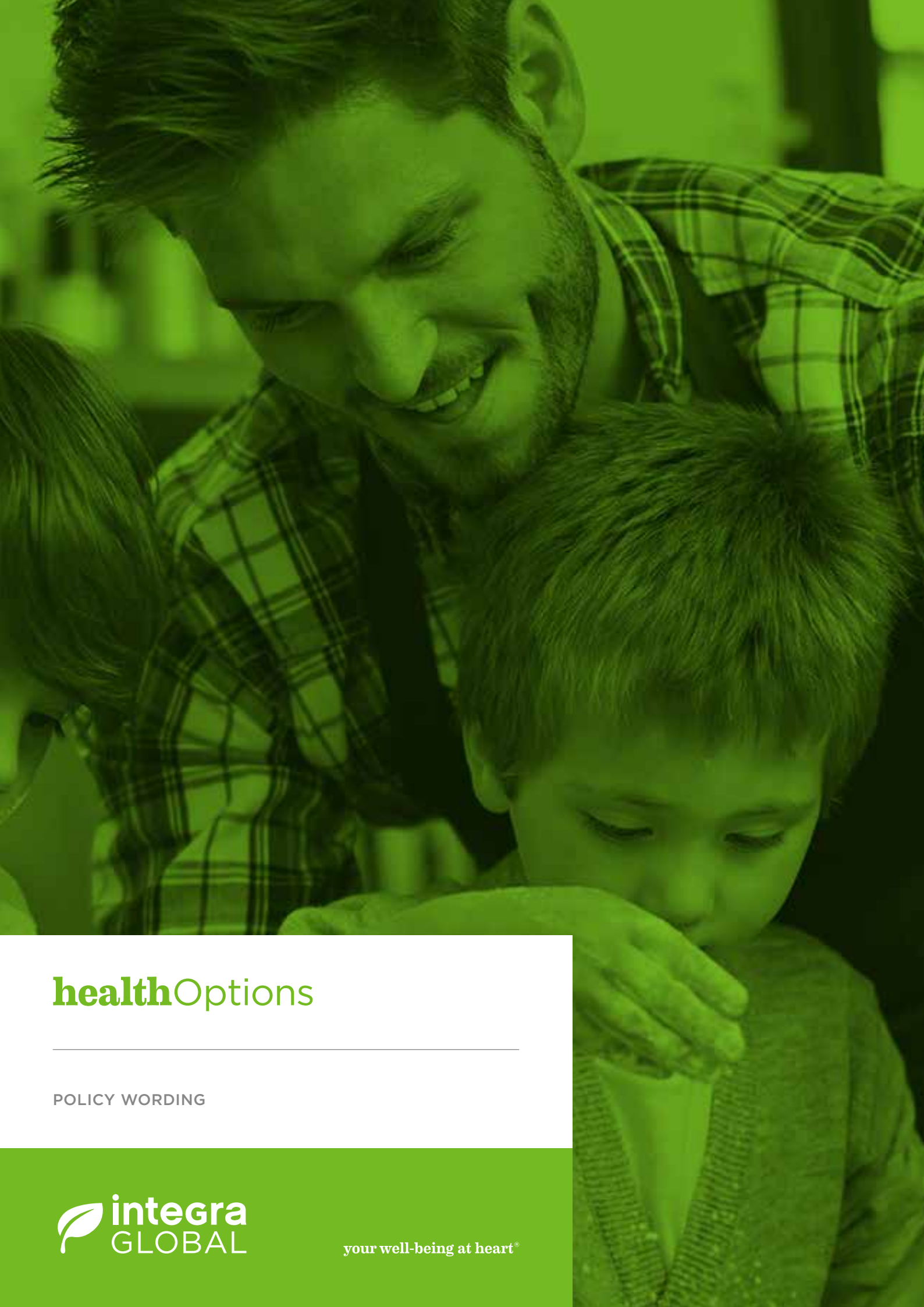

healthOptions

POLICY WORDING

integra GLOBAL

your well-being at heart®

Contents

Policy introduction

Policy holder means the primary insured person who subscribes to this policy and pays or undertakes to pay the appropriate premium.

Insured person(s) an eligible individual and his or her dependents entitled to benefit under this policy, each of whom is named or described on a completed enrolment form or subsequent notification and for whom the appropriate premium has been paid to us, and whom we have accepted for cover.

This policy forms part of a master contract for companies effected by Integra Global Health Deutschland GmbH, and MGEN.

Integra Global Health Deutschland GmbH, Bahnhofstrasse 81, 82166, Gräfelfing, Germany is a Registered Intermediary with authorisation according to § 34 d para. 1 GWO [German Trade Regulation] with registration number: D-VWTV-OIPY1-28. Court of registration: Munich HRB246266. Managing Directors: Philip Catterton and Paul Matthews. For further information please see integraglobal.com/ig/legal_notice. MarineSure is a trading name of Integra Global Health Deutschland GmbH.

This policy is underwritten by MGEN, SIREN number 775 685 399, regulated by the provisions of Tome II of the French mutual insurance companies code – 3-7 Square Max Hymans, 75748 Paris Cedex 15, France; and MGEN Vie, 3-7 Square Max Hymans, 75748 Paris Cedex 15, France, registered under number Siren 441 922 002.

The purpose of this insurance policy is to provide cover to individuals and their eligible dependents.

How the healthcare plan operates

This policy describes the benefits which are available, but the cover which will be provided to each insured person will be in accordance with the selected plan as shown in the certificate issued to the insured person and with the table of benefits each of which attach to and form part of this policy. Any benefit not included in the cover selected and the table of benefits does not apply.

We reserve the right to modify the table of benefits from time to time, and shall provide a copy of the current table of benefits to the Policyholder at the time of such modification. The Policyholder acknowledges having received the provisions of the current table of benefits. The table of benefits as per our records shall prevail regardless of whether the insured person has received a copy.

Covered medical expenses does not cover for the disease or injury itself. This means that this policy will pay benefits only for expenses incurred while this cover is in force.

No benefits are payable for health expenses incurred before cover has commenced or after cover has terminated; even if the expenses incurred as a result of an accident, injury or disease which occurred, commenced or existed while cover was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. We will determine the pro rata share. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of services or supplies.

We assume no responsibility for the outcome of any covered services or supplies. We make no express or implied warranties concerning the outcome of any covered services or supplies.

The insurance is not intended to be a source of profit. The combined reimbursements from this policy, another insurance policy or government plan should not exceed the actual costs of the healthcare received by the insured person to treat a medical condition.

Important notes

The benefits payable

After any applicable deductible, the benefits payable under this plan are paid at the payment percentage specified in the table of benefits which applies to the type of covered medical expense which is incurred, except for any different benefit level which may be provided later in this policy.

Benefits may vary depending upon whether a preferred provider organisation (PPO) is utilised. Visit the website shown on your membership card for information regarding the PPO in the area of North America in which you will be seeking care.

Any charge for a service or supply furnished by a PPO in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the individual cover.

