



UltraCare Plan Guide

For plans with a start date on or after 1 January 2012

 **InterGlobal**
International Private Medical Insurance

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Your plan guide

We would like to welcome **you** and thank **you** for choosing an UltraCare **plan**. We aim to give **you** an international healthcare **plan** **you** can rely on. To do this, it is important that **you** fully understand how **your plan** works. This **plan** guide, along with **your** chosen **plan's** table of **benefits**, explains what is, and is not, covered under **your** UltraCare **plan** and any of the following optional add-on **plans** **you** may have chosen:

- optional maternity add-on **plan** (available with individual UltraCare Elite, Plus, Comprehensive and Select **plans** only);
- optional personal **accident** add-on **plan**;
- optional travel add-on **plan**.

This **plan** guide will also give **you** important information about managing **your plan**, how to make a **claim** and what to do in a medical **emergency**. Please spend some time reading carefully through this **plan** guide to make sure that **you** are completely satisfied with the cover **we** are providing and that it meets **your** needs. If **you** have any questions about the information in this **plan** guide or any questions **you** think it does not answer, please contact **us** and **we** will be more than happy to help.

Some words and phrases used in this **plan** guide and **your** table of **benefits** have specific meanings that are relevant to **your plan**. We have highlighted them in bold print and defined them in the **plan** definitions section of this **plan** guide.

Individual plans

The individual application form, table of **benefits**, certificate of insurance, membership cards and this **plan** guide form **your** contract of insurance with **us** and **you** must read them together.

The general conditions, **benefit** conditions and **benefit** exclusions in this **plan** guide apply to **you**. We can change the general conditions, **benefit** conditions, **benefit** exclusions and any other terms and conditions in this **plan** guide, the premium rates, discounts and/or surcharges at the beginning of **your plan year**. We will tell the **planholder** about any changes before they renew.

All the **benefits** covered under this **plan** are shown on **your** table of **benefits**. The currency of **your benefit** limits will depend on the currency in which **your** premiums are paid. **Your** premiums can be paid in GB pounds (£), US dollars (\$) or Euros (€).

30-day money-back guarantee

If **you** feel this **plan** does not meet **your** needs, the **planholder** may cancel it. The **planholder** must tell **us** in writing by letter, fax or email and return all membership cards and certificates of insurance within 30 days of the **date of joining** or receiving the **plan** documents, whichever is later. As long as no **claims** have been made under the **plan**, **we** will gladly and promptly refund the premium in full. We will not make a charge for this. We can only refund the premium to the account it was originally paid from.

If any **claims** have been made, no refund will be due and the premium will be payable in full.

If the **planholder** decides not to cancel within the period shown above and decides to cancel at a later date, the cancellation will be governed by the terms and conditions of the 'Cancelling cover' section in this **plan** guide.

Eligibility

Your eligibility depends on **us** accepting the individual application form.

The **plan** is available to people (depending on the age limits shown below) of all nationalities and their **dependants**, except citizens of the USA who live in the USA and people who are governed by

exchange controls or local licensing regulations. Cover may also be illegal under local laws.

All **dependant** children under the **plan** must be unmarried. **Dependant** children aged 18 to 24 must be in continuous full-time education at their **start date**.

The minimum age to join the **plan** is 18. If someone applying is under 18 at their **start date**, **we** will need a parent or guardian to sign their application form. We will then consider the parent or guardian as the **planholder** and charge the adult rate of 18 to 25 years. We will charge the adult rate of 18 to 25 years for all others applying who are under the age of 18 at their **start date**. A parent or guardian must also sign their application form and will be considered as the **planholder**. No discounts will apply.

You cannot be older than 74 at **your start date**.

The **planholder** and their **dependants** must have the same **area of cover**.

The optional travel add-on **plan** can apply to the **planholder** only or can include all of their **dependants**.

The optional personal **accident** add-on **plan** can apply to the **planholder** only, the **planholder** and specific **dependants** or the **planholder** and all of their **dependants**.

We can refuse cover for any reason. We may provide cover under the **plan** with any special terms which **we** may set and which will be shown on the certificate of insurance.

Plan start date

With **our** agreement, cover under **your plan** will begin as soon as **we** receive the individual application, or on a future date given to **us** by the **planholder**. We will tell the **planholder** the **start date** in writing.

We cannot backdate cover under any circumstances. The **plan** will continue for 12 months, until the next **renewal date** or until the **plan** is cancelled or extended for any reason.

The premiums and **benefits** applied will be those in force at the **plan start date**. We will collect any premiums due.

Paying your premium

The **plan** is a yearly contract and premiums must be paid either every month, every three months or every year. Maternity optional add-on **plan** premiums can be paid every year or as often as the UltraCare **plan** premium is paid. Optional travel and optional personal **accident** add-on **plan** premiums can only be paid yearly.

Premiums must be paid in GB pounds (£), US dollars (\$) or Euros (€). **Your plan** will be based on the currency in which it is paid.

Premiums are based on the age of the **planholder** and each **dependant** at the **plan start date**. We must receive all premiums (including any local taxes which apply) on or before the premium due dates and in the currency of **your plan**.

Ways to pay your premium

For yearly premium payments, the **planholder** can choose to pay by:

- credit card;
- banker's draft or cheque;
- bank transfer; or
- direct debit.

For payments made every month or every three months, the **planholder** can choose to pay by:

- credit card; or
- direct debit.

We can accept credit card payments by Visa or MasterCard. Please contact **us** about any other card type as **we** may still be able to accept it.

Completing our credit card authority form authorises us to take the relevant amount from the named account on or around the due date. This also authorises us to process any premiums for all future renewals until we receive written instructions from the planholder to change the method of payment, or cancel the plan. If we cannot collect a premium by credit card, for any reason, we may need to collect more than one premium on the next payment date.

The planholder is responsible for giving us current credit card details. The planholder must tell us about any changes to the credit card details to make sure that we can continue to collect any premiums due.

Cheques, banker's drafts and bank transfers must be in the currency of your plan. When making a bank transfer, the planholder must give their full name and quotation or plan number as the reference.

We can only accept direct debits from UK bank accounts for plans in GB pounds (£). Completing our direct debit form authorises us to take the relevant amount from the named account on or around the due date. This also authorises us to process any premiums for all future renewals until we receive written instructions from the planholder to change the method of payment, or cancel the plan. If we cannot collect a premium by direct debit, for any reason, we may need to collect more than one premium on the next payment date.

Unpaid or late premium payments

For you to enjoy the full benefit of the plan, the planholder must make sure the premiums are paid on or before the premium due date. We will tell the planholder, in writing, if a premium payment has been missed.

If the planholder has not paid the premiums, we will suspend all claims until the premiums are up to date.

We can cancel the plan if we do not receive payment within 30 days of the premium due date. If we cancel the plan, the planholder will have to reapply for a new plan. We will charge the premiums in force at that time and cover may have new terms. Any existing no-claims discount will be lost.

Adding or removing dependants

With our agreement, the planholder may add dependants after the plan start date. The planholder must do this in writing by letter, fax or email. When making the request the planholder must also tell us all material facts. If there is any doubt about whether a fact is material, the planholder must tell us. Cover will start on the date that we receive the request, or on a future date given to us. We will not backdate cover under any circumstances.

With our agreement, the planholder may add newborn children as dependants during the plan year. When making the request the planholder must tell us all material facts. We will not apply any moratorium to the newborn child's cover and their date of joining will be their date of birth if the planholder applies before the child is 30 days old.

If the planholder applies after the child is 30 days old, a moratorium will apply. We will not backdate cover under these circumstances.

With our agreement, the planholder may remove a dependant after the plan start date. The planholder must make this request in writing by letter, fax or email and cover will end on the date that we receive the request, or on a future date given to us. The dependant's membership card and the certificate of insurance must be returned to us.

Premiums may change in line with any agreed requests. The planholder is responsible for paying any extra premiums.

We will send the planholder a revised certificate of insurance and a new membership card, if this applies, showing the changes and any special terms that may apply.

Transfers

If a new person wants to transfer cover from another insurer, we will need an original certificate of insurance from their previous insurer, which shows their original start date with that insurer, underwriting terms, and any special terms that may have applied. If there is a break in cover between the end date of the previous insurance plan and the application, we will not be able to offer a transfer of previous underwriting terms.

An individual application form must be completed. If we accept the transfer application we may charge an increased premium.

Our policy terms, conditions and benefits may be different from those offered by other insurers.

Making changes to your plan

If the planholder wants to change the area of cover, they must tell us in writing by letter, fax or email giving the reason for the change in circumstances. When making the request the planholder must also tell us all material facts. If there is any doubt about whether a fact is material, for your own protection, the planholder must tell us. With our agreement, this change can be made at any time during the plan year. We will make this change from the date the planholder tells us or any future date they have given.

