover	Full cover	Full cover	Full cover
Return airfare Following an emergency evacuation covered by **your plan**, **we** will pay for **your** economy return airfare to **your country of residence**.	Full cover	Full cover	Full cover	Full cover
Travel expenses of a companion The transportation costs of another person to accompany **you** on **your** emergency evacuation, and their economy-class ticket back. If it is not possible for them to accompany **you** on **your** medical evacuation because of the method of evacuation, **we** 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.	Full cover	Full cover	Full cover	Full cover
Accommodation expenses of a companion If **your** companion is then staying with **you** while **you** are hospitalised following **your** emergency evacuation, **we** will pay towards the costs of their hotel accommodation (limited to a maximum of 15 nights per **policy year**).	Up to US$75 or £50 or €56 per night	Up to US$100 or £67 or €75 per night	Up to US$150 or £100 or €113 per night	Up to US$250 or £167 or €188 per night
Compassionate home visit (12-month waiting period) If a **close family member** dies during **your policy year** and after **you** have been insured by **your plan** for a continuous period of 12 months, **we** will pay for **your** economy-class round-trip airfare to attend the funeral. **Your** travel must take place within 28 days of the date of death.	Lifetime limit of one claim per member	No cover	Lifetime limit of one claim per member	Lifetime limit of one claim per member
Repatriation of mortal remains If **you** die as the result of a condition that is covered by **your plan** while **you** are outside **your country of nationality**, **we** will pay for **your** body or ashes to be transported to **your country of nationality** or **country of residence**. This benefit is not available if a **claim** is made for the burial or cremation benefit at the place where **you** died.	Full cover	Up to US$5,000 or £3,330 or €3,750	Full cover	Full cover

Key ✓ Full cover within annual benefit limit | ✎ Partial or limited cover | ✗ No cover | ⊕ Optional cover

	Bronze	Silver*Lite*	Silver	Gold
Expat benefits (continued)				
Important notes: • **You** are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**. • **You** must obtain pre-authorisation for all benefits in this section.				
Burial or cremation If **you** die as the result of a condition that is covered by **your plan** while **you** are outside **your country of nationality**, **we** will pay for **you** to be buried or cremated at the place where **you** died. This benefit is not available if a **claim** is made under the repatriation of mortal remains benefit. **We** do not provide cover under this benefit if **you** die in **your country of nationality**. **We** do not provide cover under this benefit for the costs of a religious practitioner.	✎ Up to US$1,600 or £1,060 or €1,200	✎ Up to US$1,600 or £1,060 or €1,200	✎ Up to US$1,600 or £1,060 or €1,200	✎ Up to US$1,600 or £1,060 or €1,200
Medevac Plus The following benefits apply in addition to those under the Medevac Basic benefit. Evacuation if **you** need **advanced imaging** or cancer **treatment** such as radiotherapy or chemotherapy that cannot be adequately provided locally. All eligible evacuations will include repatriation to **your country of nationality** if it is within **your coverage zone**, or to **your country of residence**. **We** do not cover emergency evacuation or repatriation to, from or within the United States of America. If **you** request repatriation to **your country of nationality** or to **your country of residence**, it may, in some cases, not be appropriate immediately due to **your** medical condition. In such cases, **we** will first evacuate **you** to the nearest place within **your coverage zone** where appropriate **treatment** is available. Once **you** have been stabilised, **we** will then repatriate **you** to **your country of nationality** if it is within **your coverage zone**, or **your country of residence**. If **you** are evacuated to a country which is not **your country of residence** and not **your country of nationality**, and **you** do not have anyone to accompany **you**, **we** will pay the economy-class round-trip airfare to have one companion flown from anywhere in the world to be with **you** while **you** receive **your treatment**. **We** will also pay up to US$150 per day (for a maximum of 30 days per **policy year**) towards their hotel accommodation expenses whilst **you** have **your treatment**, or until the date on which **you** return to your **country of nationality** or your **country of residence** (whichever is the sooner). Cover is only available if the Medevac Plus option is selected by **your employer**.	⊕ Full cover (only if selected by **your employer**)	⊕ Full cover (only if selected by **your employer**)	⊕ Full cover (only if selected by **your employer**)	⊕ Full cover (only if selected by **your employer**)
Accidental death benefit				
Accidental death benefit The accidental death benefit becomes payable if a m**ember** dies as a consequence of an accidental bodily injury that is suffered during the **policy year**, provided that: • The **plan** was in full force at the time the accidental bodily injury is sustained • Death occurs within one year of the date on which accidental bodily injury is sustained • The accidental bodily injury is not caused directly or indirectly by any risk excluded in this **agreement** or by any **special terms** stated on **your certificate of insurance**.	✗ No cover	✗ No cover	✗ No cover	✎ US$15,000 or £10,000 or €11,250

What you're 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**.

