Personal Health Plan Agreement

Individuals & Families

William Russell

For members with a personal health plan whose period of cover starts on or after **01 January 2021**

Welcome to William Russell

Thank **you** for choosing a personal health **plan** from William Russell. **We** want to provide **you** with an insurance policy **you** can rely on, so it is important that **you** fully understand the scope of the cover **we** provide. This **agreement** explains what is and what is not covered by **your plan**, and how y**our claims** will be administered.

By taking out a personal health **plan** from William Russell **you** have become a member of 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 Certificate of Insurance** and **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 **insured persons** on this **plan**, as shown on **your Certificate of Insurance**

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 plan. William Russell Europe SRL is registered in Belgium with the Financial Services and Markets Authority ("FSMA"), as mandated underwriter, acting on behalf of AWP Health &Life SA (part of the Allianz group of companies).

Allianz

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

Your right to cancel within 30 days

If **you** decide **your plan** does not meet **your** needs, simply contact **us** and advise **us** that **you** wish to cancel. Provided **we** receive **your** written instruction within 30 days of **your date of entry**, and provided no **claims** have been made, **we** will refund **your premium in** full.

If **we** receive **your** instruction to cancel **your plan** more than 30 days after **your date of entry**, the terms of **our** cancellation policy will apply.

Contact details

If you have an enquiry about your plan or insurance	**Phone** +44 1276 486 455 **Fax** +44 1276 486 466 **Email** enquiries@william-russell.com
If you need to make a claim	**Phone** +44 1276 486 460 **Fax** +44 1276 486 476 **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: -** william.russell@cegagroup.com **Web** william-russell.com/contact/emergency
If you'd like to write to us	**William Russell Europe SRL** 8, Place Marcel Broodthaers 1060 Saint-Gilles Brussels, Belgium

Your plan agreement

This **agreement**, together with **your application form** and **your Certificate of Insurance** determine the terms and conditions of **your** cover under the **master policy.** The terms of this **agreement** apply to **you** and to all of **your eligible dependants** as stated in the schedule of **insured persons** on **your Certificate of Insurance**.

The purpose of your plan

Your plan provides **you** with benefit for the cost of 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**. **We** will only pay for such **treatment** if it is received during **your period of cover**, and provided **your premium** payments have been kept up to date.

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**.

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

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

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

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

Pre-existing medical conditions and related conditions

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

Age limits

You must be under 76 years of age at the commencement date of **your plan**.

You may apply for cover on behalf of **your** spouse or partner (provided they are under 76 years of age) and/or on behalf of **your** unmarried children, provided they are aged less than 18 years old, or less than 25 years old if in continuous full-time education.

Commencement of your cover

Your cover will commence from the **date of entry** stated on **your Certificate of Insurance**. **We** will not commence **your** cover until **we** have accepted **your application** and **we** have received payment of **your** full annual, half-yearly, quarterly or monthly **premium**.

Your area of cover

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

Zone 1

Worldwide, excluding the United States of America.

Zone 2

Worldwide, excluding the United States of America and 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 (treatment is only restricted within the Bumrungrad Hospital and Bangkok Hospital Group facilities) China, Hong Kong, Macau, Taiwan, Japan, Australia, New Zealand, Canada, and the ***Caribbean countries and islands****.*

When **you** travel to one of these countries and regions, **you** will only be covered for **accident & emergency treatment**. The maximum **we** will pay in respect of **treatment you** receive in any of these countries and regions is US$100,000 or £66,000 or €75,000 per **period of cover**.

Zone 3

Worldwide, excluding the United States of America and with restricted cover in the following countries and regions: -

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

When **you** travel to one of these countries and regions, **your** cover is subject to the following restrictions: -

- 80% cover for eligible elective **treatment** costs; and
- 100% cover up to US$100,000 or £66,000 or €75,000 per **insured person** for eligible **accident & emergency treatment**.

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

USA cover options

The following two options provide limited cover in the United States of America. They are only available if **you** have selected Zone 1 as **your area of cover**.

If **you** have one of the options for limited cover in the United States of America**,** it will be stated on **your Certificate of Insurance**.

Cover in the USA limited to temporary trips of up to 45 days (USA-45)

We will cover **you** in the United States of America for **temporary trips** of up to 45 days' duration from the date on which **you** enter the country. Any trip of longer than 45 days will not be covered, but there is no limit to the number of **temporary trips you** can make to the United States of America during any one **period of cover**.

The overall maximum amount **we** will pay in respect of **treatment you** receive in the United States of America is US$250,000 per **insured person**, per **period of cover**. Within this amount, **we** will pay: -

- up to US$100,000 for elective **treatment**; and
- up to US$250,000 for **accident & emergency treatment** of a condition that **you** have not previously suffered from prior to commencing **your temporary trip**.

We do not cover emergency evacuation to, from or within the United States of America, even if **you** have selected the USA-45 option.

Cover in the USA limited to temporary trips of up to 90 days (USA-90)

We will cover **you** in the United States of America for **temporary trips** of up to 90 days' duration from the date on which **you** enter the country. Any trip of longer than 90 days will not be covered, but there is no limit to the number of **temporary trips you** can make to the United States of America during any one **period of cover**.

The overall maximum amount **we** will pay in respect of **treatment you** receive in the United States of America is US$250,000 per **insured person**, per **period of cover**. This overall maximum amount includes both elective **treatment** and **accident & emergency treatment** that **you** receive.

We do not cover emergency evacuation to, from or within the United States of America, even if **you** have selected the USA-90 option.