If the country where you live changes, the planholder must tell us in writing by letter, fax or email. The planholder must also tell us all material facts.

The planholder cannot make changes to how often the premium is paid, the plan type, currency, excess or optional add-on plans during the plan year. With our agreement, these changes can be made at the next plan renewal date. The planholder must tell us about the changes in writing by letter, fax or email before the plan renewal date. When making the request the planholder must also tell us all material facts.

Optional add-on plans cannot be added during the plan year. With our agreement, these can be included from the next plan renewal date. The planholder must tell us in writing by letter, fax or email before the next plan renewal date. The planholder must also tell us all material facts. If there is any doubt about whether a fact is material, for your own protection, the planholder must tell us. Optional add-on plans are only valid when the UltraCare plan is in force.

Your premium and benefit limits are determined by the area of cover and currency of the UltraCare plan.

Renewing your plan

With our agreement, the planholder may renew the plan each year. The planholder must tell us all material facts about themselves and all dependants before the renewal date (please read general condition GC3).

If the planholder wants to renew the plan, they must tell us in writing by letter, fax or email before the renewal date.

We may change the definitions, benefits, general conditions, benefit conditions and benefit exclusions that apply to the plan. These will be sent to the planholder together with the renewal quotation at least six weeks before the renewal date. The planholder must pay the renewal premium on or before the renewal date.

Renewal premiums depend on the age of the planholder and all dependants, increases in medical inflation, the country you live in and the level of cover chosen.

A child will no longer be eligible as a dependant under the plan at the next renewal if they:

- marry;
- reach the age of 18;
- leave full-time education; or
- are in continuous full-time education but have reached the age of 25.

With **our** agreement, they can apply to have their own **plan** by completing an individual application form. As long as there is no break in their insurance cover, their **date of joining** will stay the same. Their application will be governed by the definitions, **benefits**, general conditions, **benefit** conditions and **benefit** exclusions in force at the time they move to their own **plan**.

Automatic renewal

If **your** premiums are paid by credit card or direct debit, **we** will automatically renew the **plan** and **we** will take the renewal premium from the named account, as long as the details **we** hold are still valid at the time of the renewal.

If the credit card details given to **us** by the **planholder** are due to expire within three months of the **renewal date**, they will need to complete a new credit card authority form. Please contact **us** for a copy of **our** credit card authority form.

If the **planholder** does not want to renew the **plan**, they must tell **us** in writing by letter, fax or email before the **renewal date**.

No-claims discount

As long as no **claims** are made by the **planholder** or any **dependant** on the **plan**, **we** will give no-claims discounts on renewal premiums. These are based on the amount of time the **plan** has been **claim** free. If the **planholder** or any **dependant** has one or more **claims** paid during a **plan year**, the no-claims discount will be lost until the **plan** has been **claim** free for at least one **plan year**.

The following discounts will apply once the **plan** has been **claim** free for the amount of time shown.

- For less than one **plan year** – no discount
- For one **plan year** – 10% premium discount
- For two **plan years** – 15% premium discount
- For three or more **plan years** – 20% premium discount

The maximum no-claims discount is 20%.

If a **claim** relating to a previous **plan year** is made and **we** have already given a no-claims discount, **we** can recover the extra premium due for the **plan year** to which **we** gave the no-claims discount.

Any **claims** made for the wellness **benefit** or optional add-on **plans** will not affect the no-claims discount. The no-claims discount does not apply to the premiums of any optional add-on **plans**.

Cancelling cover

If the **planholder** wants to cancel the **plan** after 30 days, they must send a request to **us** in writing, by letter, fax or email. The **planholder** must confirm in writing that there are no further **claims** to be made. **We** will cancel the **plan** from the date **we** receive the instruction or on a future date given to **us**. **We** will not backdate the cancellation date of the **plan**.

We will issue a pro-rata refund as long as no **claims** have been made and accepted by **us**. If **we** have accepted a **claim**, **we** will not pay a refund. If the premium is paid every month or every three months and a **claim** has been made and accepted by **us**, the **planholder** must pay any outstanding premium for the rest of the **plan year** and no refund is due.

We can only refund the premium to the account it was originally paid from. **We** will not pay any further **claims** after the **plan** is cancelled.

We will charge an administration fee of £50, \$85 or €75 for cancelling the **plan**. **We** reserve the right to make an additional charge if **we** incur additional or unexpected costs as a result of the cancellation. The **planholder** must return all membership cards and the certificate of insurance on the **plan** cancellation date.

Death

If the **planholder** dies, **we** will offer their **dependants** continued cover, as long as **we** receive a signed individual application form from them within four weeks of the date of death.

If the **planholder's** **dependants** or personal representatives do not want to continue cover, they must tell **us** in writing by letter, fax or email. **We** can then cancel the **plan** and issue a pro-rata refund, as long as no **claims** have been made and accepted by **us**. If **we** have accepted a **claim**, **we** will not pay a refund.

We will ask to see a certified copy of the death certificate before **we** can issue a refund.

Corporate and group plans

The terms of this agreement apply to **you** and the **planholder**.

You must read the group **member** application form (if this applies), table of **benefits**, certificate of insurance, membership cards and this **plan** guide.

The group application form, group **member** application forms (if these apply), group declaration of health form (if this applies), group membership census, corporate agreement, table of **benefits**, certificates of insurance, membership cards and this **plan** guide form the contract between **us** and the **planholder**. The **planholder** must read these together.

The general conditions, **benefit** conditions and **benefit** exclusions in this **plan** guide apply to **you**. **We** can change the general conditions, **benefit** conditions, **benefit** exclusions and any other terms and conditions in this **plan** guide, the premium rates, discounts and/or surcharges at the beginning of the **plan year**. **We** will tell the **planholder** about any changes before they renew the **plan**.

All the **benefits** covered under this **plan** are shown on the table of **benefits**. The currency of **your** **benefit** limits will depend on the currency in which the premiums are paid. **Your** premiums can be paid in GB pounds (£), US dollars (\$) or Euros (€).

Group eligibility

Eligibility depends on **us** accepting the group application form, group **member** application forms (if these apply), group declaration of health form (if this applies), previous certificates of insurance (if these apply) and a complete group membership census.

A **plan** must be made up of a group of employees of the same company or **members** of an existing affinity group. The size of a group **plan** at the **start date** must be at least three main **members** (employees or affinity **members**). If the membership is below three at the **start date** or at a **renewal date**, the group cannot continue and **we** will offer individual **plans**.

The **plan** is available to people (depending on the age limits shown below) of all nationalities and their **dependants**, except citizens of the USA who live in the USA and people who are governed by exchange controls or local licensing regulations. Cover may also be illegal under local laws.

All **dependant** children under the **plan** must be unmarried. **Dependant** children aged 18 to 24 must be in continuous full-time education at their **start date**.

You cannot be older than 74 at **your** **start date**.

Any **dependants** of an employee or affinity **member** on the group **plan** must have the same **area of cover** as them. Under special circumstances **we** may allow groups of **dependants** to have different **areas of cover** to employees or affinity **members**.

Any optional add-on **plans** chosen for employees or affinity **members** can apply to them only or may also include all of their **dependants**. All **dependants** must have the same level of cover as the employee or affinity **member** on the optional personal **accident** add-on **plan**.

We can refuse cover under the **plan** for whatever reason. We may provide cover under the **plan** depending on any special terms which we may set and which will be shown on the certificate of insurance.

Group plan start date

Cover under the **plan** will begin immediately or on a future date given by the **planholder**, as long as we accept the application and have received the:

- group application form;
- group **member** application forms (if these apply);
- group declaration of health form (if this applies);
- previous certificates of insurance (if these apply); and
- group membership census.

We will tell the **planholder** the **start date** in writing after receiving the relevant documentation.

We cannot backdate cover under any circumstances. The **plan** will continue for 12 months or until the next **renewal date** or until the **plan** is cancelled or extended for any reason.

The premiums and **benefits** applied will be those in the quotation accepted by the **planholder**. We will collect any premiums due.

Group premiums

The **plan** is a yearly contract and the **planholder** must pay premiums either every three months, every six months or every year. The **planholder** can only pay optional add-on **plan** premiums yearly.

The **planholder** must pay premiums in GB pounds (£), US dollars (\$) or Euros (€). Your **plan** will be based on the currency in which it is paid.

We must receive the premiums (including any local taxes which apply) on or before the premium due dates and in the currency of the **plan**.

Premiums will change as a result of adding or removing employees, affinity **members** or **dependants** on the **plan**. Any extra premiums must be paid when we produce the next reconciliation statement. Any refund due to the **planholder** will be carried forward to the next reconciliation statement.