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 and **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; and
- any charges made by **your** bank or credit card company.

Accidents or injuries resulting from your failure to adhere to local motoring laws

You are not covered for accidents or injuries arising from:

- travelling in, or on, a motorised vehicle as a driver or passenger, if the driver does not have a valid license and insurance, as required by the law of the country where the accident or injury occurred; and
- failure to wear the relevant safety equipment, (including, but not limited to helmets and seatbelts) as required by the law of the country where the accident or injury occurred.

Accidental death

You are not covered for the accidental death benefit when **your** death results from:

- war, warlike activities, military action, acts of foreign hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection, usurped power, mutiny, riot, strike, martial law, state of siege, attempted overthrow of government, any acts of terrorism, murder, attempted murder, kidnap (including attempted kidnap or attempted rescue from kidnapping), or assault of any kind, anywhere in the world (irrespective of whether the **member** is an active participant in any of the above activities or merely an innocent bystander);
- any illness or disease;
- food poisoning or bacterial infections (except infection which occurs through accidental cut or wound);
- suicide, or the consequences of attempted suicide;
- intentionally self-inflicted injuries, whether sane or insane;
- intentional inhalation of gas, or intentional ingestion of poisons or drugs;
- intentionally contracted infection by bacteria or virus;
- being under the influence of alcohol or drugs; or
- an accident whilst participating in a hazardous activity.

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 caused directly or indirectly as a result of any such abuse or addiction; or
- any illness or injury caused 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; or
- allergy desensitisation or food neutralising injections.

Alternative treatment and therapies

You are not covered for alternative **treatments** 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 in the *lifetime care* section of the **table of benefits**.

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); or
- gender reassignment

Chemical exposure and contamination

You are not covered for investigations or **treatment** related to 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**.

Commercially available substances

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 in the *maternity costs* section of the **table of benefits**.

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; or
- 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/treatment and the removal of healthy tissue

You are not covered for investigations or **treatment**, even when medically prescribed, that are related to:

- cosmetic or aesthetic **treatment** to enhance **your** appearance;
- the removal of healthy tissue, including fat, skin or breast tissue;
- breast enlargement or reduction;
- sclerotherapy for spider veins, **treatment** of superficial varicose veins; or
- Botox, dermal fillers, or **treatment** of vitiligo or any skin pigmentation **disorder**.

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

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.

Dietitian

You are not covered for **treatment** or advice by a dietitian or nutritionist (unless covered under **your plan** under the dietitian benefit in 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 accepted current clinical evidence and generally accepted medical practice.

Eyesight

You are not covered for:

- LASIK eye surgery or any other surgical correction of short-sightedness (myopia), long-sightedness (hyperopia) or irregular-shaped cornea (astigmatism);
- any lens other than a standard mono-focal replacement lens as part of an eye operation, such as cataract surgery;
- spectacles, and other visual aids, treatment of strabismus (squint) or amblyopia (lazy eye); or
- sight tests (unless covered under **your plan** in the *well-being benefits* section of the **table of benefits**).

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**; or
- 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 or genetic testing for cancer benefits in the *cancer treatment* 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** (unless covered under **your plan** under the **treatment** for **congenital conditions** or hereditary conditions for newborn babies benefit in the *maternity costs* section of the **table of benefits**);
- hearing aids; or
- hearing tests (unless covered under **your plan** in the *well-being benefits* section of the **table of benefits**).

Infertility, IVF, and assisted reproduction

You are not covered for:

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

Learning and educational difficulties

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

Natural changes as a result of ageing

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 (unless covered under **your plan** in the *well-being benefits* section of the **table of benefits**); or
- reproductive hormone testing, reproductive hormone therapy or hormone replacement therapy (unless covered under **your plan** under the hormone replacement therapy benefit in the *outpatient treatment* section of the **table of benefits**).

Palliative care

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

Physical development, learning difficulties, speech disorders, and behavioural problems

You are not covered for any consultations, tests required to diagnose or exclude a diagnosis, 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), autism spectrum disorder (ASD), and Tourette's syndrome;
- physical development of any kind;
- teething; or
- bed wetting.