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

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

Certain benefits in the **table of benefits** are optional. **You** are only eligible for these benefits if **you** have 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 **insured person** can **claim** during any one **period of cover**.	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 Private hospital room - the cost of a standard single room with an en-suite bath or shower room, when **you** are an **in-patient** or **day-patient**. Semi-private hospital room - the cost of a standard shared room with an en-suite bath or shower room, when **you** are an **in-patient** or **day-patient**. Accommodation in a private hospital room is only available under the Bronze and Silver*Lite* plans if **you** have 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 **in-patient** or **day-patient**, including surgeons' and anaesthetists' and **doctors'** fees, nursing care, drugs and surgical dressings, operating theatre charges and intensive care, pathology, X-rays, scans, **diagnostic tests** and physiotherapy. **We** will also pay for **pre-admission tests** that **you** undergo on an **out-patient** basis for **hospital treatment you** are scheduled to receive that is covered by **your plan**. **We** will also pay for **in-patient** 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 **medical 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
Road ambulance The cost of a private road ambulance if **you** need **hospital treatment** covered by **your plan** and if it is **medically necessary** for **you** to travel to **hospital** by ambulance.	Full cover	Up to US$1,600 or £1,065 or €1,200 per **period of cover**	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**. Benefit is paid for up to a maximum of 60 nights per **period of cover**. If selected, **your excess** will not be applied 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
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.	Up to US$6,000 or £4,000 or €4,500 per **period of cover**	Up to US$6,000 or £4,000 or €4,500 per **period of cover**	Up to US$6,000 or £4,000 or €4,500 per **period of cover**	Up to US$6,000 or £4,000 or €4,500 per **period of cover**
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 **insured person**

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

	Bronze	SilverLite	Silver	Gold
Cancer treatment (continued) Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.				
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
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 **medical doctor** for out-patient 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 **out-patient 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 **in-patient** or **day-patient**.	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 **in-patient**, **day-patient** or **out-patient**.	Full cover	Full cover	Full cover	Full cover

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

	Bronze	SilverLite	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.	**In-patient**, **day-patient** and **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**	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 commencement of **your** cover, **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**.	**In-patient**, **day-patient** 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$20,000 or £13,300 or €15,000	Lifetime limit of US$20,000 or £13,300 or €15,000	Lifetime limit of US$40,000 or £26,600 or €30,000	Lifetime limit of US$80,000 or £53,300 or €60,000
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
In-patient and day-patient mental health treatment (12-month waiting period) **In-patient** and **day-patient treatment** received in a recognised mental health unit of a **hospital**.	Up to 30 days per **period of cover**	No cover	Up to 30 days per **period of cover**	Up to 30 days per **period of cover**

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

	Bronze	Silver*Lite*	Silver	Gold
Mental health treatment (continued) 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.				
Out-patient 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 **medical doctor**. **We** do not pay for drugs prescribed for **out-patient** mental health **treatment**.	Up to 10 consultations per **period of cover** for **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**	No cover	Up to 10 consultations per **period of cover**	Up to 10 consultations per **period of cover**
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**.	**In-patient** and **day-patient treatment** only, up to US$5,000 or £3,300 or €3,750 per **period of cover**	Up to US$5,000 or £3,300 or €3,750 per **period of cover**	Up to US$75,000 or £50,000 or €56,250 per **period of cover**	Up to US$100,000 or £66,600 or €75,000 per **period of cover**
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 **in-patient**, **day-patient** 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.	Up to US$250 or £160 or €188 per medical condition per **period of cover**	No cover	Up to US$500 or £330 or €375 per medical condition per **period of cover**	Up to US$1,000 or £660 or €750 per medical condition per **period of cover**
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

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

	Bronze	Silver*Lite*	Silver	Gold
Medical appliances (continued)				
Prosthetic devices External prosthetic body parts, such as prosthetic limbs, fitted after the healing of an amputation covered by **your plan**.	Up to US$500 or £330 or €375 per device	Up to US$1,000 or £660 or €750 per device	Up to US$1,000 or £660 or €750 per device	Up to US$1,500 or £1,000 or €1,125 per device
Out-patient treatment Important notes: - • **You** must obtain pre-authorisation for certain benefits in this section.				
Annual limit for out-patient treatment The overall maximum limit to the amount **you** can **claim** for **treatment you** receive as an **out-patient** during any one **period of cover**. The annual limit for out-patient treatment option selected under the Silver*Lite* **plan** will also be the option that applies to the primary medical care beneft. **You** are not eligible for additional cover if **you** do not select an option.	No annual limit	Up to US$5,000 or £3,300 or €3,750 **per period of cover** Option A Up to US$7,500 or £5,000 or €5,625 **per period of cover** Option B Up to US$10,000 or £6,600 or €7,500 **per period of cover**	No annual limit	No annual limit
Primary medical care Visits to a GP or **doctor**, **specialist** consultations, prescribed drugs and dressings, pathology, scans, radiology and **diagnostic tests** received as an **out-patient**. **We** do not cover home visits. The primary medical care option selected under the Silver*Lite* **plan** will also be the option that applies to the annual limit for out-patient treatment. **You** are not eligible for additional cover if **you** do not select an option.	**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 period of cover** Option A Up to US$2,500 or £1,665 or €1,875 **per period of cover** Option B Up to US$3,500 or £2,310 or €2,625 **per period of cover**	Full cover	Full cover

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

	Bronze	SilverLite	Silver	Gold
Out-patient treatment (continued) Important notes: - • **You** must obtain pre-authorisation for certain benefits in this section.				
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 **medical doctor**	Up to the annual limit for **out-patient treatment**	Full cover	Full cover
Out-patient surgical procedures Surgical procedures where it is not **medically necessary** for **you** to be admitted to **hospital** as an **in-patient** or **day-patient**.	Full cover	Up to the annual limit for **out-patient treatment**	Full cover	Full cover
Advanced diagnostic tests MRI and CAT (CT) scans performed on the advice of a **medical 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 **diagnostic test**. **You** must obtain pre-authorisation for all advanced **diagnostic tests**.	Full cover	Up to the annual limit for **out-patient treatment**	Full cover	Full cover
Complementary treatments **Treatment** by a chiropractor, osteopath, chiropodist, podiatrist, homeopath or acupuncturist on the advice of a **medical 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 **period of cover** 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 **period of cover** 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 **period of cover**	Up to 15 **sessions** per **period of cover**
Hormone replacement therapy When prescribed by a **medical 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 **period of cover**. **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**