Ways to pay your group premiums

The **planholder** can choose to pay by:

- credit card;
- banker's draft or cheque;
- bank transfer; or
- direct debit.

We can accept credit card payments by Visa or MasterCard. Please contact us about any other card types as we may still be able to accept it.

Completing our credit card authority form authorises us to take the relevant amount from the named account on or around the due date. This also authorises us to process any premiums for all future renewals until we receive written instructions from the **planholder** to change the method of payment, or cancel the **plan**. If we cannot collect a premium by credit card, for any reason, we may need to collect more than one premium on the next payment date.

The **planholder** is responsible for giving us current credit card details. The **planholder** must tell us about any changes to the credit card details to make sure that we can continue to collect any premiums due.

Cheques, banker's drafts and bank transfers must be in the currency of your **plan**. When making a bank transfer, the **planholder** must give their full name and quotation or **plan** number as the reference.

We can only accept direct debits from UK bank accounts for **plans** in GB pounds (£). Completing our direct debit form authorises us to take the relevant amount from the named account on or around the due date. This also authorises us to process any premiums for all future renewals until we receive written instructions from the **planholder** to change the method of payment, or cancel the **plan**.

If we cannot collect a premium by direct debit, for any reason, we may need to collect more than one premium on the next payment date.

Unpaid or late group premium payments

For you to enjoy the full **benefit** of the **plan**, the **planholder** must make sure the premiums are paid on or before the premium due date. We will tell the **planholder**, in writing, if a premium payment has been missed.

If the **planholder** has not paid the premiums, we will suspend all **claims** until the premiums are up to date.

We can cancel the **plan** if we do not receive payment within 30 days of the premium due date. If we cancel the **plan**, the **planholder** will have to reapply for a new **plan**. We will charge the premiums in force at that time and cover may have new terms.

Adding or removing group members

With our agreement, the **plan administrator** may add a new **member** after the **plan start date**. The **plan administrator** must do this in writing by letter, fax or email. When making the request the **plan administrator** must also tell us all **material facts**. If there is any doubt about whether a fact is material, the **plan administrator** must tell us. Cover will start on the date that we receive the request, or on a future date given to us. We will not backdate cover under any circumstances.

With our agreement, the **plan administrator** may add your newborn children as **dependants** during the **plan year**. When making the request the **plan administrator** must tell us all **material facts**. We will not apply any **moratorium** to a newborn child's cover and their **date of joining** will be their date of birth if the **plan administrator** applies before the child is 30 days old.

If the **plan administrator** applies after the child is 30 days old, a **moratorium** will apply. We will not backdate cover under these circumstances.

With our agreement, the **plan administrator** may remove a **member** after the **plan start date**. The **plan administrator** must make this request in writing by letter, fax or email. Cover will end on the date that we receive the request, or on a future date given to us. The **plan administrator** is responsible for collecting and destroying the **member's** certificates of insurance and membership cards on or by the **end date**. If the **plan administrator** does not collect and destroy the **member's** certificates of insurance and membership cards and the **member** uses these to get **treatment** at a direct billing facility, the **planholder** will be responsible for paying any costs to the **treatment** provider. We will not be responsible for any costs after cover has ended.

Premiums may change in line with any agreed requests. We will send the **planholder** a reconciliation statement every three months to show these changes. The **planholder** must pay any extra premiums when we produce the next reconciliation statement. Any refund due to the **planholder** will be carried forward to the next reconciliation statement.

We will send the **plan administrator** a revised certificate of insurance and a new membership card (if this applies) showing the changes and any special terms that may apply.

Group member transfers

If a new **member** wants to transfer cover from another insurer, we will need an original certificate of insurance from their previous insurer, which shows their original **start date** with that insurer, underwriting terms, and any special terms that may have applied. If there is a break in cover between the end date of the previous insurance **plan** and the application, we will not be able to offer a transfer of previous underwriting terms.

A group **member** application form must be completed by each **member** to be transferred and sent to us by the **plan administrator**.

If **we** accept the transfer application, **we** may charge an increased premium.

Our policy terms, conditions and **benefits** may be different from those offered by other insurers.

Continuing cover when leaving a group plan

If **your** cover with the group **plan** comes to an end, with **our** agreement **you** can be transferred to an individual **plan**, as long as **you** still meet the eligibility section on page 3 of this **plan** guide.

You must send **us** **your** application to continue cover before **you** leave the group **plan**. The premiums and **benefits** applied will be those in force at **your** new individual **plan start date**. If **we** accept the transfer application **we** may charge an increased premium.

The **start date** for **your** new individual **plan** will be the first day after leaving the group **plan**. **We** will collect any premiums due.

Changing the cover and optional add-on plans for groups

If a **member** needs to change their **area of cover**, the **plan administrator** must tell **us** in writing by letter, fax or email giving the reason for the change in circumstances. When making the request the **plan administrator** must also tell **us** all **material facts**. If there is any doubt about whether a fact is material, for **your** own protection, the **plan administrator** must tell **us**. With **our** agreement, this change can be made at any time during the **plan year**. **We** will make this change from the date the **plan administrator** tells **us** or any future date they have given.

If the **country where a member lives** changes, the **plan administrator** must tell **us** in writing by letter, fax or email. The **plan administrator** must also tell **us** all **material facts**.

The **planholder** cannot make changes to how often the premium is paid, a **member's** plan type, the **plan** currency, **benefits**, **excesses**, **co-insurance** or optional add-on **plans** during the **plan year**. With **our** agreement, these changes can be made at the next **plan renewal date**. The **plan administrator** must tell **us** about the changes in writing by letter, fax or email before the **plan renewal date**. When making the request the **plan administrator** must also tell **us** all **material facts**.

Optional add-on **plans** cannot be added during the **plan year**. With **our** agreement, these can be included from the next **plan renewal date**. The **plan administrator** must tell **us** in writing by letter, fax or email before the next **plan renewal date**. The **plan administrator** must also tell **us** all **material facts**. Optional add-on **plans** are only valid when the UltraCare **plan** is in force.

Renewing your group plan

With **our** agreement, the **planholder** may renew the **plan** each year. The **planholder** must tell **us** all **material facts** about all **members** before the **renewal date** (please read general condition GC3).

If the **planholder** wants to renew the **plan**, they must tell **us** in writing by letter, fax or email before the **renewal date**.

We may change the definitions, **benefits**, general conditions, **benefit** conditions and **benefit** exclusions that apply to the **plan**. These will be sent to the **planholder** together with the renewal quotation at least six weeks before the **renewal date**. The **planholder** must pay the renewal premium on or before the **renewal date**.

With **our** agreement, the **planholder** can make changes to the **plan** at renewal.

A child will no longer be eligible as a **dependant** under the **plan** at the next **renewal date** if they:

- marry;
- reach the age of 18;
- leave full-time education; or
- are in continuous full-time education but have reached the age of 25.

With **our** agreement, they can apply to have their own **plan** by completing an individual application form. As long as there is no break in their insurance cover, their **date of joining** will stay the same. Their application will be governed by the definitions, **benefits**, general conditions, **benefit** conditions and **benefit** exclusions in force at the time they move to their own **plan**.

We will not renew the group **plan** automatically.

If the **planholder** does not want to renew the **plan**, they must tell **us** in writing by letter, fax or email before the **renewal date**.

Cancelling the group plan

If the **planholder** wants to cancel the **plan** after 30 days, the **plan administrator** must send a request to **us** in writing, by letter, fax or email. **We** will cancel the **plan** from the date **we** receive the instruction or on a future date given to **us**. **We** will not backdate the cancellation date of the **plan**.

As the **plan** is a yearly contract, **we** must receive any premium the **planholder** owes for the rest of the **plan year**. **We** will not refund any premium.

The **planholder** may have to pay charges for cancelling the **plan**. The **plan administrator** must return all membership cards and certificates of insurance on the **plan** cancellation date.

If a membership card is used to get **treatment** at a direct billing facility after the **plan** has been cancelled, the **planholder** will be responsible for paying any costs to the **treatment** provider. **We** will not be responsible for any costs after cover has been cancelled.

General conditions and benefit conditions

We will only pay **claims** under this contract of insurance if **you** meet these general conditions and the **benefit** conditions.

The following general conditions and **benefit** conditions apply to **your plan** and any optional add-on **plans** in this **plan** guide.

Your plan is governed by the following general conditions and **benefit** conditions.

General conditions

GC1 **We** will send all correspondence about the **plan** to the **planholder**.

GC2 The **planholder** or **your plan administrator** must tell **us** immediately in writing by letter, fax or email about any important change that affects information given in connection with the application for cover under the **plan**, for example:

- **you** change **your** name, address, occupation, family doctor details, or there is a change of **planholder**; or
- **you** plan to take part in any **hazardous pursuits**.