Pre-existing medical conditions or related conditions

The terms and conditions governing **pre-existing medical conditions** or **related conditions** depend on the **medical underwriting** type of **your employer's plan**. The type of **medical underwriting you** have is stated on **your certificate of insurance**.

Full medical underwriting or CPME underwriting

You are not covered for **treatment** related to any **pre-existing medical conditions** and **related conditions** that **you** did not declare on **your application form**.

We rely on the information **you** provide **us** when **we** decide whether or not to accept **your application**, and whether or not **we** need to apply **special terms**. Unless **we** have agreed otherwise, **your** policy does not cover any **pre-existing medical condition** or **related conditions**.

Moratorium underwriting

You are not covered for **treatment** related to **pre-existing medical conditions** or **related conditions** that **you** knew about or for which **you** have experienced symptoms, sought medical advice, or received medical **treatment** in the two-year period before **your date of entry**.

A **pre-existing medical condition** may become eligible for benefit after two years of continuous cover, provided **you** have not experienced symptoms, consulted a **doctor**, sought medical advice, received medical **treatment** (including routine check-ups), taken medication (including injections), or been advised to follow a special diet for that **pre-existing medical condition** or a **related condition** during that two-year period.

If sound medical advice dictates that you *should* have consulted a **doctor**, sought medical advice, received medical **treatment** (including routine check-ups), taken medication (including injections), or been advised to follow a special diet for a **pre-existing medical condition** or a **related condition** during that two-year period, the **pre-existing medical condition** will not become eligible for benefit. Please do not delay receiving medical **treatment** or advice in order to qualify a **pre-existing medical condition** for benefit.

If there is any doubt whether a medical condition is a **pre-existing medical condition** or not, the decision of **our** Chief Medical Officer is final. **We** reserve the right to request a further medical opinion.

MHD underwriting

You, and any **eligible dependants**, have cover for **pre-existing medical conditions** and **related conditions** provided that **you** joined your **employer's plan** on its original start date and provided that **your employer** completed its **application form** to the best of its knowledge and belief.

Preventive surgery

You are not covered for surgery when no physical signs or symptoms are shown, or no diagnosis has been made, other than **treatment you're** eligible for under the cancer preventive **treatment** benefit in the *cancer treatment* section of the **table of benefits**.

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 in (including training for or practising for) any kind of professional sport or professional racing (by professional, **we** mean sport where **you** are being paid to participate and/or **you** are receiving sponsorship or other benefits as a result of **your** participation); or
- participation in (including training for or practising for) 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; or
- wigs (unless covered under **your plan** in the *cancer treatment* section 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, rescue from ski slopes or pistes, underground rescue, or underwater rescue; or
- evacuations from offshore installations such as oil rigs, or from any type of sea going vessel such as a ship, ferry or yacht.

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 infections

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

Sleep disorders

You are not covered for **imaging 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.

Temporomandibular joint (TMJ) disorders

You are not covered for treatment of disorders of the Temporomandibular joint (TMJ) including any **related condition**.

Travel costs

You are not covered for travel costs including airfares and hotel accommodation (unless covered under **your plan** in 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; or
- any **medical services provider**, **medical practitioner** or **specialist** where the **member** has a financial interest and/or a professional interest, including, but not limited to, employees, employers, consultants and owners.

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 siege or attempted overthrow of a government, unless **you** are an **innocent bystander**.

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; or
- 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.

Eligible medical services providers

You have the freedom to choose when and where **you** receive **your** medical **treatment** within **your coverage zone**. Please note that **we** will only pay up to the **reasonable and customary** monetary amount which is typically charged in the country where **treatment** is being received.

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

All **treatment you** receive in the United States of America must be pre-authorised in advance by **us** or by the **Assistance Service**. **We** will not pay for any **treatment** in the United States of America that has not been pre-authorised.

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

If you are admitted to hospital

All **inpatient** and **daypatient hospital treatment** must be pre-authorised by **us** or by the **Assistance Service.**

Please contact **us** as soon as **you** know that **you** need **inpatient** or **daypatient treatment**. **You** must let **us** know that **you** need **inpatient** or **daypatient treatment** at least 5 days in advance of **your admission**. This gives **us** sufficient time to contact the **hospital** to obtain the necessary medical information.

When **you** contact **us**, **we** will ask **you** to complete a pre-authorisation form and a consent form that permits the **hospital** to release the necessary medical information to **us**. Once **we** have received all the medical information that **we** require, both from the **hospital** and **yourself** (including any other information **we** might need), **we** will advise **you** if the proposed medical **treatment** will be covered by **your plan**.