Deductible

Means the amount of covered expenses which an insured person is responsible to pay before benefits are payable under this policy. Such amount will not be reimbursed under the policy. After the deductible amount has been paid by the insured person, benefits for covered medical expenses will be payable under this policy at the percentage rates shown on the table of benefits.

Coinsurance/co-pays

After the deductible is met we will pay at the percentage level specified in the table of benefits of allowable charges to the out of pocket maximum if applicable. Thereafter the benefit is payable at 100% of allowable charges.

Annual maximum

Payment of benefits is subject to the annual aggregate maximum per insured person as long as benefit for such insured person remains in force. The annual maximum includes all benefit maximums specified in this policy, including those specified in the table of benefits and in any endorsement.

Out of pocket maximum

This is the cap on the coinsurance specified in the table of benefits.

International healthcare plan

Eligible expenses

Eligible expenses shall be the reasonable charges for the services and supplies listed below, actually made to the insured person and, unless otherwise shown, will be considered eligible only if the expenses are:

1 given for the diagnosis or treatment of illness, pregnancy or accidental injury
2 ordered or performed by a physician
3 medically necessary; and
4 usual, reasonable and customary.

You and your physician decide which services and supplies are given, but the plan only pays for covered medical expenses which we deem to be medically necessary.

A service or supply may not be medically necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at our discretion consider the cost of that alternative to be covered medical expenses. In this case, covered medical expenses are limited to the usual, reasonable and customary charges for that diagnostic or treatment alternative.

It is the insured person's responsibility to keep records of what has been paid. You will not be given notification when the maximum is approaching or when the maximum is reached and claims submitted after the maximum is reached will be disallowed.

Covered medical expenses

These are expenses for certain hospital and other medical services and supplies. They must be for the treatment of an injury or disease.

The maximum benefit amount for medical expenses includes any and all other maximum benefit amounts shown in the table of benefits or added/amended by policy endorsement. Any unused portion of the maximum benefit is only payable for expenses incurred while an insured person is eligible for cover and while this policy is in force.

Hospital expenses

We will arrange and pay for the insured person's inpatient or day-care admission to the hospital and for the following covered medical expenses and services when recommended and/or approved by our medical coordinator:

- **inpatient hospital services** – charges made by a hospital for giving accommodation and other hospital services and supplies to a person who is confined as a full-time inpatient
- **accommodation**
  yourLife and yourFamily plans
  In a semi-private room and meals. All charges in excess of the allowable semi-private room and board rate are the responsibility of the insured person
  PremierLife and PremierFamily plans
  accommodation applying to Premier Health members is a private room as shown in the table of benefits
- **intensive care unit** – when medically necessary
- **inpatient ancillary services** – if medically necessary for the diagnosis and treatment of the illness or injury for which the insured person is hospitalised, the following services are also covered and benefits paid for charges for:
  - use of operating room and recovery room
  - all medicines listed in the U.S. Pharmacopoeia or national formulary
  - blood transfusion, blood plasma expanders, and all related testing, components, equipment and services
  - surgical dressings
  - machine testing
  - durable medical equipment
  - diagnostic X-ray examination
  - electric shock therapy rendered by a physician
  - radiation therapy rendered by a radiologist for proven malignancy and/or neoplastic diseases
  - respiratory therapy rendered by a physician or registered respiratory therapist
  - chemotherapy rendered by a physician
  - physical and occupational therapy rendered by a physician or registered physical or occupational therapist, which relates specifically to the physician's written treatment plan.

Therapy must:

a. produce significant improvement in the insured person's condition in a reasonable and predictable period of time, and
b. be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a registered physical or occupational therapist or
c. be necessary to the establishment of an effective maintenance programme.

- **outpatient hospital services** – charges made by a hospital for hospital services and supplies, which are given to a person who is not confined as a full-time inpatient
- **outpatient services** – charges for emergency room, outpatient or ambulatory surgical centre
- **medical/surgical benefits** – charges for:
  - surgeon
  - outpatient physician visit (home or office)
  - inpatient medical treatment
  - inpatient consultation by specialist
  - emergency medical services
  - office surgery
  - assistant surgeon
  - anesthesiologist.

Specific exclusions applying to hospital expenses

In the case of what our medical coordinator considers to be an unreasonable length of stay or unreasonable hospital charges, we reserve the right to limit payment to what our medical coordinator considers to be usual, reasonable and customary costs.

Covered medical expenses – continued

Non-emergency care in an emergency room

If treatment:

- is received in the emergency room of a hospital while a person is not a full-time inpatient; and
- the treatment is not emergency care; covered medical expenses for charges made by the hospital for such treatment will be paid at the same rate as a standard office visit (10 min visit).

Hospital level care will be deemed to be required only if care:

- could not safely and adequately have been provided other than in a hospital; or
- adequate care was not available elsewhere in the area at the time and place it was needed.

Maternity care per pregnancy

Maternity care applies to yourFamily and PremierFamily plans, and to the primary insured person and his/her spouse only. We will arrange and pay up to the policy limits as per the table of benefits for:

- normal delivery
- Caesarean section and complications related to pregnancy
- the benefits apply to the mother only and are excluded during the first twelve (12) months of the policy.

Covered services include:

- hospital services rendered in a licensed hospital or approved birthing centre (including anesthesia, delivery and postnatal care) for any condition related to pregnancy, including but not limited to childbirth and miscarriage
- obstetrical services (including prenatal, delivery and postnatal care) and anesthesia services by physicians.

Specific exclusions applying to maternity care

Any fertility/infertility services, tests, treatments, drugs and/or procedures, including the resulting pregnancy, complications of that pregnancy, delivery and postpartum care.

Newborn, premature birth, congenital conditions, birth anomalies

The policy will pay up to the lifetime maximum (for newborns covered under the policy).

Hospital nursery services and medical care by the attending physician for newborn infants in the hospital are covered if:

- the mother's pregnancy is covered; and
- dependent cover has already been elected; and
- we must have received the baby's application and applicable premium within thirty (30) days of birth for enrolment under a parent's cover.

Charges for hospital nursery services and professional services for the newborn infant are covered separately from the mother's maternity benefits and are subject to the satisfaction of the deductible and coinsurance amounts in accordance with the policy and table of benefits.

Payment of benefits for the newborn child born of a non-covered pregnancy, children born to mothers who received fertility or infertility treatments or for a newborn that has not been enroled within the thirty (30) day limit; are conditional upon receipt of an enrolment form and applicable premium and medical underwriting acceptance by us. No guarantee is made for acceptance of cover to be agreed.

Coverage for congenital conditions is only available to infants born of a covered pregnancy and having continuous cover effective from the date of birth.

When cover is available, benefits are provided for medically necessary inpatient and outpatient treatment, services and supplies for congenital conditions as those conditions are defined herein. Benefits for congenital conditions and premature births are payable up to the lifetime maximum for newborn cover.

Diagnostic and therapeutic services (outpatient)

We will pay charges for medically necessary diagnostic and therapeutic services rendered to an insured person as an outpatient of a hospital, provider's office or approved independent facility.

Diagnostic services covered are:

- imaging services
- laboratory services (excluding allergy testing)
- machine testing.