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

	Bronze	SilverLite	Silver	Gold
Out-patient treatment (continued) Important notes: - • **You** must obtain pre-authorisation for certain benefits in this section.				
Physiotherapy **Medically necessary** physiotherapy when **you** have been referred on the advice of **your medical 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.	Partial or limited cover: **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 **period of cover**	Partial or limited cover: Up to US$250 or £165 or €188 per **period of cover** up to the annual limit for **out-patient 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**.	Partial or limited cover: **In-patient**, **day-patient,** and **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**	Partial or limited cover: **In-patient** and **day-patient treatment**, with cover for **out-patient 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	Partial or limited 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 **you** have selected them 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, including: - • health screens (e.g. tests for cholesterol, high blood pressure, diabetes, anaemia, lung/kidney/liver function, cardiac risk) • Papanicolaou (PAP) test • mammogram, prostate cancer, and colon cancer screens • flu jabs • hearing test • eye examination If **you** have selected the enhanced preventive health and well-being option, **you** are eligible for the higher benefit limit on **your plan**.	No cover	No cover	Up to US$300 or £200 or €225 per **period of cover** Up to US$500 or £330 or €375 per **period of cover** (if **you** have selected the enhanced option)	Up to US$750 or £500 or €563 per **period of cover** Up to US$1,300 or £860 or €975 per **period of cover** (if **you** have selected the enhanced option)
Vaccinations for adults Immunisations and booster injections required under regulation of the country in which **treatment** is being given, and any **medically necessary** travel vaccinations and malaria prophylaxis.	No cover	No cover	Up to US$150 or £100 or €113 per **period of cover**	Up to US$250 or £167 or €188 per **period of cover**
Well-child benefit (6-month waiting period) Routine vaccinations and developmental check-ups for children. Vaccinations are limited to all basic immunisations and booster injections that are either mandated, or part of government recommended programmes within the country in which they are administered. 6-month waiting period will be waived if either parent has been insured on the **plan** for at least 6 months when children are added to the **plan**.	No cover	No cover	Up to US$200 or £133 or €150 per **period of cover**	Up to US$400 or £260 or €300 per **period of cover**
Rehabilitation treatment Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.				
Rehabilitation treatment you receive as an **in-patient**, carried out under the control and supervision of a **specialist** in a recognised **rehabilitation hospital or unit**, and only when it immediately follows **in-patient treatment** for illness or injury covered by **your plan**. This benefit is payable only when the admission takes place on the written recommendation of **your** treating **specialist** and the admission must take place immediately following **your** discharge from **hospital**.	Up to 7 days per medical condition	Up to 7 days per medical condition	Up to 15 days per medical condition	Up to 30 days per medical condition

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

	Bronze	Silver*Lite*	Silver	Gold
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 12 weeks per medical condition	Up to 2 weeks per medical condition	Up to 12 weeks per medical condition	Up to 12 weeks per medical condition
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
Dental costs Important notes: - • **You** are eligible for certain benefits in this section only if **you** have selected them 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 consultations or **treatment** of any kind.				
Emergency restorative treatment you receive as an in-patient **In-patient 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 **period of cover**	Full cover	Full cover

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

	Bronze	SilverLite	Silver	Gold
Dental costs (continued) Important notes: - • **You** are eligible for certain benefits in this section only if **you** have selected them 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 consultations or **treatment** of any kind.				
Emergency restorative treatment you receive as an out-patient **Out-patient 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 **period of cover**	Up to US$1,000 or £660 or €750 per **period of cover**
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 Dental Basic benefit is optional on the Silver **plan**. It is included as standard on the Gold **plan**.	No cover	Up to US$500 or £330 or €375 per **period of cover**, subject to a 20% **co-insurance** (if **you** have selected the Dental Basic option)	Up to US$1,000 or £660 or €750 per **period of cover**, subject to a 20% **co-insurance** (if **you** have selected the Dental Basic option)	Up to US$1,500 or £1,000 or €1,125 per **period of cover**
Dental Plus (12-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**. Silver **plan holders** wishing to select Dental Plus must also select the Dental Basic option	No cover	No cover	Up to US$1,500 or £1,000 or €1,125 per **period of cover**, subject to a 20% **co-insurance** (if **you** have selected the Dental Plus option)	Up to US$2,000 or £1,330 or €1,500 per **period of cover**, subject to a 20% **co-insurance** (if **you** have selected the Dental Plus option)

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

	Bronze	SilverLite	Silver	Gold
Maternity costs Important notes: - • Dependant children included in **your plan** are not eligible for these benefits. • **You** must obtain pre-authorisation for all benefits in this section. • **We** do not cover the **treatment** of any newborn child born following **assisted reproduction** (e.g. IVF) in the event of the birth occurring within 36 weeks of conception. • Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and childbirth 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. • **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 **planned caesarean section** • any **hospital** accommodation costs for the newborn baby • 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 **medical doctor** The limits shown for this benefit apply to each pregnancy, regardless of the number of children born. Any **hospital** or birthing center accommodation costs will be limited to the cost of a standard **hospital** room.	No cover	No cover	No cover	Up to US$15,000 or £10,000 or €11,250 per pregnancy
Complications of pregnancy (12-month waiting period) **In-patient** or **day-patient treatment** necessary as a direct result of a **complication of 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** have been covered by **your plan**.	Up to US$4,800 or £3,200 or €3,600 per **period of cover**	Up to US$10,000 or £6,600 or €7,500 per **period of cover**	Up to US$15,000 or £10,000 or €11,250 per **period of cover**	Full cover
Childbirth necessitating an emergency surgical procedure (12-month waiting period) Surgeons', anaesthetists' and theatre fees for childbirth that necessitates an emergency surgical procedure and any additional accommodation charges incurred as the result of the surgical procedure. This includes childbirth by **emergency caesarean section**.	No cover	No cover	No cover	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: - • Dependant children included in **your plan** are not eligible for these benefits. • **You** must obtain pre-authorisation for all benefits in this section. • **We** do not cover the **treatment** of any newborn child born following **assisted reproduction** (e.g. IVF) in the event of the birth occurring within 36 weeks of conception. • Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and childbirth 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. • **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 plan** within 30-days of birth and premiums paid • **Your** newborn baby 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.	No cover	No cover	**In-patient** or **day-patient treatment** received within the 90-day period following birth, up to US$10,000 or £6,600 or €7,500 per pregnancy	**In-patient** or **day-patient 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 certain benefits in this section only if **you** have selected them 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 CEGA) at +44 (0) 1243 621 155 or william.russell@cegagroup.com.	Full cover	Full cover	Full cover	Full cover
Medevac Basic If **you** (or any child covered by the newborn benefit within its first 90 days of life) have a life-threatening or limb-threatening condition covered by **your plan** which requires immediate **in-patient treatment** that cannot be adequately provided locally, the **Assistance Service** will arrange for **you** to be moved by air and/or by surface transportation to the nearest **hospital** within **your area of cover** where appropriate medical **treatment** is available. **We** do not cover any other costs under this benefit such as hotel accommodation charges. **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