If **you** contact **us** less than 5 days in advance of **your** admission, **we** may be unable to pre-authorise **your treatment** in time. This means **you** may have to pay for the **treatment yourself** and submit a **claim** for reimbursement to **us** later. In some instances, **we** may decline **your** reimbursement **claim** or **we** may subject **your** reimbursement **claim** to a 20% **co-insurance**.

If **you** are admitted to **hospital** in an emergency and it's not reasonably possible for **you** to contact **us** in advance of **your** admission, **we** will consider **your claim** provided that **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 a 20% **co-insurance**.

If you do not obtain pre-authorisation for treatment that we have specified must be pre-authorised

For eligible **treatment**, which has not been pre-authorised, **we** will only reimburse 80% of the eligible costs.

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.

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:

- 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.
- 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 **outpatient** physiotherapy, any **treatment** by a chiropractor, mental health practitioner, osteopath, chiropodist or podiatrist, 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. 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 **inpatient** or **daypatient 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 cashless access service

To be eligible to receive the cashless access 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 cashless access 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 **cashless access medical services providers** within **our medical network**. The **cashless access medical services provider** will bill **us** directly for **your treatment**.

If the cost of **your treatment** is greater than US$500, the **cashless access medical services provider** will contact **us** for pre-authorisation 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 **cashless access medical services provider** know.

It is important to note that the **cashless access 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 **cashless access medical services provider** is not obliged to contact **us** for pre-authorisation, 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 **cashless access 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**, the **cashless access medical services provider** will contact **you** to collect payment for the ineligible expenses **you've** claimed. **We** may remove cashless access from **your policy**, and—if **you** don't repay the ineligible expenses to the **cashless access medical services provider** within 30 days—**we** may not renew **your policy**.

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.

We have the right to remove cashless access from **your plan** at any time within your **policy year**, at **our** discretion.

Exchange rates

We will settle **your claim** in the currency that **you** pay **your premium** (unless **you** instruct **us** to settle it in another currency **we** can support).

If the invoices for **your treatment** are in a currency different from **your policy** currency, then—using exchange rates from oanda.com—**we** will:

- calculate the amount payable in **your policy** currency;
- deduct any **excess** and/or **co-insurance;**
- apply any applicable benefit limits; then
- convert the amount payable into the currency in which **you** have asked **us** to pay **you**.

Exchange rates may fluctuate and **we** are not responsible for any losses **you** incur due to such fluctuations.

If **you** submit multiple invoices relating to the same **claim**, **we** will settle the invoices using the historic exchange rate from oanda.com for the date of the final invoice.

If **your treatment** spans two **policy years**, **we** will settle invoices for **treatment** received during **your** previous **policy year** at the historic exchange rate for the date of the final invoice of that **policy year**. **We** will settle subsequent invoices at the historic exchange rate for the date of the final invoice of the next **policy year**.

Excesses, co-insurance and benefit limits

The **excess** shown on **your certificate of insurance** is the amount each **member** will have to pay towards the cost of their **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 **your policy** has an **excess** per **claim**, this is the amount **you** will have to pay in respect of each course of **treatment you** receive for each specific illness or injury. When **you** renew **your policy**, the **excess** applies again. If **you** later start a new course

of **treatment** for the same illness or injury, **we** will treat course of **treatment** as a new **claim** and the **excess** will apply again.

If **your claim** is in respect of the well-being benefits, **your excess** will be applied once per **policy year**.

If **your excess** is per annum it will be applied once per **policy year**. For example, if **your excess** is US$500 per annum, **we** will not pay for the first US$500 of eligible expenses **you** incur during **your policy year**. **We** will apply one **excess** per **policy year** 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 **policy year**.

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 (i.e., 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 (or 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 **member**, 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 **member** 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** portion of the claim **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**.

Making a claim under the accidental death benefit

If a **member** has a Gold **plan** and they die as a result of an accident, **you** must let **us** know about their death. **You** must also provide the following documentation as soon as possible:

- An official death certificate confirming the cause of death and stating the date of death
- A medical or official certificate stating the cause and circumstances of death, and all other reports including police reports, ambulance reports and the reports of any eyewitnesses and such other documents as **we** may reasonably require to establish the cause of death and the circumstances of the death
- Any other medical reports or proof that **we** may reasonably require to enable **us** to assess **the claim**
- Identification for any beneficiaries showing date of birth, proof of life, proof of address and full bank details

If **you** have no dependants included on **your employer's policy**, **your** next of kin can get in touch with **us**. We'll need **your policy** number from **your** next of kin, plus the above documentation.