The **planholder** or **your plan administrator** must also tell **us** all **material facts**. If there is any doubt about whether a fact is material, for **your** own protection, the **planholder** or **your plan administrator** must tell **us**.

After the **planholder** has told **us** about a change, **we** have the right to reassess **your** cover. **We** can change any of the terms or cancel the **plan**. Any **claim** related to a change in risk that the **planholder** has not told **us** about may be reduced or rejected, or **your plan** may be cancelled.

GC3 The **planholder** or **your plan administrator** must tell **us** about all **material facts** before **we** accept an application, make changes to the **plan** or renew the **plan**. If the **planholder** or **your plan administrator** do not tell **us** all **material facts** or misrepresents any **material facts**, it may affect **your** rights under the **plan**. A **material fact** is information likely to influence **us** in assessing or accepting the insurance. If there is any doubt about whether a fact is material, for **your** own protection, the **planholder** or **your plan administrator** must tell **us**.

The 24-month moratorium will still apply even if the **planholder** or **your plan administrator** tells us about any **pre-existing medical conditions** you may have.

If we find out that the **planholder** or the **plan administrator** has not told us about all **material facts** we can cancel the **plan** or apply different terms to the **plan**.

GC4 If we ask for more information to support a **claim**, this must be provided or we may not pay **your claim**. We also have the right to instruct a **specialist** of our choice to examine you as often as we feel is necessary to support a **claim**.

GC5 If there is a break in cover for any reason, we can change the terms of the **plan** and apply any special conditions.

GC6 The limits on **your** table of **benefits** will be shown in the same currency as the **plan** premium.

GC7 If the **country where you live** is in an area where we have to collect **insurance premium tax (IPT)** or local taxes, we will charge these on top of the premium due.

GC8 We can make an administration charge to replace or reissue policy documents or membership cards.

GC9 If you have paid for **out-patient treatment** and need to make a **claim**, you must follow **your claims** procedures and send all the information we have asked for as soon as possible. We recommend you do this within a maximum period of six months from the first date of **treatment**.

GC10 If you make a **claim** which you know is false or fraudulent, we will refuse to make any **benefit** payments for that **claim**. If we have already paid any **benefit** we will recover any costs from the **planholder**. We will cancel cover from a date given by us.

GC11 If there is another insurance **plan** or a policy that covers the **claim**, including any reciprocal health insurance arrangements and they cover any of the same **benefits**, we will only pay our share of the **claim**.

GC12 If we reject a **claim** under the **plan** for any reason, you will have to prove that the **claim** is covered under the **plan**.

GC13 The **planholder** must tell us immediately in writing by letter, fax or email, about any **claim** or right of action against anyone else due to any circumstances which led to a **claim** under this **plan**. The **planholder** must continue to keep us informed in writing and take all steps we reasonably need to make a **claim** against the other person.

GC14 We are entitled to take proceedings in **your** name for our own benefit to recover any **claim** for costs, damages or otherwise, which relate to any **benefits** paid or due under the **plan**. We will decide how we handle any **claim**. We will have no responsibility for any **claim** for uninsured losses.

GC15 The **planholder** must tell us about any settlement discussions or negotiations that you enter into with anyone about any action which leads to a **claim** under this **plan**. You must not agree to a settlement with any person before we give our written agreement.

GC16 If you want to take legal action under the **plan**, you must do so within three years from the date the relevant event took place.

GC17 This **plan** is governed by the laws of England and Wales and any disputes will be dealt with by the exclusive jurisdiction of the courts of England and Wales (including non-contractual disputes and **claims**).

GC18 If the currency of a country becomes unstable due to political or economic problems and **claims** are received in the local currency, we will only pay for covered **medical treatment** up to an amount which, in our opinion, is **reasonable** for that country.

GC19 Any translated versions of our documents issued by us are for **your** information only. In the case of any dispute or discrepancy of wording or interpretation, the English version will apply.

GC20 When dealing with **your claim** we will always:

- communicate directly with you if you are aged 18 or over;
- communicate directly with the **main member** if you are under 18;

unless you give us explicit consent to contact any other individual

about **your claim** in accordance with our data protection policy.

GC21 If you or one of your **dependants**, attend a **hospital**, clinic or medical facility where direct billing or cashless arrangements are in place and the **claim** is subsequently found to be ineligible, we have the right to recover the full amount of the ineligible **claim** from you, your **dependants** or the **planholder**.

Benefit conditions

BC1 All **treatment** must be given by **medical practitioners, specialists, consultants, registered nurses or therapists** with the aim to cure or substantially relieve **medical conditions**.

BC2 We must agree any **in-patient** and **daycare treatment** or medical evacuation before it takes place. Once you have received our agreement, we will settle all covered costs directly with the **treatment** providers concerned. If you do not get our agreement before it takes place, and you go ahead, we will only provide **benefit** for the eligible costs we would have negotiated, had we been involved.

BC3 We will pay for **hospital** accommodation up to the cost of a standard single en-suite room. This will include **your hospital** meals.

BC4 If we have not been given details of **your family medical practitioner** on your application form and a **claim** is made that we believe is for a **pre-existing medical condition**, we will reject the **claim**.

BC5 If you have area 3 cover and are a citizen of the USA, we will cancel **your plan** if you have spent more than 180 continuous days in the USA in any one **plan year**.

BC6 If we receive new information which means that a **claim** we have already approved is not valid, we will recover any costs we have already paid from the **planholder**.

BC7 If a local situation makes it impossible, dangerous or not practical to enter a specific area or country, we may be unable to arrange a medical evacuation.

BC8 If you choose to use a **visiting doctor** instead of an **in-house doctor**, we will only pay **reasonable** costs. If the **visiting doctor's** costs are not **reasonable** and not in line with the **in-house doctor's** costs, you will have to pay the difference.

BC9 We will only pay **reasonable** costs for covered **claims** up to the limits shown in **your** table of **benefits**.

BC10 Under the normal pregnancy and childbirth **benefit**, we will cover no more than three routine antenatal 2D ultrasound scans (one in each trimester) during the term of a normal uncomplicated pregnancy. If any more ultrasound scans are needed, **your** treating doctor must provide full reasons in the medical section of the **claim** form. We will cover 12 routine antenatal visits during the term of a normal pregnancy. If any more antenatal visits are needed, **your** treating doctor must provide full reasons in the medical section of the **claim** form, so we can consider cover.

Under the childbirth **benefit**, we will cover the following for the newborn child:

- one consultation to cover a physical examination, vitamin K, hepatitis B and BCG vaccine;
- one hearing test;
- routine blood tests for PKU, congenital hypothyroidism and G6PD;
- **reasonable** accommodation costs for no more than four nights for the newborn child, if the mother is admitted and not suffering any complications.

BC11 Complementary **treatment** must be on referral by a **medical practitioner, consultant or specialist**.

BC12 Once **claim** documents have been submitted to us and we have made a payment under the terms and conditions of the **plan**, to you or the **treatment** provider, we will not return the original documents to you.

BC13 Under the physiotherapy **benefit**, we will cover no more than six physiotherapy sessions in relation to each **medical condition** suffered. If any more sessions are needed to treat the **medical condition**, your

treating **therapist** must provide full reasons in the medical section of the **claim** form, so **we** can consider cover.

BC14 Under the complementary medicine **benefit**, **we** will cover no more than four osteopathic, chiropractic, homeopathic or acupuncture sessions in relation to each **medical condition** suffered. If any more sessions are needed to treat the **medical condition**, **your** treating **therapist** must provide full reasons in the medical section of the **claim** form, so **we** can consider cover.

Benefit exclusions

Although **we** cover most **medical conditions**, the UltraCare **plan** does not cover **claims** for, arising from or connected with the following **benefit** exclusions unless shown on **your** table of **benefits**, in any written **plan** endorsement, or agreed by **us** in writing.

BE1 (*This **benefit** exclusion does not apply if **your** underwriting terms are **MHD**, as shown on **your** certificate of insurance.*)

A **pre-existing medical condition** or **related medical condition** that, within a 24 month period before the **date of joining**, or the date shown on the special terms section of **your** certificate of insurance, has one or more of the following characteristics:

- was **foreseeable**;
- clearly showed itself;
- **you** had signs or symptoms of;
- **you** asked for advice about;
- **you** received **treatment** for;
- to the best of **your** knowledge, **you** were aware **you** had.

Pre-existing medical conditions or **related medical conditions** may be covered after **you** have had 24 months continuous cover under the **plan** and within that time **you** have not:

- experienced symptoms;
- asked for advice;
- needed **treatment**, medication, or a special diet; or
- received **treatment**, medication or a special diet.