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

	Bronze	SilverLite	Silver	Gold
Expat benefits (continued) Important notes: - • **You** are eligible for certain benefits in this section only if **you** have selected them and they are stated on **your Certificate of Insurance**. • **You** must obtain pre-authorisation for all benefits in this section.				
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 **period of cover**).	Up to US$72 or £48 or €54 per night	Up to US$50 or £33 or €38 per night	Up to US$96 or £64 or €72 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 period of cover** 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 insured person	No cover	Lifetime limit of one claim per insured person	Lifetime limit of one claim per insured person
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
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

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 certain benefits in this section only if **you** have selected them and they are stated on **your Certificate of Insurance**. • **You** must obtain pre-authorisation for all benefits in this section.				
Medevac Plus The following benefits apply in addition to those under the Medevac Basic benefit. Evacuation if **you** (or any child covered by the newborn benefit within its first 90 days of life) need **advanced diagnostics** 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 area of cover**, 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 area of cover** 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 area of cover**, 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 **period of cover**) 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). The Medevac Plus benefit is optional on all **plans.**	Full cover (if **you** have selected the Medevac Plus option)	Full cover (if **you** have selected the Medevac Plus option)	Full cover (if **you** have selected the Medevac Plus option)	Full cover (if **you** have selected the Medevac Plus option)

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. **You** will be responsible for them.

- fees for the completion or providing of **claim** forms or any other medical reports or forms such as **medical referral letters**, even if **we** have requested them
- bank charges incurred as a result of **us** transferring money
- losses **you** may incur due to fluctuations in exchange rates
- charges incurred as the result of payment errors that arise as the result of **you** having provided **us** with incorrect information
- administration, registration, or cancellation fees charged by **hospitals**, **doctors**, or other providers of medical services
- any charges made by **your** bank or credit card company

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
- 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

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
- 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
- allergy desensitisation or food neutralising injections

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

Alternative treatment and therapies

You are not covered for alternative **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)
- 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**.

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

You are not covered for: -

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

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

Cosmetic surgery and treatment

You are not covered for investigations or **treatment** related to: -

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

Criminal activity

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

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**).

Drugs prescribed for out-patient mental health treatment

You are not covered for drugs prescribed for **out-patient** mental health **treatment**. However, there may be some cover under the the *cancer **treatment**, counselling* 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)
- 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**
- complications arising from ignoring such advice

Foetal surgery

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

Genetic testing or genetic engineering

You are not covered for genetic testing or genetic engineering, other than **treatment you** are eligible for under the cancer genome tests benefit 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
- 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
- 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
- reproductive hormone testing, reproductive hormone therapy or hormone replacement therapy (unless covered under **your plan** under the hormone replacement therapy benefit in the *out-patient 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
- **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
- bed wetting

Pre-existing medical conditions or related conditions

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

- any **pre-existing medical conditions** of the following types and any **related conditions**, if **you** have ever had them at any time before **your date of entry**, unless **we** have agreed otherwise: -
  - *brain or nervous system conditions*
  - *cancer, tumours or growths*
  - *heart or circulatory conditions*
  - *mental health conditions, drug and alcohol issues or sleep disorders*
  - *joint replacements*; and
- any other **pre-existing medical conditions** and **related conditions** that **you** have had during the five years before **your date of entry**, unless **we** have agreed otherwise.

Preventive surgery

You are not covered for surgery when no physical signs or symptoms are shown, or no diagnosis has been made.

Professional sports and motorised racing as an amateur or a professional

You are not covered for **treatment** for an illness or injury related to: -

- participation 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)
- 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
- 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 or rescue from ski slopes or pistes
- evacuations from offshore installations such as oil rigs, or from any type of sea going vessel such as a ship, ferry or yacht

Second opinions or duplicate tests

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

Self-inflicted injuries

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

Sexually-transmitted infections

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

Sleep disorders

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

Stem-cell harvesting

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

Sundry medical supplies

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

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

Vitamins, dietary supplements, natural substances, and creams

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

War and terrorism

You are not covered for **treatment** arising directly or indirectly from war, foreign enemy hostility, terrorism, rebellion, civil war, revolution, military coup, riot, strike, martial law, state of 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
- eating disorders of any kind, such as anorexia nervosa or bulimia

Wilful exposure to needless danger

You are not covered for **treatment** of any conditions arising directly or indirectly from **your** gross negligence and/or **your** wilful exposure to needless danger except in an attempt to save a human life.

If you need to make a claim

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

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

Eligible medical services providers

You have the freedom to choose when and where **you** receive **your** medical **treatment** within **your area of cover**. 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 optional USA cover and you seek treatment in the USA

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 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 area of cover* section of this **agreement**.