Receiving treatment in a private hospital room if you have the semi-private hospital room option

If **you** receive **inpatient** or **daypatient treatment** in a private room, but **your employer** has selected the semi-private **hospital** room option for **you**, **we** will apply a 20% **co-insurance** to **your** accommodation costs.

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 start **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 may 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

When adding an **eligible dependant** to **your employer's plan**, **our medical underwriting** requirements depend on the **medical underwriting** type selected by your employer and the age of **your eligible dependant** at the time of joining. Please ask **your employer** for full details of the requirements for adding a dependant to **your plan**.

We will not start 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**, and their **date of entry** can be backdated to birth, provided:

- **you** notify **us** of their full name and date of birth
- **your employer** pays the additional **premium** required, within 30 days of their date of birth
- **you** have been insured with **us** for a continuous period of twelve months or more at the date of birth

The child's cover will be restricted to the cover provided by **your employer's plan**.

A new **application** and **medical underwriting** will be required if:

- **your employer** does not pay the additional **premium** within 30 days of their date of birth
- **you** have not been insured with **us** for a continuous period of twelve months or more at the date of birth
- **your** newborn child has been born as a result of **assisted reproduction** treatment and born within 36 weeks of conception

The child's cover will be restricted to the cover provided by **your employer's plan**. For all newborn children **you** wish to add to **your plan**, **we** will require a copy of the child's birth certificate.

Adding a baby born by surrogacy, or adding an adopted/fostered child, to your policy

If **you** apply to add to **your** policy a baby born by surrogacy, or a child **you** have adopted or fostered, **we** will only consider their application once **you** have completed all legalities. **We** will need to see all relevant legal documents alongside a completed **application form**. The child must also reside with **you**, in the **country of residence** of the **policyholder** (as stated on the **certificate of insurance**).

We subject all such applications to full **medical underwriting**, and their cover will only start once **we** have received the additional **premium** following **our** acceptance of the application. For children under 3 months old, **we** require a copy of their hospital birth discharge report.

In the event of the death of a member

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 **policyholder**, **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 the Zone 2, 3, 4, 5 **coverage zone** and **you** move to a country where cover is restricted, **your employer** must apply to change **your coverage zone** to another Zone. **Your** application will be subject to **medical underwriting**.

If the USA, Ireland, or Switzerland is or becomes your country of residence

Under the terms of this **agreement**, insurance cover is not available to **you** if the United States of America, Ireland, or Switzerland is or becomes **your country of residence**, irrespective of **your** nationality. If the United States of America, Ireland, or Switzerland becomes **your country of residence you** must tell **us**. **Your** insurance cover will automatically terminate from the renewal date after **you** take up residence in the United States of America, Ireland, or Switzerland.

Sanctions restrictions

We will not provide insurance cover or pay any **claims** under **your employer's policy** if the laws of any relevant jurisdiction (including France, the UK, and the European Union), the resolutions, trade sanctions, and economic sanctions of the United Nations, or other sanctions under international law prevent or restrict **us** from doing so.

We will not provide **you** with any services or insurance cover including (but not limited to) acceptance of **premium** payments, **claim** payments, and other reimbursements if, in doing so, **we** would violate any applicable laws, regulations, codes, or court orders, or **we** are (or will be) otherwise sanctioned, prevented, or restricted.

We may cancel **your** insurance cover if **we** consider **you** a sanctioned person, or if **you** conduct an activity that is sanctioned according to trade or economic laws and regulations.

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 a personal health **plan** with no additional **medical underwriting**, but subject to **our premium** rates for personal health **plans**. 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 employer** ceases to be a member of the **William Russell Association for Health, Financial Protection and Well-Being**
- **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** 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 **member** 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 **member** 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** cover for any of the above reasons **we**:

- will not refund **your employer** with any **premium** they have paid to **us**
- may also report the matter to the relevant authorities, if appropriate

- reserve the right to recover from **you** the costs of any fraudulent **claims we** have paid

We have the right to cancel **your** plan from **your renewal date** if you move to a country where **we** are unable to offer continued cover due to compliance and/or legal reasons.

When we can change 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**.

When we may apply special terms to your plan

We may change the benefits offered by **your plan** and/or **your excess**. If **we** do, **we** will write to **your employer** before the **renewal date** to confirm these benefit changes and/or change in **excess**. Any changes **we** make to the benefits or **excess** will come into effect from the **renewal date** of **your plan**.