If **you** have:

- experienced symptoms;
- asked for advice;
- needed **treatment**, medication, or a special diet; or
- received **treatment**, medication or a special diet;

then **you** will have to wait until **you** have completed a continuous 24 month period when none of these apply to **you**. **Pre-existing medical conditions** or **related medical conditions** may then be covered. This is the rolling part of the **moratorium**.

BE2 **You** exceeding a limit shown on **your** table of **benefits**.

BE3 A **benefit** not available on **your** **plan**.

BE4 **You** not completing a waiting period shown on **your** table of **benefits**.

BE5 Pregnancy, childbirth and postnatal costs whether complicated or not.

BE6 Travel costs for journeys from the **country where you live**, specifically made for the purpose of getting **medical treatment**, unless **we** have **pre-authorized** this.

BE7 Non-emergency transportation.

BE8 Burial, cremation or moving **your** body or mortal remains if **you** die in **your home country**.

BE9 Any journey, activity, action or pursuit carried out against the advice of a **medical practitioner**, **specialist** or **consultant**, **registered nurse** or **therapist**.

BE10 **Treatment** by a **medical practitioner**, **specialist** or **consultant** who is in any way related to **you**.

BE11 Alcohol, drug or any other intoxicating substance **abuse**, any addictive condition of any kind and any **medical condition** arising directly or indirectly from any such **abuse** or addiction.

BE12 A **medical condition** due to **you** being under the influence of alcohol, drugs or any other intoxicating substance.

BE13 Male to female or female to male gender reassignment.

BE14 Tests and **treatment** for, or because of, sexually transmitted diseases.

BE15 Experimental or unproven **treatment**, unless **we** have **pre-authorized** this.

BE16 Bone-marrow transplants, the costs of finding and obtaining an organ, **treatment** as a result of removing an organ from a donor, **treatment** for removing an organ from **you** to transplant it into another person and any resulting complications.

BE17 Cryopreservation, implantation or re-implantation of living cells or living tissue, whether autologous or provided by a donor.

BE18 Foetal **treatment**.

BE19 Terminating a pregnancy.

BE20 Congenital abnormalities or birth defects.

BE21 Suicide, attempted suicide or any deliberate, self-inflicted **medical conditions**.

BE22 Putting **yourself** in needless danger, except in an attempt to save human life.

BE23 **Medical conditions** suffered by military, naval or air force personnel due to **you** taking part in any military, naval or air force operation or exercise.

BE24 Including but not limited to taking part in war, riots, revolution or any similar event, strikes, lock-outs, civic commotion, terrorism, military or usurped power or any illegal or criminal act.

BE25 Weapons of mass destruction (nuclear, biological or chemical), whether this involves an explosion or not.

BE26 Contamination from chemical, biological and nuclear materials, including waste products from the combustion of nuclear fuel.

BE27 **You** taking part in **professional sports** or using a weapon or firearm.

BE28 Sleep apnoea, sleep-related breathing disorders, snoring or insomnia.

BE29 Learning difficulties or disorders, developmental disorders and speech or voice problems.

BE30 Cosmetic, reconstructive, or remedial **treatment**, whether or not for psychological reasons and any complications, unless they are needed as the direct result of a covered **medical condition**.

BE31 Removing fat from any part of the body, breast reduction or breast enlargement.

BE32 **Treatment** in a quarantine, isolation ward or unit, nursing home, hydro spa, spa, health farm or similar establishment.

BE33 Preventative services for sight and hearing examinations.

BE34 Myopia, hypermetropia, astigmatism, natural or non-medical degenerative sight disorders, non-medical or natural degenerative hearing disorders, aids to help with **your** sight and hearing, contact lens solutions, eye drops, sunglasses and prescription sunglasses.

BE35 Ear or body piercing and tattooing, and any **treatment** needed as a result of any of these.

BE36 Preventative services for **dental** examinations and **treatment**, scraping, scaling, cleaning, polishing, removable bridges, dentures, false teeth, **dental** implants or **orthodontic treatment**.

BE37 Compulsive or addictive eating disorders or being homesick.

BE38 Obesity, special diet and weight control.

BE39 Children's food, baby supplies, vitamin, mineral or organic supplements, products that can be obtained without a doctor's prescription, including, but not limited to, mouthwash, toothpaste, antiseptic lozenges or sprays, shampoo or sunscreen.

BE40 Supplying, maintaining or fitting any external prostheses, appliance or device, and renting or buying crutches, wheelchairs or other equipment, medical or otherwise. **We** will pay for a spinal support, knee brace or air cast boot if it is part of a surgical operation or part of the **treatment** for a covered **medical condition**.

BE41 Costs for completing **claim** forms, **hospital** administration fees, registration fees or other documentation.

BE42 Any consequential loss.

BE43 Treatment before your start date or treatment after your end date unless your cover has been renewed, the premium is paid and the treatment is eligible.

BE44 Any treatment relating to a hospital admission at the time of your start date, which you did not tell us about and we have not accepted.

BE45 Any treatment relating to a planned hospital admission that you were aware of at your start date, which you did not tell us about and we have not accepted.

BE46 Medication, drugs and dressings which are not recognised by the pharmaceutical regulator in a given country or are available without prescription from a medical practitioner, specialist or consultant, registered nurse or therapist.

BE47 Treatment as a result of proven medical negligence or malpractice.

BE48 Any excess or co-insurance which applies to your plan.

BE49 Infertility tests and treatment, contraception, sterilisation or fertilisation, treatment for sexual problems (including impotence, whatever the cause), assisted reproduction (for example, IVF treatment) or surrogacy.

BE50 Any treatment needed for a newborn child as a result of a pregnancy following assisted conception. For example, a premature newborn child requiring admittance into a Special Care Baby Unit or other Paediatric Intensive Care Unit. Any complication arising from a pregnancy resulting from assisted conception will be limited to the amounts shown in the normal pregnancy and childbirth section of your table of benefits if cover applies.

BE51 Invoices that have been altered or amended.

BE52 Riding on a motorcycle, moped or motorised scooter as a driver or passenger:

- if the driver does not have a valid licence as required by local law; and
- you are not wearing the necessary safety equipment.

BE53 Antenatal 3D and 4D ultrasound scans.

Extra benefit conditions and benefit exclusions that apply to optional add-on plans

The following extra benefit conditions and benefit exclusions will apply to your optional add-on plan. If you have an optional add-on plan, this will be shown on your certificate of insurance.

Benefit conditions for the optional maternity add-on plan

BCM1 The minimum age at entry for this plan is 18. The maximum age at entry is 44. Once you have reached the age of 46 during your plan year, your cover will not be renewed.

BCM2 The co-insurance you choose will apply for the first 24 months continuous cover under this plan.

Benefit exclusions for the optional maternity add-on plan

The optional maternity add-on plan does not cover claims for, arising from or connected with the benefit exclusions listed on pages 9 to 10 and the benefit exclusions listed below.

BEM1 Claims for treatment received within 12 months of your date of joining the optional maternity add-on plan.

BEM2 Birth defects or congenital abnormalities of a newborn child that either parent:

- knows exists;
- suffers from;
- has had treatment or medication for; or
- knows has been present in their immediate family;

before the date of joining the optional maternity add-on plan.

BEM3 Treatment of birthmarks.

Benefit conditions for the optional personal accident add-on plan

BCPA1 We provide cover for managerial, clerical and administrative occupations only. If you take part in any hazardous pursuit or occupation which puts you at greater risk of a bodily injury caused by an accident, the planholder or your plan administrator must tell us. We will tell the planholder or plan administrator if we agree to cover you and let them know any extra premium that will apply.

BCPA2 We will not be legally responsible for paying any compensation higher than the amount shown as the maximum accumulation limit in the table of benefits, from all sources for any one location or conveyance.

BCPA3 We will not pay you more than the overall maximum limit for each unit shown in the table of benefits, for any one or more accidents.

BCPA4 If you suffer one or more permanent total or permanent partial disablements within 12 months of an accident, we will only pay up to the benefit limits shown on your table of benefits that applied in the plan year when you had the accident.

We will not pay any more than the overall limit shown on your table of benefits.

BCPA5 If you die within 12 months of an accident, we will only pay up to the benefit limit shown on your table of benefits that applied in the plan year when you had the accident. If you die before we pay any disablement benefit, we will only pay the accidental death benefit.

If we have already paid you for any disablement benefit under this plan for any accident which happened in the same plan year, the accidental death benefit amount we will pay to your personal representative will be reduced by the value of any claims we have already paid.

We will not pay any more than the overall limit shown on your table of benefits.

BCPA6 We must be told as soon as possible about any accident which causes or may cause a claim.

BCPA7 Cover is not provided for sickness or disease.

BCPA8 You must make all medical records, notes and correspondence we need available to us and any medical adviser we have appointed.

BCPA9 For any claim to be considered for loss of sight of both eyes, you must be diagnosed as blind on the authority of a fully qualified ophthalmic specialist.