If you are admitted to hospital

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

Please contact **us** as soon as **you** know that **you** need **in-patient** or **day-patient treatment**. **You** must let **us** know that **you** need **in-patient** or **day-patient 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 **out-patient** physiotherapy, any **treatment** by a chiropractor, **out-patient** mental health **treatment**, 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 **in-patient** or **day-patient treatment** direct with the **hospital** or **medical services provider**. **We** will deduct any **excess** or **co-insurance** amount, as well as any other ineligible items, and **you** will be responsible for paying the shortfall direct to the **hospital** or **medical services provider**.

If **we** are paying **you** direct, **our** preferred method of payment is bank transfer. If **you** provide us with incorrect payment details and **we** cannot recover the payments, **we** will not make the payment again to **you**.

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

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

Using the direct billing service

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

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

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

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

This means that, for **claims** of less than US$500 where the **direct billing medical services provider** is not obliged to contact **us** for pre-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 **direct billing medical services providers** within **our medical network**, provided that they fall within the terms of the contract between **us** and them.

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

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

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

We have the right to remove direct billing from **your plan** at any time within **your period of cover,** at **our** discretion.

Exchange rates

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

If **we** make a currency conversion for a **claim** with a single invoice, **we** will use the exchange rate applicable on the date stated on the invoice.

For multiple invoices **you** submit for one **claim**, **we** will use the exchange rate applicable on the **claim** payment date.

We import exchange rates from oanda.com into **our** IT system each night. **We** use the exchange rates at the time of the import, which may differ slightly from the historic exchange rates shown on oanda.com. Historic exchange rates are based on the average exchange rate for any particular day.

Excesses, co-insurance, and benefit limits

The **excess** shown on **your Certificate of Insurance** is the amount each **insured person** 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** or limits, **we** will apply the **co-insurance** first, then the **excess**, then the limit.

If **you** have a **plan** which has an **excess** per **claim**, this is the amount **you** will have to pay each time **you** make a new **claim** for **treatment** of a condition that is covered by **your plan.** If **you** subsequently suffer a new occurrence of that condition, this will be treated as a new **claim**, and **we** will apply the **excess** again to that new **claim**. If your course of **treatment** spans two **periods of cover**, **we** will apply the **excess** again when **your plan** renews.

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

If **your excess** is per annum it will be applied once per **period of cover**. For example, if **your excess** is US$500 per annum, **we** will not pay for the first US$500 of eligible expenses **you** incur during **your period of cover**. **We** will apply one **excess** per **period of cover** irrespective of the number of **claims you** make. **You** must

submit all eligible **claims** to **us** - even **claims** within **your** annual **excess**, as **we** will only be able to reimburse **you** when the value of the eligible expenses **you** incur exceeds the amount of **your** annual **excess**. When **you** renew the **plan**, the annual **excess** will apply again in respect of **your** new **period of cover**.

Our right to request additional information

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

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

Our right to request a treatment review

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

Illness or injury caused by a third party

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

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

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

If you are covered by another insurance plan

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

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

Other information about your plan

Plan premiums

The **plan premiums** are age-related and will increase as **you** get older. The **plan premiums** are not guaranteed for the duration of **your plan** and are subject to annual review. The **plan premiums** are also dependent upon **your country of residence**. **You** must tell **us** if **your country of residence** changes.

All **premiums** are payable in advance of the **premium due date** as shown on **your** invoice. **Premiums** must be paid in the **plan** currency.

You may pay **your premiums** by the following method: -

- annually by cheque or direct debit from a UK bank account, bank transfer, or an acceptable credit or debit card
- half-yearly, quarterly, or monthly by an acceptable credit or debit card, or by direct debit from a UK bank account

We can only accept direct debit payments if **you** have a sterling **plan**.

If **you** pay **your premiums** by direct debit, **we** will require **your** original, signed direct debit mandate before **we** can commence **your plan**.

If insurance **premium** tax or any similar charge is levied by the government in **your country of residence**, **you** must also pay to **us** the amount of such tax.

Premiums must be paid directly to **us**. If **you** pay **your premiums** to anyone else such as an intermediary or insurance broker, then that person is acting on **your** behalf as **your** agent. **We** are not responsible for any **premiums** paid to any third party.

When **you** provide **us** with **your** credit or debit card details or direct debit mandate **you** are authorising **us** to debit **your** account with the appropriate **premiums** due for the current **plan** year and for all subsequent renewal **premiums** due as invoiced by **us**, until such time as **you** advise **us** in writing that **you** wish to alter **your** payment method or cancel **your plan**. It is **your** responsibility to keep **us** informed about **your** current credit or debit card details. Provided the details **we** hold for **you** are still valid, **we** will automatically debit **your** account with **your** renewal **premium** on or before **your renewal date**.

Unpaid or late premiums

We will automatically cancel **your** cover if **you** fail to pay **your premium** on or before the **premium due date**, or if **we** are unable to collect **your premium** from **your** credit or debit card, or by direct debit for any reason.

We may allow **your** cover to continue without **you** having to complete a new **application form** and health declaration if **you** pay 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 **you** have paid the **premium** due. This also applies to **treatment** that **we** have already pre-authorised.

If **you** do not pay **your 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**, **you** will have to complete a new **application form** which will be subject to **medical underwriting**.

Enhancing your cover

You may apply to enhance **your** cover at any time by completing a new **application form**, and the enhanced cover will be subject to **medical underwriting**.

If **we** accept **your application** for enhanced cover, **we** will issue an invoice for the increased **premium**. **Your** enhanced cover will commence from the date **we** receive **your premium**, provided it is received within 30 days of the date of **your application**.

If **you** enhance **your plan**, **claims** in respect of benefits that are subject to a **waiting period** will be assessed in accordance with **your** former **plan** until the expiry of **your** new **plan's waiting period** for that benefit. For example, if **you** are covered by the Silver **plan**, and **you** enhance **your plan** to the Gold **plan**, any benefit payable in respect of the *well-being benefits* section will be restricted to the Silver **plan** benefit limit for the first 6 months of **your** Gold **plan**.