From time to time, **we** may decide to discontinue the **plan you** are insured on and/or change the **excesses** available. If this happens, **we** will transfer **your** membership to a similar **pl**an.

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 **member** 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 **member**, change
- keep **us** advised of **your** current email address
- inform **us** if **you** change **your** address, **country of residency** or **country of nationality**

Limitations on actions

The provisions relating to the statute of limitations on actions arising from the insurance contract are established by Articles L.114-1 - L.114-3 of the French Insurance Code indicated hereafter:

Article L. 114-1 of the French Insurance Code

All actions arising from an insurance contract are limited to two years after the incident giving rise thereto. However, this statute of limitations only applies:

1° In case of concealment, omission, false or inaccurate declaration of the risk involved, from the day on which the **insurer** had knowledge thereof;

2° In the event of a **claim** of damages, from the day on which the Parties involved became aware thereof, if they prove that they were unaware of it until then.

When the action of the Insured Party against the **Insurer** is due to the action of a third party, the statute of limitations only starts to run from the day on which the third party initiated legal proceedings against the Insured Party or was compensated by him.

The limitation is extended to ten years in life insurance contracts when the beneficiary is a person distinct from the policyholder and, in accident insurance contracts affecting people, when the beneficiaries are the beneficiaries of the deceased insured party.

For life insurance contracts, notwithstanding the provisions of Item 2, the actions of beneficiaries are limited to thirty years after the death of the Insured Party.

Article L. 114-2 of the French Insurance Code

The running of the statute of limitations is interrupted by one of the ordinary causes of interruption and by the appointment of experts following an incident. The interruption of the statute of limitations of the action can furthermore result from the sending of a registered letter with return receipt requested sent by the **Insurer** to the Insured Party regarding the action for the payment of the **premium** and by the Insured Party to the **Insurer** for the payment of the compensation.

Article L. 114-3 of the French Insurance Code

As an exception to article 2254 of the French Civil Code, the Parties to the insurance contract cannot, even by joint agreement, modify the duration of the statute of limitations, nor add to the causes of its suspension or interruption.

Additional information

The ordinary causes of interruption of the statute of limitations are mentioned in Article 2240 and in accordance with the Civil Code; among the latter include notably: the questioning of one of the joint debtors by a judicial action or by an act of compulsory execution or the acknowledgement by the debtor of the right of the person against whom he applied the statute of limitations. For the exhaustive list of the ordinary causes of interruption of the statute of limitations refer to the aforementioned articles of the Civil Code herein above.

How to make a complaint

At William Russell, each one of **our members** 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 Europe SRL
Place Marcel Broodthaers, 8
1060 Saint-Gilles
Brussels, Belgium

Phone +44 1276 486 455
Email contact@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 acts as mandated underwriter 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 insurers** (e.g., a decision regarding a **claim you** have made), **you** can write to the **insurers** at any stage in the process.

AWP Health & Life SA
Customer Relationships
Eurosquare, 2
7 rue Dora Maar
93400 Saint Ouen
France

Email client.care@allianzworldwidecare.com

AWP Health & Life SA is a signatory to the French Insurance Mediation charter. In the event of a persistent and definitive disagreement, the **policyholder** 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

If **your** complaint relates to a service provided by William Russell Europe SRL 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 Financial Ombudsman Service in the UK or the Belgian Ombudsman des assurances.

Financial Ombudsman Service
Exchange Tower
London E14 9SR, UK

Phone +44 (0)20 7964 0500
Email complaint.info@financial-ombudsman.org.uk
Web financial-ombudsman.org.uk

L'Ombudsman des assurances

Square de Meeûs, 35
1000 Brussels, Belgium

Phone +32 (0)2 547 58 71
Fax +32 (0)2 547 59 75
Email info@ombudsman-insurance.be
Web ombudsman-insurance.be

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 French 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 data

Your employer's policy is underwritten by AWP Health & Life SA and administered by William Russell Europe SRL. What follows here is a summary of the William Russell privacy policy and the AWP privacy policy.

The following information refers to **your** personal data and the personal data of all other **members** included on **your employer's policy**. Please ensure that all **members** included on **your employer's policy** read the information in this section and the information on the privacy policies linked above.

The personal data we collect

We collect data about **you** and other **members** included on **your employer's policy** from **you**, from those other **members**, **your medical practitioners**, **your employer's** insurance adviser (if they have appointed one), and other third parties involved in arranging and administering **your employer's policy**.