Therapeutic services covered are:

- chemotherapy rendered by a physician
- radiation therapy provided by a physician for a proven malignancy or neoplastic disease
- respiratory therapy rendered by a physician or registered respiratory therapist
- physical and occupational therapy provided by a physician or registered physical or occupational therapist. Services must be pursuant to a physicians written treatment plan, which contains short and long term treatment goals and is provided to us for review. Services must either:
  1 produce significant improvement in the insured person's condition in a reasonable and predictable period of time; and
  2 be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed; or
  3 be necessary to the establishment of an effective maintenance programme.

A medically necessary video laryngoscopy may be performed by a registered speech therapist for the diagnosis of a swallowing dysfunction.

Specific exclusions applying to diagnostic and therapeutic services

All other speech therapy services or treatments not mentioned above.

Human organ transplant procedures benefits

The policy will pay up to the policy limits in the table of benefits for charges for medically necessary, non-experimental transplantation of a human organ including related services, supplies, drugs and treatments. Organs covered for transplants are limited to the following: heart, lung, kidney, liver, pancreas, and cornea. Bone marrow transplants are covered only for approved diagnosis.

Benefits are only payable if the managed transplant programme is used – all transplants need to be pre-authorised.

- benefits are provided to the insured transplant recipients only. Costs related to organ donors are not covered
- transplant must be deemed necessary by two (2) independent medical or surgical consultants in the relevant medical specialty most closely related to the transplant.

Transplants resulting from or made necessary by congenital conditions are not covered under this organ transplant benefit. They are subject to the limitations and benefits applicable to the congenital condition benefit specified in this contract in accordance with the current table of benefits.

Specific exclusions applying to human organ transplant procedures

- any treatment or service which is not pre-authorised or does not use the managed transplant network
- organ transplant benefits within the first twenty-four (24) months of the insured person's cover. This period is determined from the date of entry
- subsequent transplants if the initial transplant was not covered under this contract for any reason
- any transplant procedures and related services we deem to be experimental.

Covered medical expenses – continued

Mental health benefits (inpatient and outpatient)

The policy will pay up to the policy limits in the table of benefits for allowable charges in respect of psycho-therapeutic treatment and psychiatric counselling and treatment for approved psychiatric diagnosis. The relevant annual and lifetime maximum will be applied to each insured person for benefits paid for both inpatient mental health treatment in a hospital or approved facility and for outpatient mental health treatment.

- A physician or a licensed clinical psychologist or psychiatrist must provide all mental healthcare services. Services of a clinical psychologist or psychiatrist must be rendered in the provider's office or in the outpatient department of a hospital.

Specific exclusions to mental health benefits (inpatient and outpatient)

- aptitude testing, educational testing and services
- services for conditions we classify as emotional or personality illnesses
- psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation
- services for mental disorders or illnesses which are not amenable to favourable modification
- services related to drug and alcohol abuse.

Convalescent facility expenses

We will pay for charges made by a convalescent facility for the following services and supplies. They must be furnished to a person while confined to a convalescent facility by a disease or injury. The confinement must start during a convalescent period.

- accommodation on the room basis as per the table of benefits – this includes charges for services, such as general nursing care, made in connection with room occupancy
- use of special treatment rooms
- X-ray and lab work
- physical, occupational or speech therapy
- oxygen and other gas therapy
- other medical services usually given by a convalescent facility
- medical supplies.

Benefits will be paid for up to the maximum number of days during any one convalescent period. This starts on the first day an insured person is confined in a convalescent facility if he or she:

- was confined in a hospital for at least three days in a row, while covered under this policy, for treatment of a disease or injury; and
- is confined in the facility within 14 days after discharge from the hospital; and
- is confined in the facility for services needed to convalesce from the condition that caused the hospital stay. These include skilled nursing and physical restorative services.

It ends when the insured person has not been confined in a hospital, convalescent facility, or other place giving nursing care for 90 days in a row.

Specific exclusions to convalescent facility expenses

- private or special nursing, or physician services
- drug addiction
- chronic brain syndrome
- alcoholism
- senility
- mental retardation
- any other mental disorder.

Hospice care expenses

We will pay up to the policy limits in the table of benefits for charges incurred in a hospice facility, hospital or convalescence facility for accommodation and other services and supplies furnished to an insured person while a full-time inpatient, for pain control and other acute and chronic symptom management, when given as a part of a hospice care programme are included as covered medical expenses. We must approve the hospice care programme to provide a centrally administered programme of palliative and support services to terminally ill persons and their families. Terminally ill means the patient has a prognosis of two hundred and forty (240) days or less. A medically supervised interdisciplinary team of professionals and volunteers provides services.

Other expenses

We will also pay for charges made by a hospice care agency for:

- part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours in any one day
- medical social services under the direction of a physician. These include:
  - assessment of the insured person's social, emotional and medical needs, and the home and family situation;
  - identification of the community resources which are available to the insured person; and
  - assisting the person to obtain those resources needed to meet the insured person's assessed needs.
- psychological and dietary counselling
- consultation or case management services by a physician
- physical and occupational therapy
- part-time or intermittent home health aide services for up to eight hours in any one day. These consist mainly of caring for the person
- medical supplies, drugs and medicines prescribed by a physician.

Charges made by the providers below, but only if the provider is not a participant of a hospice care agency; and such agency retains responsibility for the care of the insured person:

- a physician for consultant or case management services
- a physical or occupational therapist
- a home healthcare agency for:
  - physical or occupational therapy;
  - part-time or intermittent home health aide services for up to eight hours in any one day; these may consist mainly of caring for the person;
  - medical supplies, drugs and medicines prescribed by a physician; and
  - psychological and dietary counselling.

Not more than policy limits as per the table of benefits will be paid for all hospice care or expenses incurred while the insured person is not confined as a full-time inpatient.

If the insured person's condition improves and is no longer considered terminal, then the insured person is no longer eligible for hospice care.

Specific exclusions to hospice care expense

- private or special nursing, or physician services
- drug addiction
- chronic brain syndrome
- alcoholism
- senility
- mental retardation
- any other mental disorder
- charges for any day of confinement in excess of the maximum number of days for all confinements for hospice care.

Charges for:

- services not prescribed in the approved treatment plan
- chemotherapy and radiation therapy except for palliative control
- bereavement counselling
- funeral arrangements
- pastoral counselling
- financial or legal counselling. These include estate planning or the drafting of a will
- homemaker or caretaker services. These include:
  - sitter or companion services for either the person who is ill or other members of the family;
  - transportation;
  - house cleaning; and
  - maintenance of the house.
- respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Emergency ambulance services

We will pay charges for professional ambulance services including road ambulance and air ambulance, if necessary, to transport an insured person from the place where he or she is injured or stricken by disease to the first hospital where treatment is given.

Covered medical expenses – continued

Emergency air ambulance

- covered based on medical necessity
- evacuation is provided if an insured person is involved in an accident or suffers a sudden illness and adequate medical facilities are not available locally. A medically supervised medical evacuation to the nearest facility capable of providing an adequate level of care will be co-coordinated by our emergency medical assistance provider
- repatriation of mortal remains: our emergency medical assistance provider will coordinate the necessary clearances for the return of an insured person's mortal remains by air transport to the home country.