If **you** apply to reduce **your excess**, **we** will continue to apply **your** previous **excess** to any **claim** for any condition that first manifests itself after **your** original **date of entry** to **your** previous **plan**, but before the date **your excess** is reduced.

If **we** accept **your application** for enhanced cover, all conditions that existed prior to the date on which **your** cover is enhanced will be restricted to the level of cover that **you** held immediately prior to that date, even if **you** have previously held a higher level of cover.

Reducing your cover

If **you** wish to reduce the cover under **your plan** in any way, **you** must tell **us** in writing and **we** will make the change from **your** next **renewal date** only.

We may refuse any request to change **your excess** to a per annum basis.

If **you** wish to cancel the optional Dental Basic, Dental Plus or Medevac Plus benefits, they will be cancelled for all **insured persons** on **your plan**.

Changing your plan currency

Once cover under **your plan** has commenced, **you** cannot change **your plan** currency.

However **you** can cancel **your plan** and apply for a new **plan**. **You** will have to complete a new **application form** which will be subject to **medical underwriting**.

Adding dependants to your plan

You may apply for cover on behalf of **your** spouse or partner, provided they are under 76 years of age on their **date of entry**.

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

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

Adding newborn babies to your plan

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
- **you** pay 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 plan**.

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

- **you** do not inform **us** about the birth of **your** child within 30 days of their birth
- **you** do 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** child has been born as a result of **assisted reproduction treatment** and born within 36 weeks of conception
- **you** apply for enhanced cover for **your** child

In the event of the death of an insured person

If **you** (the **plan holder**) die, provided no **claim** has been made on **your plan**, **we** will refund any **unused premium** from **your** date of death.

If **you** (the **plan holder**) have **eligible dependants** insured under **your plan**, as the contract is between **us** and **you** as the **plan holder**, **we** will have to transfer **your eligible dependants** on to their own **plan**.

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

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

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

If an insured **eligible dependant** dies, please inform **us** as soon as possible. If they have made no **claim** on their **plan**, any **unused premium** from their date of death will be refunded. However if the deceased **insured person** had made a **claim**, no **premium** refund will be made.

Divorce and separation

If **you** (the **plan holder**) 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**. 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** continue to be paid up to date, **we** will continue to cover **your** insured ex-spouse or partner as before. 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 your plan

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

However, **your** child may apply to continue their cover on their own **plan**, at the applicable adult **premium** rate, provided they send **us** their completed **application form** and **we** receive the appropriate **premium** within 30 days of **your renewal date**.

If they want to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and any enhancement in their cover 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 or Zone 3 **area of cover** and **you** move to a country where cover is restricted, **you** must apply to change **your area of cover** to Zone 1. **Your** application will be subject to **medical underwriting**.

If **you** return to **your country of nationality**, **you** may continue to renew **your plan** provided that the local laws in **your country of nationality** permit **us** to offer **you** cover, and provided that **we** agree to offer cover in that country. **We** reserve the right to refuse to offer cover in certain countries.

If the UK is or becomes your country of residence

Under the terms of this **agreement** cover is not available to **you** if the UK is or becomes **your country of residence**, irrespective of **your** nationality. If the UK becomes **your country of residence** **you** must tell **us**. **Your** cover will automatically terminate from the renewal date after **you** take up residence in the UK. However, **we** may be able to offer **you** continuation of cover under another William Russell **plan**.

If Switzerland is or becomes your country of residence

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

If the USA is or becomes your country of residence

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

We will refund any **unused premium** if **we** have cancelled **your** cover because the USA has become **your country of residence**.

Renewing your plan

You may continue to renew **your plan** each year regardless of **your** age or state of health, or the number or value of **claims you** have made. **We** will not cancel **your plan** unless **we** are entitled to do so under **our** cancellation policy.

Prior to **your plan renewal date we** will send **you** an invoice by email stating **your premiums** for **your** new **period of cover**.

Your premium for each new **period of cover** will be determined by the following: -

- **your** age at the start of **your** new **period of cover**
- the ages of **your eligible dependants** at the start of their new **period of cover**
- the number of eligible children **you** insure
- **your plan**
- **your area of cover**
- **your excess** amount
- **your country of residence**

Other factors may affect **your** renewal **premiums**, such as general changes **we** make to **our premiums** annually, and changes to the discounts and loadings **we** apply to **excesses**, to the child **premium** discounts, and to the surcharge for instalment **premiums**.

We may also change the methods of payment **we** offer.

Your premiums may also be affected by the introduction of or increase to insurance **premium** tax or other tax, levy or charge applicable in **your country of residence**.

We may also change the benefits offered by **your plan** and/or **your excess** amount. If **we** do, **we** will write to **you** before **your renewal date** to confirm these benefit changes and/or change in **excess** amount. Any changes **we** make to **your** benefits or **excess** amount 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 similar **plan**.

Paying your renewal premium

You must pay **your** renewal **premium** on or before the due date.

If **you** pay **your premium** by credit or debit card or by direct debit, unless **you** tell **us** not to, and provided **your** credit or debit card details are current, **we** will withdraw **your** renewal **premium** on or around its due date.

If **you** do not pay **your** renewal **premium** within 30 days of the **premium due date**, **we** will cancel **your plan** from midnight on the day before **your premium due date**.

We may allow **your** cover to continue without **you** having to complete a new **application form** and health declaration if **you** pay 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 **you** have paid the **premium** due. This also applies to **treatment** that **we** have already pre-authorised.

If **you** do not wish to renew **your plan you** must inform **us** in writing as soon as **you** receive **your** renewal **premium** invoice and prior to **your renewal date**.