We collect data as part of **your application** and in correspondence with **you** by phone, email, post, or other means of communication. This data may include sensitive medical data such as details of **your** physical health, mental health, and well-being.

Failing to provide the personal data **we** require in order to underwrite and administer **your** insurance cover, or to process **your claims**, could result in **us** rejecting or not fully paying **your claims**, or **us** cancelling **your** insurance cover.

How we use your personal data

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

- Underwriting and administration of **your** insurance cover
- 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**

We only use **your** personal data in ways the law permits **us**. Where the use of **your** personal data relies on **your** consent, **you** can withdraw **your** consent. But if **you** do, **we** may not be able to process **your claims** or manage **your** insurance cover properly.

Who we may share data with

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

- **Our** providers of payment services
- Organisations (such as regulatory authorities) with which **we** have a duty to disclose or share **your** personal data to comply with **our** legal obligations
- Providers of research, marketing, and analysis services
- The **insurers** or reinsurers of **your employer's policy**
- **Our** emergency **Assistance Service** providers
- **Your employer's** insurance adviser (if they have appointed one)

Your personal data may be disclosed to other parties (such as other insurance companies) with a view to preventing fraudulent or improper **claims**. **We** never sell, rent or share unlawfully **your** personal data to third parties.

Processing claims

In the event of a **claim**, **we** may have to share **your** personal data to those involved in **your treatment** or care, or to **your** representative (if **you** have appointed one). This will be done confidentially.

Unless specifically instructed, correspondence about all **claims** (including those made by other **members** included on **your employer's policy**) will be addressed to the **policyholder**. An insured dependant over the age of 16 has the right to confidentiality in relation to their **claims** and personal data. For them to exercise this right, they should contact **our** policy services team.

If **you** have another insurance policy that covers the same costs that **you** are claiming from **us**, then **we** may also disclose **your** relevant personal data to the other insurer so **we** can ensure that **we** only pay **our** portion of the **claim** costs.

How we keep, store, and dispose of your personal data

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

Where we store your personal data

The personal data **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 data, **you** agree to this transfer, storing, and processing. **We** will take all steps necessary to ensure that **your** personal data are treated securely and in accordance with the information in this section.

Marketing

You have the right to ask **us** not to process **your** personal data for marketing purposes. **We** will always seek **your** explicit consent before collecting **your** personal data for marketing purposes. **You** can withdraw **your** consent for **us** to use **your** personal data in this way at anytime by emailing **us** at marketing@william-russell.com.

Obtaining a copy of the information we hold about you

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

The Data Protection Officer
William Russell Europe SRL
Place Marcel Broodthaers, 8
1060 Saint-Gilles
Brussels, Belgium

Phone +44 1276 486 455
Email contact@william-russell.com

Where personal data has been supplied by a **medical practitioner**, **you** should be aware that **we** need their consent before **we** can supply this to **you**. Alternatively, **you** can request such personal data directly from the **medical practitioner**.

If **you** believe **we** are not processing **your** personal data in accordance with the law, **you** can complain to:

The Data Protection Authority
Rue de la Presse-Drukpersstraat, 35
1000 Brussels, Belgium

You can view **our** full privacy policy at william-russell.com/privacy.

Definitions

This section explains what **we** mean by certain emboldened 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.

Advanced imaging

Diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET).

Africa

Algeria, Angola, Ascension Island, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Djibouti, Egypt, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mayotte, Morocco, Mozambique, Namibia, Niger, Nigeria, Republic of the Congo, Reunion, Rwanda, Saint Helena, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, Western Sahara, Zambia and Zimbabwe.

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**. Together, these items make up **your** agreement and determine the terms and conditions of **your** cover under the **master policy.**

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.

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 a **member** at the time of a **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-cytoblastic 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 countries and islands

All countries in the Caribbean region; Anguilla, Antigua and Barbuda, Aruba, Barbados, British Virgin Islands, Cayman Islands, Cuba, Curacao, Dominica, Dominican Republic, Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Monserrat, Netherlands Antilles, Saint Barthelemy, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Vincent and the Grenadines, Sint Maarten, Trinidad and Tobago, Turks and Caicos Islands and U.S. Virgin Islands.

Cashless access medical services provider

A **hospital**, **outpatient** clinic or **doctor** with whom **we** hold a current, cashless access agreement.