To comply with the terms and conditions of the policy the insured person must contact us for pre-authorisation before any costs for evacuation and assistance costs are incurred.

Specific exclusions to emergency ambulance services

Any other expenses in connection with air travel. Any costs which are not pre-authorised.

Any costs for a road ambulance if the insured person could have been transported in a private car, whether or not one was available.

Outpatient prescription drugs

Benefit is provided for prescription drugs and medicines, which by law need a physician's prescription and are approved by us for use outside of a hospital.

Contraceptive drugs and all related devices/treatment are excluded even if prescribed for other than contraceptive purposes. Weight reduction, smoking cessation, fertility/infertility or hair restoration drugs, over the counter medications are not covered, even if prescribed by the physician.

Prescribed drugs related to human organ transplants and subsequent treatment are governed by the benefits and limitations listed in the human organ transplant section of this contract. All prescription drug benefits are payable in accordance with the current table of benefits.

Durable medical equipment

We will pay up to the policy limits in the table of benefits for costs for prosthetic devices (artificial devices replacing body parts), orthopedic braces and durable medical equipment (including wheelchairs and hospital beds) that are:

1 prescribed by a physician and
2 customarily and generally useful to a person only during an illness or injury, and
3 determined by us to be medically necessary and appropriate.

Rental fees of durable medical or surgical equipment must not exceed the allowable purchase price of the durable medical equipment.

The initial purchase of such equipment and accessories needed to operate it; this will only be covered if:

- long term use is planned; and
- the equipment cannot be rented; or
- it is likely to cost less to buy it than to rent it.

Repair or replacement of such purchased equipment and accessories: We will only cover replacement if:

- it is needed due to a change in the insured person's physical condition; or
- it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

Specific exclusions to durable medical equipment

Charges for more than one item of equipment for the same or similar purpose. Charges in relation to artificial limbs and eyes: eye exams and eyeglasses; hearing aids; orthopedic shoes or other devices to support the feet.

Visiting nurse/home healthcare expense

We will pay up to the policy limits in the table of benefits for charges relating to visiting nurse/home health expenses if:

- the charge is made by a home healthcare agency; and
- the care is given under a home healthcare plan; and
- the care is given to a person in his or her home.

Visiting nurse/home healthcare expenses are charges for:

- part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available

- part-time or intermittent home health aide services for patient care
- physical, occupational and speech therapy
- the following to the extent they would have been covered under this policy if the insured person had been confined in a hospital or convalescent facility:
  - medical supplies, drugs and medicines prescribed by a physician; and
  - lab services provided by or for a home healthcare agency.

In each period of insurance there is a maximum to the number of visits covered as per the table of benefits. Each visit by a nurse or therapist is one visit. Each visit of up to four hours by a home health aide is one visit.

Specific exclusions to visiting nurse/home healthcare expense

Charges made for:

- services or supplies that are not a part of the visiting nurse/home healthcare plan
- services to an insured person by anyone who usually lives with you or is a member of your or your wife's or husband's family
- services of a social worker
- transportation.

Private duty nursing (inpatient service only)

We will pay up to the policy limits in the table of benefits for costs of private duty nursing by an R.N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

This benefit is provided only when *all* of the following conditions are met:

- the nursing service is available and the service is prescribed by the attending physician; and
- the service is related to the condition for which hospital care and treatment are being rendered; and
- the service is medically necessary; and
- the service is approved by the hospital.

We may elect to review a case in advance and then approve benefits for this service for up to 80 hours at a time.

Specific exclusions to private duty nursing

Benefits will not be paid for private duty nursing:

- For any shifts in excess of the private duty nursing care maximum shifts. Each period of private nursing of up to eight hours will be deemed to be one private duty nursing shift.
- When it is provided as a convenience for the patient, whether or not prescribed by a physician, or when it is provided at the request of the patient or his/her family.
- When it is rendered in such special care facilities of the hospital as self-care, selective care, and intensive care units.

Benefits will not be paid for skilled nursing care for:

- a visit of more than four hours for the purpose of performing specific skilled nursing tasks
- that part or all of any nursing care that does not require the education, training and technical skills of an R.N. or L.P.N.; such as transportation, meal preparation, charting of vital signs and companionship activities; or
- any private duty nursing care, given while the person is an inpatient in a hospital or other healthcare facility; or
- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- care provided solely for skilled observation except as follows:
  - more than one four hour period per day for a period of no more than 10 consecutive days following the occurrence of:
  - change in patient medication;
  - need for treatment of an emergency condition by a physician or the onset of symptoms indicating the likely need for such treatment; or
  - any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a R.N. or L.P.N.

Covered medical expenses – continued

Wellness and preventive benefits

(Six month waiting period – not subject to deductible) waiting period does not apply if premium is paid annually.

We will pay the costs up to the policy limits in the table of benefits for the cost of examinations of the insured person (having regard to their age) to ascertain the potential presence of illness or disease; these may include, (but not limited to):

- vital signs, including blood pressure, cholesterol, pulse, respiration, temperature; and
- cardiovascular and neurological examinations; cancer screening including mammogram, pap smear, colon, prostate
- A physical exam may also include the materials for and the administration of immunisations and vaccinations for infectious disease and testing for tuberculosis.

Well child examination

Wellness and preventative benefits for children are only available with yourFamily and PremierFamily plans

- for all exams given to your children under aged six covered medical expenses will exclude charges for:
  - more than six exams in the first year of the child's life; and
  - more than one exam in each year of life thereafter.
- for all exams given to your child age six and over, covered medical expenses will exclude charges for more than one exam per period of insurance.

Specific exclusions to wellness and preventative benefits

- exams in any way related to employment
- premarital exams
- vision, hearing (except for children under age 15 who are members of yourFamily and PremierFamily plans) or dental exams
- costs where the medical results and report from the examination have not been provided to us.

Vision care benefit

(Six month waiting period – not subject to deductible) waiting period does not apply if premium is paid annually.

We will pay up to the policy limits in the table of benefits for:

Ophthalmology

Benefits apply for eye examinations.

Eyeglasses and contacts

Benefits apply for eyeglasses or contact lenses prescribed as the result of an eye examination to correct defective eyesight.

The benefit applies only if the eyeglasses or contact lenses are prescribed as a result of an eye examination made during the period of insurance. The date that the eyeglasses or contact lenses are ordered shall be considered to be the date that charges are incurred and the eyeglasses or contact lenses are furnished.

Specific exclusions to vision care

Experimental surgery, care, treatment, services or supplies. Experimental means:

- not approved or accepted as essential to the treatment of an injury or sickness by nationally recognised medical organisation or appropriate government agencies
- not recognised by the medical community as potentially safe and efficacious for the case and treatment of the injury or sickness; or
- not approved for reimbursement under national medical programmes.

Emergency medical assistance and evacuation

Insured persons have access to the following services, which are provided by our appointed 24-hour emergency medical assistance company.