BCPA10 For any claim to be considered for loss of sight of one eye, the degree of sight after correction must be 3/60 or less on the Snellen Scale (seeing at 3 feet what you should see at 60 feet) or an equivalent scale.

BCPA11 If you have an existing medical condition and suffer a bodily injury because of an accident, we will ask an independent medical consultant to assess if your existing medical condition has contributed to your disability after the accident, or if your disability after the accident has made your existing medical condition worse. We will decide the difference between your existing medical condition and the disability suffered after the accident and pay any claim based on this difference. This will be expressed as a percentage and applied to the appropriate benefit.

An example of this is;

You are partially deaf in your right ear. You have an accident which causes total permanent loss of hearing in your right ear.

We will ask an independent ENT specialist to assess the difference between the level of deafness you had before and after the accident. If the independent ENT specialist advises that the deafness in your right ear before the accident was at 25%, we will pay 75% of your benefit limit for total deafness of one ear.

BCPA12 This plan is only available for members aged 18 and over.

Benefit exclusions for the optional personal accident add-on plan

The optional personal accident add-on plan does not cover claims for, arising from or connected with benefit exclusions BE2, BE3, BE9, BE10, BE11, BE12, BE21, BE22, BE23, BE24, BE25, BE26, BE27, BE41, BE42, BE51, BE52 and the benefit exclusions listed below.

BEPA1 Claims directly or indirectly, caused by, happening through, or as a result of aviation, other than as a fare-paying passenger in a fully-certified passenger carrying aircraft, flown in the course of licensed operation for transporting passengers by licensed crew.

BEPA2 Claims caused by taking part in manual or dangerous occupations, dangerous sports, or hazardous pursuits.

BEPA3 Any accident that happens before your start date or after your end date.

Benefit conditions for the optional travel add-on plan

BCT1 You should tell us about a claim no later than 31 days after a trip has ended and submit the claim documents within a maximum period of six months.

BCT2 We have the right to move you from one hospital to another or arrange to move you to a different location. We will do this if, in our opinion or that of the attending medical practitioner, you can be moved safely to continue treatment.

BCT3 You must get a report from repairers if your claim is because of breakdown or damage to your vehicle.

BCT4 You must keep any damaged items that you want to claim for and, if we ask, send them to us at your own cost. If we pay a claim for the full value of an item, it will become our property.

BCT5 We may discharge any of our legal responsibilities under this plan by replacing or repairing any item or items lost or damaged.

BCT6 If you want to change your original plans for returning home and claim any extra costs, you must tell us. If you do not tell us, it may affect your claim.

BCT7 You must take care of your property at all times and take all practical steps to recover any item lost or stolen. If you do not do this, it may affect your claim.

BCT8 You must provide us with a statement from your carrier giving details of your delayed departure when making a claim.

BCT9 You must have planned to arrive at your departure point before your earliest scheduled check-in time and give us a written report from the carrier, police or relevant transport authority confirming the delay and stating its cause.

Benefit exclusions for the optional travel add-on plan

Section A of the optional travel add-on plan does not cover claims for, arising from or connected with the benefit exclusions listed on pages 9 to 10 and the benefit exclusions below.

BET1 Trips made for the specific purpose of receiving medical treatment.

BET2 A pre-existing medical condition you had before the date of booking a trip or the date shown on your certificate of insurance, whichever is later.

BET3 A pregnancy where:

- you are travelling against your doctor's advice;
- you are 26 weeks or more into your pregnancy when you start your trip;
- there have been complications relating to your pregnancy before your trip;
- it is a multiple pregnancy; or
- the pregnancy is the result of assisted reproductive programmes (for example, IVF).

BET4 Any treatment which is not immediately necessary and can wait until you return to the country where you live.

Sections B to I of the optional travel add-on plan do not cover claims for, arising from or connected with benefit exclusions BE2, BE3, BE9, BE10, BE11, BE12, BE21, BE22, BE23, BE24, BE25, BE26, BE27, BE37, BE41, BE42, BE47, BE51, BE52, BET2 and the benefit exclusions listed below.

BET5 Claims brought against a tour operator, travel agent or carrier.

BET6 Pressure waves resulting from any aircraft or other flying object travelling at, or above the speed of sound.

BET7 Changes in exchange rates.

BET8 Any costs you would normally have to pay in connection with your trip.

BET9 Any person, organisation or company becoming insolvent or being unable or unwilling to fulfil any part of their obligation to you.

BET10 Any costs you have to pay for visas needed in connection with your trip.

BET11 You deciding not to travel, not enjoying your trip or not travelling because you could not afford it.

BET12 Cancellation due to terrorist acts, or the threat of a terrorist act unless government advice is changed to advise against travelling to the area.

BET13 Unauthorised use of traveller's cheques or credit cards.

BET14 More than the cost of the original trip.

BET15 Any extra value an item may have had because it formed part of a pair or set.

BET16 Loss or theft of any one, pair or set of articles from an unattended vehicle at any time, unless secured in a locked boot or locked glove compartment and there are signs of forcible entry.

BET17 Loss, damage or expense as a result of travelling to an area that the government of the country where you live has advised against travelling to.

Sections B, D, G and H of the optional travel add-on plan do not cover claims for, arising from or connected with the below.

BET18 Unattended baggage.

BET19 Government regulations or acts and currency restrictions.

BET20 Neglect or failure to act by the provider of transport or accommodation or an agent the travel arrangements were made through.

BET21 Expenses payable by or to the tour operator, hotel, airline or other carrier.

BET22 Unused accommodation, activities or travel arrangements or any administration costs for refunds of these charged by your travel agent, tour operator or provider.

BET23 Extra charges made by the tour operator.

BET24 Failure to tell your travel agent, tour operator or provider of transport or accommodation as soon as you know that you need to cancel your travel arrangements.

BET25 Failure to check-in at the place of departure, unless supported by a signed statement or report confirming the period of delay from:

- the carrier (or the carrier's handling agents);
- the tour operator or tour operator's representative; or
- public transport provider;

at the place of departure.

BET26 Withdrawal from service of an aircraft or sea vessel, whether temporary or otherwise, on the recommendation of a relevant port authority, the civil aviation authority or any similar organisation.

BET27 Strike or industrial action taking place or publicly declared on or before the date the **trip** is booked.

BET28 Cancelling or cutting short **your trip** if **you** knew that **you** may need to do so when joining this **plan** or booking **your trip**, whichever is later.

Sections F, G, H and I of the optional travel add-on **plan** do not cover **claims** for, arising from or connected with the below.

BET29 Damage due to moth, vermin, wear and tear, atmospheric or climatic conditions, gradual deterioration, loss of value, mechanical or electrical breakdown or damage caused by any process of cleaning, repairing or restoring, or damage caused by leaking powder or fluid carried within **your** baggage.

BET30 Breakage of fragile items including china, glass or sculptures.

BET31 Damage to sports equipment or clothing when in use.

BET32 Loss due to customs or any other authority legally taking or destroying **your** belongings.

BET33 Loss of, or damage to, stamps, documents, deeds, manuscripts or securities of any kind.

BET34 Loss or damage to items when in the custody of an airline or other carrier unless reported immediately upon discovering the loss and in the case of an airline, getting a property irregularity report.

BET35 Loss of, or damage to, goods, samples or tools hired or held in trust by **you**, but **you** do not own.

BET36 Loss of, or damage to, jewellery or photographic equipment carried in **your** luggage unless with **you** at all times.

BET37 Loss of, or damage to, contact or corneal lenses.

BET38 Shortages due to loss of value, omission, exchange or mistakes.

BET39 Theft or suspected theft not reported to the local police within 24 hours of discovery and supported by a report.

BET40 Loss or theft of cash or valuables not personally carried by **you** unless held in a safety deposit box or safe that is not in **your** room or apartment.

Protecting against healthcare fraud and maladministration

Healthcare fraud and the maladministration of **claims** increases premiums for **our** customers and **we** do **our** very best to eliminate it. There may only be a relatively small number of individuals or providers who engage in fraudulent activities, but innocent and careless overcharging for medical **treatment** also raises the cost of private medical insurance.

Fraud is the dishonest intent to obtain a financial gain from, or cause a financial loss to, a person or party through false representation, failing to disclose information or abuse of position.

Fraud is a crime.

Some examples of fraud under a medical insurance **plan** are:

- providing false or misleading information in order to obtain healthcare insurance or a reduction in premium;
- deliberately failing to disclose previous medical history when required;
- claiming for **treatments** or services not received;
- using somebody else's insurance to obtain **treatments** or services;
- altering invoices;
- claiming from more than one insurer for the same **treatment** or service; and
- falsifying diagnosis.

Some examples of maladministration would include duplicate billing and incorrect billing for medical **treatment** and procedures.