Certificate of insurance

The confirmation of **your** insurance cover issued by **us**. It confirms the **plan your employer** has chosen, the **plan** currency, **your coverage zone**, **policy year**, **date of entry**, **renewal date**, **excess** amount, **special terms**, **your country of residence**, **your country of nationality**, and the schedule of **members**. The schedule of **members** lists the **members** 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 a benefit in the *Expat benefits* section of the **table of benefits**.

Close family member

Your spouse, civil or co-habiting partner, parent, brother, sister, child or grandchild.

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 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**.

Country of residence

The country in which **you** are habitually resident, as specified on **your application form** or subsequently advised to **us** in writing. **Your country of residence** is a factor when **we** calculate the **premium your employer** pays for **your** cover. If **you** regularly have **your treatment** in a country which is not **your** declared **country of residence**, **we** reserve the right to use the country where **you** regularly have **your treatment** as **your country of residence** when **we** calculate **your renewal premium**.

Coverage zone

The territorial limits of **your plan**.

Date of entry

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

Daypatient

A patient admitted to a **hospital** or **daypatient** unit for a medical procedure which for medical reasons could not have been performed on an **outpatient** 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.

Doctor

A doctor 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.

Eligible dependants

Your spouse or **partner**, provided they are under age 76 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 dependant child being in full-time education.

Emergency caesarean section

A caesarean section which must take place immediately and cannot be planned.

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** under the health **plan** provided by **your employer**.

Employer

The **policyholder** 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**.

Experimental drugs and treatments

Any **treatment** that independent, randomised clinical trials have not—in reputable, peer-reviewed studies in medical/scientific journals—established as having clear benefits over existing, conventional **treatments**.

Hospital

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

Imaging tests

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

Indian Subcontinent

Bangladesh, India, Pakistan and Sri Lanka

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.

Inpatient

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

Insurer

The insurance company that provides the insurance cover for **your plan**. The **insurer** is Allianz (AWP Health & Life SA).

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 **inpatient treatment**.

London area

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

Master certificate of insurance

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

Master policy

The contract of insurance issued by **us** to the **William Russell Association for Health, Financial Protection and Well-Being**, for the benefit of its members and their **employees**.

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 **doctor**.

Medical referral letter

A letter from **your 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**, **outpatient** 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.

Member

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

Outpatient

A patient who attends a **hospital** consulting room, emergency room or **outpatient** clinic, when it is not **medically necessary** for them to be admitted as a **daypatient** or an **inpatient**.

Outpatient surgical procedure

An **outpatient** 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 **doctor**

- invasive surgical procedures
- invasive diagnostic procedures involving venous cannulation
- the use of endoscopic equipment

Palliative care

The care that takes place when all other active modalities of **treatment** for **your** medical condition have been withdrawn, and **treatment** is not longer aimed at curing **your** condition. The aim of such care is to prevent and relieve suffering through the correct assessment and **treatment** of pain and other problems, whether physical, psychosocial, or spiritual.

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

Bronze **plan**, Silver*Lite* **plan**, Silver **plan**, or Gold **plan** on which **you** and **your eligible dependants** are covered.

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.

Policy

The contract of insurance between **us** and **your employer** from which **you** and **your eligible dependants** derive **your** insurance cover.

Policy year

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

Policyholder

Your employer, stated as the **policyholder** on **your certificate of insurance**.

Post-hospital treatment

Medically necessary follow-up consultations, physiotherapy, **imaging tests** and/or **treatment** required on an **outpatient** basis following **inpatient** or **daypatient treatment** covered by **your plan**.

Pre-admission tests

An **outpatient** 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.

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 in this **agreement** that sets out the benefits covered by each **plan**.

Temporary trip

A trip for business and/or recreational purposes, which has a defined return date, and is for a period of no more than 90 days. If **your** trip to a country where **you** only have restricted cover extends beyond the number of days specified for **your coverage zone**, **we** will not pay for **treatment you** receive after that number of days has elapsed. For example, if **your employer** has selected the USA-45 option and **you** are on a 30-day trip to the United States of America, which becomes extended to 60 days, **your** cover in the United States of America will cease 45 days after **your** entry date to the United States of America.

Terminal medical condition

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

Treatment

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

Us, we, our

William Russell Europe SRL 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.

William Russell Association for Health, Financial Protection and Wellbeing (WRA)

The not-for-profit association registered in Belgium as the **William Russell Association for Health, Financial Protection and Well-Being.**

You, your, yourself

Any and all persons named in the schedule of **members** on **your certificate of insurance**.

We're here to help

Call us on
+44 1276 486 455

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