Scope of services available

Our 24-hour emergency medical assistance company can provide the following services, subject to the policy terms and conditions, and to the table of benefits:

- pre-travel advice to the insured person with information on visas, consulates, vaccinations and foreign office travel warnings
- a 24-hour dedicated emergency telephone and assistance service, in the event of a medical emergency
- liaison with your attending doctor or hospital administration staff to obtain medical reports on your condition and treatment needs, and ongoing medical monitoring of your condition
- communication with you and/or your close relative to keep you informed at all times
- arrangement of emergency evacuation to the nearest suitable medical facilities, including medical escort, where medically necessary
- arrangement of repatriation to your home country where appropriate, by commercial flight or by air ambulance, and with medical escort, according to the attending doctors recommendations, and subject to medical necessity
- locate and arrange the dispatch of medical supplies, blood or medical equipment to the insured person's location
- guarantee payment of emergency medical expenses to the hospital, doctor, or other service provider
- arrange for and guarantee, additional reasonable travel and accommodation costs for a relative or friend of the insured person who is reasonably required to travel to and/or remain with the sick or injured insured person.
- in the event of death of an insured person, arrangement of repatriation of human remains to their home country, or burial/cremation in their country of residence and return of their ashes to their home country

Important: pre-authorisation is required in all cases of hospitalisation and medical transportation (except for local emergency transportation), and should be obtained in advance. The contact information is on your membership card. In the event of an emergency hospitalisation or medical transportation, where you are medically incapacitated from obtaining pre-authorisation, we must be notified with 48 hours of admission or transportation.

Pre-authorisation

Medical treatment worldwide, outside the USA

No restrictions are imposed regarding the choice of physician, laboratory, hospital, clinic, etc., except that the facilities must be licensed and the treatment performed by legally qualified providers and physicians practising within the scope of their license.

Pre-authorisation is required in all cases of:

- hospitalisation,
- outpatient surgery,
- medical transportation (except for local emergency transportation),
- high costs claims such as MRI (magnetic resonance imaging), CT (computerised tomography) and PET (positron emission tomography).

You must contact us at least two (2) weeks before a scheduled hospitalisation, outpatient surgery, or medical transportation. The contact details for obtaining pre-authorisation are shown on your membership card.

In the event of an emergency hospitalisation, we must be notified within 48 hours of admission.

Medical treatment within the USA (Cover Region 1 only)

Your policy provides access to our Preferred Provider Organisation (PPO) network in the USA. You are advised to utilise healthcare providers within the PPO network, and details of how to locate a network provider are shown on your membership card.

If you use a provider outside of the PPO network, benefit payments will be reduced to the percentage shown in your Table of Benefits.

Pre-authorisation is required for all medical services except for local emergency medical transportation

Dental treatment and orthodontic services worldwide (subject to selection of applicable Dental Plan option)

You must submit the dentist or orthodontists treatment plan and obtain pre-authorisation before any treatment or services (other than Class I - diagnostic and preventive) commence.

Pre-authorisation is subject to a review by us of a dentist or orthodontists planned treatment and expected charges. If there is a material change in the treatment plan, a revised plan must be sent to us.

Failure to obtain pre-authorisation where required

In the event that you do not obtain pre-authorisation in accordance with the above requirements, we reserve the right to reduce benefits payable by 25%.

General exclusions

You are not insured, and will not be paid under any part of this policy for:

1 Services and supplies which we deem to be unnecessary for the diagnosis, care or treatment of the physical or mental condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.

2 Care, treatment, services or supplies that are not prescribed, recommended and approved by the insured person's attending physician or dentist.

3 Expenses covered under workers' compensation or similar law or programmes.

4 Charges for services or supplies ordered or received prior to the date of entry of cover or after the termination date of cover.

5 Health check-ups, inoculations, visits and tests necessary for administrative purposes, for example for determining insurability.

6 Plastic surgery; reconstructive surgery; cosmetic surgery; or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, unless required because of a non-occupational injury that occurs while covered under the policy.

7 Treatment for morbid obesity, weight control, gastric bypass or gastric stapling procedure.

8 Tobacco dependence treatment.

9 Infertility and/or fertility procedures and any resulting pregnancy or childbirth(s).

10 Charges related to in-vitro fertilisation, artificial insemination or similar procedures.

11 Travel and hotel expenses related to medical or dental care.

12 Routine podiatry or other foot treatment not resulting from an illness or injury.

13 Hearing aids.

14 Treatment for or in connection with pregnancy or childbirth during the first 12 months a person is insured unless so indicated under "waiting periods".

15 Radial keratotomy procedures (myopia surgery), lasik, or eye surgery to correct refractive error or deficiencies.

16 Dental care which is not the result of accidental injury of sound, natural teeth sustained while covered under this policy.

17 A dental surgical implant of any type.

18 Care in a nursing home or home for the aged or custodial care. Custodial care means care comprised of, or services and supplies including room and board, and other institutional services, which are provided to an individual, whether disabled or not, primarily to assist in the activities of daily living. Such services are considered custodial care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed.

19 Anything not ordered by a physician or not necessary for medical care, as well as medical and dental services that do not meet professionally recognised standards or are not considered as being necessary for proper treatment.

20 Services or supplies that we deem to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:
- there is insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- if required by the Food and Drug Administration, approval has not been granted for marketing; or
- a recognised national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

General exclusions continued

21 Treatment not recognised by the medical community as potentially safe and efficacious for the care and treatment of the injury or sickness; or

22 Treatment not approved for reimbursement under national medical programmes.

23 Charges which we deem to be unusual or excessive.

24 Expenses covered by a government programme such as social security, whether or not a insured person applies for reimbursement from that programme.

25 Care provided in a government hospital or medical facility for which an individual would not be charged in the absence of this cover.

26 Expenses reimbursed or reimbursable by another insurance contract or programme.

27 Missed appointments.

28 Orthodontic and class III dental expenses incurred during the first six months from the insured person's date of entry if the dental cover option has been selected.

29 All treatments, services or supplies covered by the optional benefit groups identified as dental, or orthodontic cover, unless the insured person has chosen one or more of these covers and the cover is specifically indicated in the dental insurance option endorsement.

30 Any injury or sickness in connection with or caused by war or an act of war whether declared or undeclared, riot, civil commotion, or police action whether participating or not.

31 Donor expenses connected with organ transplant are not covered.

32 Any expense for male or female: reversal of sterilisation; sex change or implantation; or treatment for sexual transformation; sexual dysfunctions or inadequacies.

33 Charges for breast reduction or augmentation and complications arising from these procedures.

34 Personal or comfort items such as radio, television, barber or beauty services or supplies.

35 An injury or illness that is self-inflicted, or an attempt at self-destruction, while sane or insane.

36 Any participation in an assault, felony or illegal act, including but not limited to injuries sustained in fights initiated by you or your dependent.