How can you help us in our efforts to contain your costs?

There are some steps **you** can take to help protect **yourself** and keep costs down:

- compare medical bills with **your** records. Check the dates are correct and the **treatments** or services were actually provided to **you**;
- ask questions if **you** do not understand or if there are any discrepancies;
- liaise closely with **us** in the event of a **claim**;
- contact **us** if **you** consider that **your medical practitioner** is providing **treatment** that is not necessary for **you**;
- carefully complete any **claim** forms. If there is anything **you** do not understand or are unsure of, please ask **us**;
- look after **your** insurance details and documentation;
- make sure **you** understand any documentation before **you** sign;
- keep copies of any documentation and correspondence sent; and
- report suspected fraud to **us**.

We work closely with others to prevent fraud

We are committed to protecting **you** against fraud and also have statutory responsibilities to prevent **our** products from being used as a vehicle for financial crime. **We** operate strict controls to deter, prevent, detect and investigate fraud.

We work with other insurance providers and the following organisations to prevent and detect fraud:

- Health Insurance Counter Fraud Group (HICFG);
- International Insurance bodies;
- International Police and Investigative agencies; and
- Governmental Departments.

We will share information with other organisations under S29(3) of the Data Protection Act with a view to:

- preventing fraudulent or improper **claims**;
- the prevention and detection of crime; and
- the apprehension and prosecution of offenders.

If you suspect fraud

If **you** suspect fraud or have any information relating to fraudulent activity, please contact **our** Investigation Team:

fraudgovernance@interglobalpmi.com

InterGlobal Fraud and Governance Team

Woolmead House East

The Woolmead

Farnham

Surrey

GU9 7TT

United Kingdom

+44 (0) 1252 745 939

InterGlobal is an Associate Member of the Health Insurance Counter Fraud Group



Data Protection

We are committed to protecting **your** personal data and privacy. Any personal information that **we** collect will be kept confidential and will be processed in accordance with the UK Data Protection Act 1998, Medical Confidentiality guidelines, other related legislation and **our** own strict internal policy.

We will use any personal data to process **your claims**, administer **your plan**, service **our** relationship with **you**, provide **you** with products and services and evaluate their effectiveness, provide **you** with better customer services and for statistical analysis. This information may also be used for fraud prevention and audit purposes.

We may also, in carrying out **your** instructions, processing and administering **claims**, transfer **your** personal data to other InterGlobal entities and/or third parties acting on **our** behalf inside or outside the European Union where there may be less stringent data protection laws. However, wherever it is held and processed, **your** personal data will be protected by a strict code of secrecy and security which **we** and any third parties working on **our** behalf are subject to and will only be used in accordance with **our** instructions.

Your information may also be used for fraud prevention and audit purposes. If **you** give **us** false or inaccurate information and **we** suspect fraud, **we** will record this. **We** may pass such information to other InterGlobal entities or agents or others as permitted by law so that they may do the same, and they may pass information held by them about **you** to **us** so that **we** may do the same.

We will not disclose such information outside of InterGlobal except for fraud prevention purposes, or if **we** are required to do so by law enforcement or other legal agencies, governmental or judicial bodies, or to **our** regulators under proper authority.

In order to assess the terms of the contract of insurance, including specific medical exclusions, or to administer **claims**, **we** may collect medical information which the UK Data Protection Act defines as 'sensitive' information. **Your** medical information will only be disclosed to those involved with **your treatment** or care, including **your medical practitioner**, or their agents. If **you** ask **us** to, **we** will also send **your** medical information to any person or organisation that may be responsible for meeting **your treatment** expenses, or their agents. **Your** information may be discussed with **your** agent or broker if **you** have requested the broker to assist **you** in handling **your claims** and **you** have authorised **us** to provide them with such medical information.

We will not disclose **your** medical information to any other individual without **your** explicit consent. If **you** want **us** to disclose **your** medical information to another individual or next of kin, **you** must tell **us**. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, **we** may be required to disclose such information to relatives, family **members** or other third parties.

We may, from time to time, provide **you** with marketing information about InterGlobal, **our** products and services and those of any associated companies which may be of interest to **you**. **You** will be given an opportunity to tell **us** if **you** do not wish to receive such information.

To help **us** ensure that **your** personal information remains accurate and up to date, please inform **us** of any changes.

You have the right to see personal information about **you** held by **us**. There may be a charge for this.

Please write to: The Compliance Officer, InterGlobal Insurance Company Limited, Woolmead House East, The Woolmead, Farnham, Surrey, GU9 7TT.

Complaints

We always aim to give **you** a first-class service. However, there may be times when **you** may feel that **we** have not achieved this aim. If this is the case, please contact:

The Complaints Team - InterGlobal Limited
Woolmead House East, The Woolmead, Farnham, Surrey, GU9 7TT, United Kingdom.

Telephone: +44 (0)1252 745 910

Email: complaints@interglobalpmi.com

We will deal with **your** complaint in a fair and speedy manner and in accordance with relevant regulation.

Our aim is to **resolve** your complaint satisfactorily by the end of the next business day in which it was received. Sometimes this may not be possible, in which case **we** will acknowledge **your** complaint within five working days of receipt of **your** complaint, and give **you** regular updates until **your** complaint is resolved. **We** will give **you** a final response within eight weeks of receipt of **your** complaint.

If **you** remain dissatisfied with the outcome of **your** complaint, **you** may be able to refer it to the Financial Ombudsman Service within six months of receiving **our** final response. Their details are provided below:

Financial Ombudsman Service

South Quay Plaza

183 Marsh Wall

London

E14 9SR

United Kingdom

Telephone: +44 (0)845 080 1800

Email: complaint.info@financial-ombudsman.org.uk

Website: www.financial-ombudsman.org.uk

To help **us**, please quote **your plan** number and **claim** number (if this applies) with as much information as **you** can about **your** complaint, as well as **your** full contact details.

Full details of **our** complaints procedures are available on **our** website and other product documentation.

Compensation arrangements

We are covered by the Financial Services Compensation Scheme (FSCS). **You** may be entitled to compensation from the scheme if **we** cannot meet **our** financial responsibilities. This depends on the type of business and the circumstances of the **claim**. Insurance advising and arranging is covered for 90% of the **claim**, with no upper limit. **You** can get more information about the compensation scheme from the FSCS website at www.fscs.org.uk

Plan definitions

Abuse – the excessive use of alcohol, drugs or any other intoxicating substance. This includes use of drugs for a reason which is different to what they were intended for, in a manner or in quantities other than as directed or prescribed on medical authority.

Accident – any involuntary, sudden or unexpected event resulting in a **bodily injury** to **you**.

Acute – a **medical condition** that responds to **treatment**, which aims to return **you** to **your** previous state of health or leads to **your** full recovery.

Area of cover – the geographic area of the world in which **your plan** applies. This is shown on **your** certificate of insurance.

Benefit, benefits – the cover provided by **your plan** and any extensions or restrictions shown in **your plan** guide, certificate of insurance and table of **benefits**.

Birth defect – any deformity, abnormality or disability, arising during pregnancy, or caused during childbirth.

Bodily injury – any physical harm or damage to **you**.

Business colleague – an associate who is employed in the same company as **you**.

Cancer – a malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Chronic – a **medical condition** which has one or more of the following characteristics:

- needs ongoing or long-term monitoring through consultations, examinations, check ups or tests;
- needs ongoing or long-term control or relief of symptoms;
- requires **your** rehabilitation or for **you** to be specially trained to cope with it;
- continues indefinitely;
- has no known cure;
- comes back or is likely to come back.

Claim, claims – when **you** or **your** agent, personal representative, assignee or trustee in bankruptcy seek payment or settlement under the terms and conditions of the **plan**.

Close family member – a **dependant**, parent, step-parent, parent-in-law, grandparent, grandchild, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law or guardian.

Co-insurance – the percentage of costs for a covered **claim** that **you** must pay.

Congenital abnormality – a **medical condition** that is present at birth or is believed to have been present since birth, whether it is inherited or caused by an environmental factor.

Consequential loss – any costs **you** must pay that may be associated with a **claim** but are not covered under the **plan**. For example, loss of earnings as a result of a **medical condition**.

Consultant – please see **specialist**.

Continuation of Personal Medical Exclusions – if **you** transfer from another insurer **we** may offer to continue the same underwriting terms including any special exclusions which previously applied to **you**. **You** will not be subject to any new personal underwriting terms. Cover will still be governed by the **benefits**, terms and conditions of **your plan** with **us** except for **benefit** exclusion BE1.

Country where you live, country where a member lives – the country **you** live in for most of the time, usually for a period of at least six months, during a **plan year**.

CPME – see **Continuation of Personal Medical Exclusions**.