Premium discounts for children

When **you** have **eligible dependant** children included in **your** (the **plan holder's**) **plan**, the child **premium** discounts will be applied as follows: -

- the discount for the oldest child insured on **your plan** is 0%
- the discount for the second oldest child insured on **your plan** is 5%
- the discount for the third oldest child, and any subsequent children, insured on **your plan** is 7.5%

If a child leaves **your plan**, **we** will recalculate the **premiums** for the remaining children with effect from the date on which the child leaves. This means that the **premium you** pay will always be based on the actual number of children **you** insure.

Child-only plans

A **premium** loading applies when **you**, as the **plan holder**, are not an **insured person**. In such cases, each child's **premium** will be increased by 20%.

No claim incentive (applicable only to insured persons whose date of entry is prior to 01 January 2007)

For as long as **you** make no **claim** on **your plan**, **we** will use **your** age at **your date of entry** (or if **your date of entry** is before 01 January 1999 **your** age at **your renewal date** in 1999), when **we** calculate **your** renewal **premium**. This does not mean that **your premium** will remain the same each year. There are other factors that may affect **your** renewal **premiums**, such as the general rate of medical inflation that **we** apply to all of **our premiums** each year, insurance **premium** tax or other tax, levy or charge applicable in **your country of residence**.If **you** make a **claim** (other than a well-being **claim**), **your** entitlement to this no **claim** incentive will cease from the date on which **you** first suffered the symptoms which gave rise to **your claim**, or from the date on which **you** first received **treatment**, whichever date is the earlier. Then, with effect from **your** next **renewal date**, **you** will be required to pay the **premium** applicable to **your** actual age at **your renewal date**.

If **we** are not notified of **your claim** until after **we** have issued **your** renewal **premium** invoice, or until after **you** have paid **your** renewal **premium**, **you** must pay to **us** the difference between the **premium we** invoiced before **we** knew about **your claim**, and the **premium** based on **your** actual age at **your renewal date**. If **you** pay **your premiums** annually, **we** will issue an invoice for the difference in **premium**. If **you** pay **your premiums** in installments, **we** will debit **your** card for the difference in **premium** and adjust **your** future **premium** instalment payments. If **you** do not pay **us** the difference in **premium we** reserve the right to deduct the amount owing to **us** from **your claim** settlement.

This incentive does not apply in respect of **eligible dependant** children, or in respect of children insured under **your plan** who leave **your plan** and take up their own **plan**.

Cancelling your plan

If **you** wish to cancel **your plan**, or if **you** want to cancel cover for one of **your dependants**, **you** must instruct **us** in writing by letter, email, or fax. **We** will cancel cover from the date we receive **your** written instructions, or from a date in the future that **you** have specified. **We** will not cancel cover from a date prior to **us** receiving **your** written instruction to cancel.

If **you** are eligible for direct billing services, **we** will cancel **your** cover from the date on which **we** receive **your** returned membership card.

We will only make a refund in respect of **unused premium** if no claim has been made. If a claim has been made by any **insured person**, no **unused premium** will be refunded in respect of that **insured person**.

When we can cancel your plan

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

- **you** do not pay **your premium** and other charges such as insurance **premium** tax within 30 days of any **premium due date**
- **you** cease to be a member of the **William Russell Association for Health, Financial Protection and Well-Being.**
- **you** have not provided **us** with medical information **we** have requested to enable **us** to assess a **claim** or any potential **claim** that may arise in the future
- **you** have not repaid to **us** fully any ineligible **claim** payments **we** have invoiced **you** with
- **you**, any **insured person** or any person acting on **your** behalf has made any threatening or abusive comment, or used any unacceptable language towards **us** or any member of **our** staff, or any service provider acting on **our** behalf, whether verbally (including any telephone conversation) or in writing (including any electronic communication)
- **we** reasonably suspect that any **insured person** has misled **us** or attempted to mislead **us**, whether intentionally or carelessly, either at the time of joining or when making a **claim**, by: -
  - making a **claim** under this policy knowing it to be dishonest, intentionally exaggerated or fraudulent in any way
  - providing **us** with incomplete or false information
  - working with another party to provide false information to **us**
  - changing original documents

If **we** cancel **your plan** for any of the above reasons **we** will not refund any **premium you** have paid to **us**. **We** may also report the matter to the relevant authorities, if appropriate.

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 may apply special terms to your plan

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

Your responsibilities as the plan holder

It is **your** responsibility to: -

- ensure that all **premiums** are paid when they are due
- inform **us** if **your** personal details, or the personal details of any **insured person**, change
- keep **us** advised of **your** current email address
- inform **us** if **you** change **your** address, **country of residency** or **country of nationality**

Our liability under this plan

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

How to make a complaint

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

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

William Russell Europe SRL
8, Place Marcel Broodthaers
1060 Saint-Gilles
Brussels, Belgium

Phone +44 1276 486 455
Fax +44 1276 486 466
Email enquiries@william-russell.com

We will investigate **your** complaint and send a response to you within 4 weeks of the receipt of **your** complaint. William Russell Europe SRL 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** insurer (*eg* a decision regarding a claim **you** have made), **you** can write to the **insurer** 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 **plan holder** has the option, after the exhaustion of all domestic remedies referred to above, to call for the French Insurance Mediator without prejudice to possibilities of legal action.

La Médiation de l'assurance
TSA 50 110
75441 Paris Cedex 09
France

Web mediation-assurance.org

If **your** complaint relates to a service provided by William Russell Europe SRL and **you** have not received a response from **us** within 4 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 Belgian Ombudsman des Assurances.

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.as
Web www.ombudsman.as

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 information

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

The information we collect

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

In addition, **we** may receive information about **you** from third parties, such as those who provide services on **our** behalf.

Failing to provide the personal information **we** require in order to underwrite and administer **your** plan, or to process **your claims**, could result in **your claims** being rejected or not being fully paid, or **your plan** being cancelled.