37 Any treatment for alcoholism or drug addiction.

38 Over-the-counter (OTC) drugs or supplies, which do not require a physician prescription, smoking cessation drugs, appetite suppressant, hair regenerative drugs, anti-photo aging drugs, cosmetics and beauty aids, acne drugs (retin A for cosmetic purposes), megavitamins, vitamin, prenatal vitamins prescribed or not, nutritional supplements

39 Charges made by a member of your family to look after you.

40 Charges relating to hypnosis or biofeedback.

41 Charges for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.

42 Charges for or related to services, treatment, education testing or training related to learning disabilities or development delays including but not limited to attention deficit/hyperactivity disorder (ADD/ADHD).

43 Charges for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) as the result of a disease or injury.

44 Services and supplies related to visual therapy or orthoptics.

45 Orthotics, including all equipment, devices, foot inserts, arch supports, lifts and correct shoes.

46 Diagnostic examinations or laboratory tests performed as a hospital inpatient for inconvenience or observation when these services can be safely performed as an outpatient.

47 Treatment by naturopaths, homeopaths, naturopathic or homeopathic medications or supplements and any other alternative methods of treatment we do not recognise unless specified in the table of benefits.

48 Any condition, illness, injury or emergency air services related to nuclear accident.

49 Allergy testing and treatment.

50 Elective abortions and complications thereof.

51 All services supplies and treatment related to primal therapy, rolfing, psychodrama, megavitamin therapy, carbon dioxide therapy and bioenergetics therapy.

52 All services, supplies and treatment related to cognitive therapy both inpatient and outpatient.

53 Participation in a professional sport (not including recreational or amateur participation) or any hazardous sport or activity such as (but not limited to) the following: motor sports, riding off-road on a motorbike or a quad-bike as a driver or passenger, aerial sports, scuba diving below 30 metres or where a Professional Association of Driving Instructors Certificate is not held, any sport involving animals, speed competition, skiing off-piste and racing of any form (other than on foot). If a hazardous sport or activity is not specified in this list, the insured person must contact us to ascertain if it is acceptable for insurance before cover will apply.

54 Any claim relating to:
- i self-inflected injury (including suicide or attempted suicide); or
- ii self-exposure to peril (except in an attempt to save human life).

General conditions

Eligibility

Individuals who meet all of the following criteria are eligible for cover as an insured person:

- the individual has completed an enrolment form for cover;
- the individual has signed and returned an enrolment form to us;
- the individual resides outside of the United States of America, or any of their territories;
- the individual and/or his or her eligible dependents will not attain 69 years of age during the period of insurance; and
- we accept the individual for cover.

Dependents

You may cover your:

- wife or husband; civil union partner; or a person who has been living with you for a period of at least one year will be deemed to be your dependent spouse if they have been publicly represented as your spouse – such persons shall be deemed to be "your domestic partner" if you have completed and signed a "declaration of dependentship" and the declaration is acceptable to us
- unmarried children who are under 19 years of age.

Any other unmarried child under 23 who goes to school on a regular basis and depends solely on you for support will be covered as a dependent at the child premium rate and child benefits apply.

Your children include:

- your biological children
- your adopted children
- any other child you support whom you are legally responsible for and who lives with you in a parent-child relationship.

Date of entry

Your cover will take effect:

- on your commencement date, if by then, you have signed and returned your enrolment form, have paid the premium and we have given our written consent Additional evidence may be required including a physician's statement and/or results of a medical examination. You will provide any additional information at your cost and is to be provided by a physician you select and we approve.

If you don't sign and return your enrolment form by your commencement date, cover will not take effect until this has been done and we give our written consent.

Dependents

Cover for those who are dependents as of the date and premium has been received by us, your cover takes effect and will become effective on that date, if, by then we have received notification of your written request for cover of such dependents and an enrolment form has been completed for the dependents, and have given our written consent and premium has been received by us. The evidence required may include a physician's statement and/or results of a medical examination performed by a physician approved by us. The evidence of insurability will be at no cost to us. Otherwise, cover for such a dependent will not go into effect until you submit evidence of insurability for the dependent which we agree is satisfactory and premium has been paid. The date of entry will be a date specified by us in writing.

If you require cover for a new dependent:

- who is your biological newborn child, cover of that dependent takes effect at birth subject to notification of birth within 30 days, otherwise, the addition will take effect from the date of notification; or
- other than who is your biological newborn child, cover for the dependent will not go into effect until you submit satisfactory evidence of insurability for the dependent. The date of entry will be a date specified in writing, by us. The evidence required may include a physician's statement and/or results of a medical examination and will be at your cost.

Any dependent aged 60 or over must supply the results of a medical exam in addition to the completion of an enrolment form. The exam will be done at the dependent's expense and performed by a physician approved by us.

Cover will only become effective if the enrolment form and medical exam results are to our satisfaction.

Each dependent must meet the eligibility requirement of this policy and all our underwriting requirements.

Residency

The insured person must reside outside the United States of America. Permanent residence in the United States of America shall be ground for termination of this policy. For purposes of this policy, we may determine that an insured person reside(s) in the United States of America in any case in which the insured person is in the United States of America for:

1 one hundred and eighty (180) or more consecutive days; or
2 more than one hundred and eighty (180) total days in any twelve (12) consecutive month period.

A full time student attending school in the United States of America may remain covered upon proof of matriculation, subject to all other eligibility requirements of this policy.

Such proof of matriculation shall be provided at time of application for cover, at each renewal during which the full-time attendance continues, or upon our request.

Cooling off period

If you cancel within the first 14 days after receiving the policy documents within the first year of insurance, we will refund your full premium, providing no claims have been made on your policy.

We reserve the right to deduct an administrative charge of US$ 30 for the costs of production and despatch of documentation.

Termination of cover

Cover under this policy terminates at the first to occur of:

- the date on which you are no longer eligible to be an insured person
- when you fail to make any required payment due to us
- the date you become a resident of the United States of America
- upon completion of any 180 day period living in the United States of America
- the end of the period of insurance in the year in which you attain the age of 69.

In any case, the cover ceases on the termination date of this policy:

– at the request of the insured person with a two-months notice before the renewal date
– or upon the next termination date of this policy after the date upon which the Master contract between Integra Global Health Deutschland GmbH and the Insurer is terminated.

Dependents coverage only

Coverage for an insured person's spouse will terminate at the first to occur of:

- the date this policy terminates
- the end of the period of insurance in which such spouse is legally separated or divorced from the insured person.

Coverage for all other dependents will terminate at the first to occur of:

- the date this policy terminates
- the end of the period of insurance in which the covered dependent marries
- the end of the period of insurance in which the covered dependent ceases to be a defined dependent.

A "Dependent" will no longer be considered to be a defined dependent on the earlier to occur of:

- the date this plan no longer allows cover for Dependent
- the date of termination of the domestic partnership. In that event, you should provide the policyholder with a completed and signed declaration of termination of domestic partnership.

Continuation of cover for a disabled dependent child

Covered medical expense benefits for your fully disabled child may be continued past the maximum age for a dependent child, if the child continues to be fully disabled.

Your child is fully disabled if:

- he or she is not able to earn his or her own living because of mental or a physical disablement which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

You must submit to us, proof that your child is fully disabled within 120 days after the date your child reaches the maximum age.