Critical – a **medical condition** which is unstable and serious, where the outcome cannot be medically predicted, prognosis is uncertain and the person may die.

Curtailed, curtailment – **you** abandon a **trip** due to a factor or factors beyond **your** control.

Date of joining – when **you** first became a **member** on the **plan**.

Daycare treatment – **treatment** at a **hospital** or daycare unit when medical supervision is needed for recovery, but **you** do not stay overnight.

Dental – that which affects the teeth and gums.

Dependant – a **planholder**, employee or affinity **member's**:

- husband, wife or partner;
- unmarried child, stepchild or legally adopted child under the age of 18;
- unmarried child under the age of 25 who is in full-time education. **We** may need written proof from the educational institution where they are enrolled.

Diagnostic tests and procedures – a **medically necessary** test or examination to investigate the cause of **your** symptoms.

Emergency – a sudden, unexpected **acute medical condition** or an unexpected **acute** episode of a **chronic medical condition** that, without **treatment** within 48 hours of onset, could result in death or serious damage to bodily functions.

Excess – the amount **you** must pay towards the cost of a covered **claim** as shown on **your** table of **benefits**. The different types of **excess** are:

- **Excess** for each visit. **You** must pay this **excess** for each doctor consultation **you** have, no matter how many **medical conditions** are treated by that doctor on that day. This **excess** applies to out-patient and **specialist** consultations for each different doctor seen on that day, even if there is a referral from one doctor to another on the same day.
- **Excess** for each **medical condition**. This **excess** applies to each **medical condition** claimed in each **plan year**. For example, if **you** send in four **claims** for two **medical conditions**, **you** must pay two **excesses** in the **plan year**.
- **Excess** for each **member**. This **excess** applies to **you** once every **plan year**, no matter how many **claims** **you** make in each **plan year**.

End date – the last day **you** have cover under the **plan**.

Foreseeable – a **medical condition** that could be reasonably anticipated.

Hazardous pursuits – Any activity or sport that places **you** at an increased risk of suffering a **medical condition** or making an existing **medical condition** worse.

Home country – the country **you** are from as given to **us** on **your** application.

Hospice – an organisation providing services for patients with **terminal** illnesses. **Hospice** care may be received as an **in-patient** or **out-patient**, at home, or at a centre for controlling pain and other symptoms.

Hospital – an establishment legally licensed as an institution for giving **treatment** under the laws of the country in which it is located.

Immediate family – a blood relative.

In-house doctor – a doctor who is employed by the **hospital**, is considered a permanent member of staff and charges in line with **hospital** tariffs.

In-patient treatment – **treatment** at a **hospital** where **you** need to stay in a bed for one or more nights.

Insurance premium tax – a government tax which **we** must collect at the rate that applies in the **country where you live**.

IPT – see **Insurance premium tax**.

Intrinsic value – the actual cash value of an item at the time of loss or damage, including appropriate deductions for wear and tear.

Main Member – The person who is named first on a valid certificate of insurance.

Material facts – information likely to influence **us** in the assessment or acceptance of **your plan**.

Medical conditions – signs or symptoms, injury, illness, sickness or disease.

Medical History Disregarded – **we** will cover **pre-existing medical conditions** suffered by **you**, subject to the **benefits**, terms and conditions of **your plan**. **Benefit** condition BC4 and **benefit** exclusion BE1 will not apply.

Medical practitioner – a person who is registered and licensed to practise medicine in the country where **treatment** is provided and has obtained the primary degrees in medicine and surgery following attendance at a recognised medical school listed within the World Directory of Medical Schools published by the World Health Organisation.

Medical necessity, medically necessary – **treatment** prescribed by **your medical practitioner**, attending **specialist** or **consultant**, which is appropriate for **your medical condition** and is in line with accepted medical standards.

Member – see **you, your, yourself**.

MHD – see **Medical History Disregarded**.

Moratorium – a waiting period of 24 months from **your date of joining**, or the date shown on the special terms section of **your certificate of insurance**, that must have passed before **claims for pre-existing medical conditions** may be eligible under the **plan**. Please read **benefit exclusion BE1**. The **moratorium** also applies to optional add-on **plans**.

Natural teeth – any teeth that are original and organic, not artificial implants or replacements.

Non-paying patient – when **you** receive **in-patient** or **daycare treatment** in a **hospital** free of charge.

Nursing at home – services of a **registered nurse** in **your home** when prescribed and supervised by a **medical practitioner, consultant or specialist** and **related** directly to a **medical condition** for which **you** are receiving **treatment** under the **plan**.

Orthodontic – that which affects the structure, function, or development of the teeth, upper or lower jaw or the oral cavity.

Our – see **us**.

Out-patient treatment – **treatment** at a **hospital**, consulting room, or **out-patient clinic** where **you** do not need a bed.

Palliative – **treatment** aimed to relieve the symptoms, rather than to stop, delay, or reverse progression of the **medical condition** causing them or provide a cure.

Personal effects – personal belongings, including clothing worn and personal luggage owned by **you** that **you** take with **you** on **your trip**.

Physiotherapist – a person who is qualified to practise physiotherapy and is licensed in the country where **treatment** is provided.

Plan – the contract between the **planholder, you** and **us**, to provide cover in line with the table of **benefits**, general conditions, **benefit conditions** and **benefit exclusions** shown in **your plan** documents.

Plan administrator – the person who acts as co-ordinator with **us** for **your group plan**, as chosen by the **planholder**.

Plan start date – the date the **plan** begins and any future **renewal date**.

Plan year – a period of 12 months from the **plan start date**, as shown on a valid certificate of insurance.

Planholder – the person or organisation **we** have issued the **plan** to as named on a valid certificate of insurance.

Pre-authorized, pre-authorisation – the process **you** must follow to get approval from **us** before receiving or incurring costs for **treatment**. **Pre-authorisation** may be withdrawn by **us** if new information means a **claim** is not covered.

Pre-existing – any **medical condition** or **related medical condition** which has one or more of the following characteristics:

- was **foreseeable**;
- clearly showed itself;
- **you** had signs or symptoms of;
- **you** asked for advice about;
- **you** received **treatment** for;
- to the best of **your** knowledge, **you** were aware **you** had.

Preventative services – **treatment** where no **medical condition** or symptoms are present.

Professional sports – sports which **you** are being paid to take part in and where any payment received is the main source of **your** income.

Psychiatric – a **medical condition** which affects **your** mind, mental function or emotions whether the cause is organic, traumatic or reactive.

Public transport – any paid and licensed form of transport.

Reasonable – the standard cost of **treatment** or services within the same country or geographical region based on **our** experience and knowledge.

Registered nurse – a qualified nurse who is currently practising and is on the professional register of nursing in the country where **treatment** is provided.

Rehabilitation – **treatment** aimed to restore **your** health or mobility to help **you** live a more independent life.

Related – a **medical condition** that in the opinion of both **your medical practitioner, specialist or consultant** and **us** is:

- a direct result of another **medical condition**;
- a result of another **medical condition**;
- associated with another **medical condition**; or
- an associated risk factor of another **medical condition**.

Renewal date – the anniversary of the **start date** of the **plan** as shown on a valid certificate of insurance.

Routine health check – **diagnostic tests and procedures** where no **medical condition** or symptoms are present.

Specialist – a **medical practitioner** who is practising and has a recognised certificate of higher **specialist** training or a **consultant** appointment (or equivalent), in the field of medicine for which the **treatment** is needed and in the country where **treatment** is provided.

Start date – the date **you** join the **plan** or any future **renewal date** as shown on a valid certificate of insurance.

Terminal – the end stages of a **medical condition** where life expectancy is considered to be weeks or months. **Treatment** is limited to relief of symptoms and no active **treatment** is being given.

Therapist – a chiropractor, osteopath, homeopath, acupuncturist or Chinese herbalist who is qualified and licensed in the country where **treatment** is provided.

Treatment – any surgical or medical services, including **diagnostic tests and procedures**, which are needed to diagnose, relieve or cure a **medical condition**.

Trip – a journey or period of travel which does not exceed the duration shown on **your** optional travel add-on **plan** table of **benefits**. This includes the dates of departure from and the return to the **country where you live** as given to **us** by the **planholder**.

Unattended baggage – leaving **your** luggage:

- with a person **you** have not previously met;
- in a public place where it can be taken without **your** knowledge; or
- at a distance from which **you** cannot prevent it from being taken.

Us – the insurer as shown on the certificate of insurance.

Visiting doctor – a doctor who is not employed by the **hospital** but has a contract to use the **hospital** facilities and may have different charges to the **hospital** tariffs.

We – see **us**.

You, your, yourself – a person who has met the eligibility criteria of the **plan** and is named on a valid certificate of insurance.



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www.interglobalpmi.com

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