How we use your personal information

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

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

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

Who we may share information with

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

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

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

Processing claims

In the event of a **claim**, **we** may have to give some information to those involved in **your treatment** or care, or to **your** representative (if **you** have chosen one). This will be done confidentially. Unless specifically instructed, correspondence about all **claims** (including those made by dependants) will be addressed to the **plan holder**. An insured dependant over the age of 16 has the right to confidentiality in relation to their **claims** and information. For them to exercise this right, they should contact customer services. If **you** have another insurance plan that covers the same costs that **you** are claiming from **us**, then **we** may also disclose **your** relevant personal information to that other **insurer** so **we** can ensure that **we** only pay **our** proportion of the costs.

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

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

Where we store your personal information

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

Marketing

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

Obtaining a copy of the information we hold about you

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

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

Phone +44 1276 486 455
Fax +44 1276 486 466
Email enquiries@william-russell.com

Where information has been supplied by a **medical practitioner**, **you** should be aware that **we** need their consent before **we** can supply this to **you**, or alternatively **you** can request such information direct from the **medical practitioner**.

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

The 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 diagnostics

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

Agreement

The contents of this document, read in conjunction with **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** or **application form** for the purpose of this **agreement**. Information on previously completed **application forms**, if applicable, may also be used by **us** for underwriting and **claims** assessment reasons.

Area of cover

The territorial limits of **your plan**.

Artificial life maintenance

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

Assistance Service

The emergency assistance company contracted by **us** to provide assistance services to an **insured person** 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 country or island

All countries in the Caribbean region; Anguilla, Antigua and Barbuda, Aruba, Barbados, British Virgin Islands, Cayman Islands, Cuba, Curacao, Dominica, Dominaican Republic, Grenada, Guadeloupe, Haiti, Jaimaca, 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.

Certificate of Insurance

The confirmation of **your** insurance cover issued by **us**. It confirms the **plan you** have bought, the currency **you** selected, **your area of cover**, **period of cover**, **date of entry**, **renewal date**, **excess** amount, **special terms**, **your country of residence**, **your country of nationality**, and the schedule of **insured persons**. The schedule of **insured persons** lists the persons insured by **us** under **your 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 postnatal stages of pregnancy.

Congenital condition

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

Country of 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.

Date of entry

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

Day-patient

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

Dental treatment

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

Dentist or dental practitioner

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

Diagnostic tests

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

Direct billing medical services provider

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

Doctor

See **medical doctor**.

Eligible dependants

Your spouse or partner, provided they are under age 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**.

Excess

The amount stated as the **excess** in **your Certificate of Insurance**, being the amount **you** must contribute to each **claim**.

Hospital

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

Innocent bystander

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

In-patient

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

Insured person

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

Insurer

The insurance company that provides the insurance cover for **your plan**. The **insurer** is Allianz (AWP Health & Life 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 **in-patient treatment**.

London area

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

Master 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.

Medical doctor

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

Medically necessary

Treatment that is **medically necessary** and appropriate. The **treatment** must be: -

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

Medical practitioner

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

Medical referral letter

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

Medical services provider(s)

A **hospital**, **out-patient** clinic, **medical practitioner**, **dental practitioner**, optician or pharmacy.

Medical underwriting

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

Out-patient

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

Out-patient surgical procedure

An **out-patient** procedure where one or more of the following is **medically necessary**: -

- general or local anaesthesia or intravenous sedation
- manipulation or relocation of a fractured bone or dislocated joint by a **medical doctor**
- invasive surgical procedures
- invasive diagnostic procedures involving venous cannulation
- the use of endoscopic equipment

Period of cover

A period of 12 months from **your date of entry** or from any subsequent **renewal date**. **Your period of cover** is as shown on **your Certificate of Insurance**.

Personal medical exclusions

A restriction on **your** cover that is stated on **your Certificate of Insurance** and specifically excludes **treatment** of a certain medical condition or conditions and any **related conditions**.

Plan

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

Plan holder

The person stated as the **plan holder** on the **Certificate of Insurance**.

Planned caesarean section

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

Post-hospital treatment

Medically necessary follow-up consultations, physiotherapy, **diagnostic tests** and/or **treatment** required on an **out-patient** basis following **in-patient** or **day-patient treatment** covered by **your plan**.

Pre-admission tests

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

Pre-existing medical conditions

Any disease, illness or injury, whether the condition has been diagnosed or not before **your date of entry**, for which: -

- **you** have received medication, advice or **treatment**; or
- **you** have experienced symptoms

Premium

The amount(s) **you** are 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.

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 anniversary date of **your plan** as shown on **your Certificate of Insurance**, normally the anniversary of **your** original **date of entry** to the **plan**.

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 that is no longer than the maximum duration specified for **your** USA cover option. If **your treatment** extends beyond the end of **your** trip's specified return date, **your cover** will cease at the end of the term defined in **your** USA cover option wording. For example, if **you** have 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** date of entry 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 **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

Unused premium

The amount of **premium** that is attributable to the period from the date after the date of cancellation, up to the date before the next **premium due date**.

In the event of a refund of **unused premium** being eligible, the **unused premium** amount refunded (using an annually paid **plan** as an example) will be the annual **premium** paid divided by 12 and multiplied by the number of whole calendar months remaining in the **period of cover**. If the **plan** is cancelled part way through a month, an additional amount, equal to one twelfth of the annual **premium** paid, multiplied by the proportion of days without cover in the calendar month of cancellation will also be paid.

For example, if the annual **premium** for an **insured person** is US$3,000, the **period of cover** is 1st January to 31st December 2020, and the **insured person** leaves the **plan** on 27th September 2020, the **unused premium** will be US$775, as: -

- (US$3,000 / 12) x 3 = US$750 for the three whole months without cover (October, November and December); added to -

- (US$3,000 / 12) x 0.1 = US$25 for the three days in September without cover (the 0.1 calculated in this example by dividing 3 (the days in September without cover, i.e. the 28th, 29th and 30th) by the total number of days in September (30))

Appropriate calculation methods using the same principle as the above example will be used if the **premium** frequency is not annual.

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 **insured persons** on **your Certificate of Insurance**.

We're here to help

Call us on
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