Cover will cease on the first to occur of:

- cessation of the disablement

General conditions continued

- failure to give proof that the disablement continues
- failure to have any required exam
- termination of dependent coverage as to your child for any reasons other than reaching the maximum age.

We will have the right to require proof of the continuation of the disablement. We also have the right to examine your child as often as needed while the disablement continues at its own expense. An exam will not be required more often than once each year after two years from the date your child reached the maximum age.

Premium payments

Your first premium payment for this policy is due on the commencement date shown on the certificate of insurance.

The premiums are set regarding the area of coverage and the selected plan. They are paid by the Insured person according to the selected frequency of payment.

Should the Insured person fail to pay all premiums within the month following their due date, the cover is suspended 30 days after the Insured has been served with formal notice. If, beyond that period, the Insured has not made the requested payment, the policy may be terminated without any further formality 10 days after expiry of the 30 day period.

Revision

Premiums are automatically indexed and effective on the policy anniversary date, according to the technical results and the medical costs trend. The premiums may also be revised according to the changes in the laws and regulations in force on the effective date of the policy or at the earliest, from the effective date of the new provisions.

Renewal

Your cover is renewed by tacit agreement on each anniversary date for a period of one year, unless cancelled by you by means of a registered letter sent to Integra Global Health Deutschland GmbH at the latest two months before the anniversary date, which is the effective date of termination.

If this policy is not renewed, it will terminate at the end of the period of insurance for which a premium has last been paid.

If you request that:

- insurance be cancelled for one or more of the insured persons; or
- that the policy be cancelled in its entirety, such insurance will cease only at the end of the period of insurance and there will be no pro rata refund of the premium. Any unpaid premium for the policy shall remain due and owing.

Physical examinations

We will have the right and opportunity to have a physician of our choice examine any person for whom certification or benefits have been requested.

This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Entire contract – changes

We must approve any change in this policy, such approval must be confirmed by a policy endorsement.

Legal Action

No legal action can be brought to recover under any benefit on this policy sooner than 60 days after the required proof of claim has been furnished. No legal action can be brought to recover under any benefit after two years from the deadline for filing claims.

Fraud/non-disclosure/mis-representation

We may terminate cover by giving written notice to the insured person for misrepresentation on the enrolment form or for fraud in obtaining cover.

Termination is effective as of the commencement date under this policy and the policy becomes void from the date of commencement. We will refund all premiums paid on behalf of the insured person less benefit payments paid to or on behalf of the insured person and his dependents. If the value of the benefits paid exceeds the amount of premium paid, the insured person will pay us an amount equal to such excess.

Recovery of benefits paid

As a condition to payment of benefits under this policy for expenses incurred by an insured person due to injury or illness for which a third party may be liable:

- we shall, to the extent of benefits it has paid, be subrogated to (have the right to pursue) all rights of recovery of insured persons against:
  - such third party; or
  - a person's insurance carrier in the event of a claim under the uninsured or underinsured auto cover provision of an auto insurance policy
- we may recover from the insured person amounts received by judgment, settlement, or otherwise from:
  - such third party or his or her insurance carrier; or
  - any other person or entity, which includes the auto insurance carrier which provides the insured person's uninsured or underinsured auto insurance cover
- the insured person (or person authorised by law to represent the insured person if he or she is not legally capable) shall (at their own expense); execute and deliver any documents that are required; and do whatever else is necessary to secure such rights.

Assignment

Cover may be assigned only with our written consent.

Recovery of overpayment

If a benefit payment is made by us, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the policy, we have the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery we may have with respect to such overpayment.

Claims

Proof of claim

- bills identifying patient, date of treatment, cost and describing in detail the medical services performed or the medical products purchased
- doctor's prescription for prescription drugs, laboratory tests, physical therapy and eyeglasses and contact lenses
- the original reimbursement statements from social security, government programmes, or other insurance plans.

The insured person must also answer any questions concerning the illness or accident and, in particular, provide a complete description of the illness or accident and indicate, when requested, the date when it was first identified or treated by a medical practitioner, etc.

Notice of claim and time limitation

A claim must be submitted to us in writing. It must give proof of the nature and extent of the loss. Please contact our claims administrators for a claim form.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 180 days after the date of the loss causing the claim.

No action for the recovery of any claim for benefits shall be sustainable unless commenced within 180 days of the event that is at the origin of the claim. After expiration of this term, the insured person, has no rights or obligations. After termination of this policy, claims for expenses incurred while the policy was in force shall be considered if they reach us within 90 days of such termination.

General conditions continued

Payment of benefits

All benefits are payable to you. However, we may pay any health benefits to the service provider. This will be done unless you have told us otherwise, by the time you file the claim.

Age limit

If we accept a premium for an insured person after the date such person would cease to be insured due to age, that person's cover will terminate and premium will be refunded less any claims paid out.

If an insured person's age is misstated and if, according to the true age, the cover provided by this policy for that person would not have been effective or would have ceased before acceptance of premium, our liability will be limited to the refund, on request, of all premiums paid for the period not covered by the policy.

Currency

Premium payments will be made to us in the respective policy's denominated currency: USD; EUR; GBP. Or in any other major currency as agreed with us. All references in this policy to dollars and cents mean dollar and cents of lawful United States of America money. Euros and cents means the lawful currency of the European Monetary Union and Pounds and pence means the lawful currency of the United Kingdom of Great Britain.

Record of expenses

Keep complete records of the expense of each person. They will be required when a claim is made. Very important are:

- names of physicians, and others who furnish services
- dates of expenses are incurred
- copies of all bills and receipts.

Medical services

We are not responsible for the availability, quantity, quality or results of any medical treatment received by an insured person or for the failure of an insured person to obtain medical services.

Applicable law

This policy is governed by French law.

Meaning of words

Certain words and phrases used in this policy are defined below. Other words and phrases may be defined where they are used:

Accident: a sudden, unexpected and unforeseen bodily injury caused by violent, visible and external means.

Air ambulance means a vehicle medically equipped to transport ill insured persons that:

- is licensed by local, county or state regulations, and/or
- has attendants who are fully trained in emergency care, such as emergency medical technician (EMT) or paramedics.

Ambulatory surgical centre means a facility which: a) has as its primary purpose to provide elective surgical care; and b) admits and discharges a patient within the same working day; and c) is not part of a hospital. "Ambulatory surgical centre" does not include: 1. any facility whose primary purpose is the termination of pregnancy; 2. an office maintained by a physician for the practice of medicine; or 3. an office maintained by a dentist for the practice of dentistry.

Birth centre means a facility which: a) is mainly a place for the delivery of a child or children at the end of a normal pregnancy; b) and meets one or both of the following tests: 1. it is licensed as a birth centre under the laws of the jurisdiction where it is located; and/or 2. it meets all the following requirements: (i) it is operated in accordance with the laws of the jurisdiction where it is located; (ii) it is equipped to perform all necessary routine diagnostic and laboratory tests; (iii) it has trained staff and equipment required to properly treat potential emergencies of the mother and of the child; (iv) it is operated under the full-time supervision of the physician or a registered nurse (R.N.); (v) it has at all times a written agreement with at least one hospital in the area for immediate acceptance of a patient in the event of a complication; (vi) it maintains medical records for each patient; (vi) and it is expected to discharge or transfer each patient within 24 hours after the delivery.

Authorisation, certify and certified means that we, following advance notification of a scheduled confinement in a hospital, have acknowledged the scheduled confinement, provided the insured person with the names and addresses of hospitals that are members of the participating provider organisation, to which the insured person may have access as a insured person under the policy, and confirmed that such confinement is medically necessary.

These terms also mean that we have received notification:

a. within 48 hours of an emergency hospital confinement;
b. 48 hours before outpatient skilled nursing care; or
c. within 48 hours of an insured person being identified as a candidate for a heart, heart and lung, single lung, pancreas and kidney, or liver transplant; in advance of any hospital stay, skilled nursing care, surgery or medical care; it means we have acknowledged such notifications, and reviewed the confinement, the outpatient skilled nursing care, and/or the proposed transplant services and procedures for medical necessity, and, when applicable, provided the insured person with the names and addresses of hospitals which are members of the participating provider network.

Close relative means mother, mother-in-law, father, father-in-law, stepmother, stepfather, daughter, daughter-in-law, son, son-in-law, (including legally adopted daughter or son), stepchild, sister, sister-in-law, brother, brother-in- law, of an insured person.

Commencement date means the date your cover becomes effective under this policy.

Complications of pregnancy means:

a. birth by non-elective, medically necessary caesarean section
b. when pregnancy is not terminated, conditions that require hospital confinement, whose diagnoses are distinct from pregnancy but are adversely affected by or are caused by pregnancy, such as:
   – acute nephritis;
   – nephrosis;
   – cardiac decompensation;
   – missed abortion; and

Meaning of words continued

c. when pregnancy is terminated by:
   – non-elective caesarean section;
   – ectopic pregnancy that is terminated; or
   – spontaneous termination of pregnancy that occurs
   – during a period of gestation in which a viable birth is not possible.

Complications of pregnancy will not include false labour; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum; and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct complication of pregnancy.

Confinement means admission to a facility as a registered inpatient. Two or more confinements will be deemed one period of confinement unless the discharge from the readmission to the facility is separated by at least 60 days

Country of residence means the country in which you are resident and working for at least nine months of any 12 month period.

Covered medical expenses means the usual, reasonable and customary charges incurred by a insured person, while covered under this policy, for medically necessary services, treatments or supplies described under the provisions titled covered medical expenses and, if applicable, covered dental expenses.

Custodial care means treatment or services which could be rendered safely and reasonably by a person not medically skilled, regardless of who recommends them and where they are provided, and which are designed mainly to help the patient with daily living activities. Such activities include but are not limited to: a) help in walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing; b) preparing meals or special diets; c) moving the patient; d) acting as a companion or sitter; and e) supervising medication which can usually be self-administered.

Custodial care: includes: 1. the provision of accommodation, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending physician, has reached the maximum level of recovery; and 2. in the case of an institutionalised person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and 3. rest cures, respite care and home care provided by family members. Upon receipt and review of a claim, we or an independent medical review will determine if a service or treatment is custodial care.

Date of entry means either the commencement date or the date from which an insured person's cover become effective.

Deductible means the amount of covered expenses which an insured person is responsible to pay before benefits are payable under this policy. Such amount will not be reimbursed under the policy. After the deductible amount has been paid by the insured person, benefits for covered medical expenses will be payable under this policy at the percentage rates shown on the table of benefits.

Domestic partner means a person who has been living with you for a period of at least one year. This person will be deemed to be your dependent spouse if they have been publicly represented as your spouse.

Durable medical equipment means requirement that is: a) medically necessary; b) made for and mainly used in the treatment of an injury or an illness; c) not useful in the absence of an illness or injury; d) made to withstand repeated use over an extended period of time; e) suited for use in the home; and f) used to improve a permanent medical condition. Durable medical equipment does not include: insulin pumps; glaucometers; motor driven wheelchairs or beds; comfort items such as telephone arms and over-bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies such as exercycles, more wheels, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment; and similar items.

Emergency treatment means a Hospitalisation required as the result of a serious injury or the onset of a life-threatening condition that requires immediate medical or surgical care to prevent loss of life or permanent damage to the organs or systems of the body. Examples of such injuries or conditions include, but are not limited to: heart

attack, stroke, poisoning, loss of breath, severe bleeding, loss of consciousness, convulsions and severe trauma.

Enrolment for life cover means, for the purpose of evaluating enrolments, such satisfactory evidence that an individual is in good health, as we require.

Evidence of insurability means a statement of health provided by a physician.

Experimental or investigative means that a medical, dental or surgical procedure, treatment, course of treatment, equipment or drug or medicine is: a) under investigation or is limited to research; b) restricted to use in disciplined clinical efforts and scientific studies; c) not proven in an objective way to have therapeutic value or benefit; d) medically questionable with respect to effectiveness; and e) not generally accepted by the medical community. We may be contacted to determine if a particular procedure, treatment, device, drug or drug therapy is considered to be experimental or investigative.

Extended care facility means an institution that meets all of the following requirements: a) it must be operated pursuant to law; b) for US facilities, it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested; c) it must be primarily engaged in providing, in addition to room and board accommodations, skilled nursing services under a licensed physician's supervision; d) registered or licensed practical nurses must supervise 24-hours-a-day; and e) a daily record for each patient must be maintained. Extended care facility does not include any institution that is primarily a clinic; a rest home; a home for the aged; a place for alcoholics or drug addicts; a place for custodial care; or a facility for mental illness.

Home healthcare agency means an agency or organisation, or subdivision thereof, which: a) is primarily engaged in providing skilled nursing care and other therapeutic services in the insured person's home; b) is duly licensed, if required, by the appropriate licensing facility; c) has policies established by a professional group associated with the agency or organisation, including at least one physician and one registered graduate nurse (R.N.) to govern the services provided; d) provides for full-time supervision of such services by a physician or by a registered nurse (R.N.); e) maintains a complete medical record on each patient; and f) has a full-time administrator.

Home healthcare plan means a programme: a) for the care and treatment of the insured person in his home; b) established and approved in writing by his attending physician; and c) certified, by the attending physician, as required for the proper treatment of the injury or illness, in place of inpatient treatment in a hospital or in an extended care facility.

Hospice care means an agency which provides a coordinated plan of home and inpatient care to a terminally ill person and which meets all of the following tests:

a) has obtained any required state or governmental license or certificate of need; b) provides service 24-hours-a-day, 7 days a week; c) is under the direct supervision of a physician; d. has a nurse coordinator who is a registered nurse (R.N.); e) has a duly licensed social service coordinator; f) has as its primary purpose the provision of hospice services; g) has a full-time administrator; and h) maintains written records of services provided to the patient.

Hospital means an institution which is licensed as a hospital under the laws of the jurisdiction where it is located, and: a) is primarily engaged in providing, for payment and on its own premises, inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities; b) is under the direction of a staff of physicians; c) provides 24-hour nursing service rendered or supervised by a registered graduate nurse; has facilities on its premises for major surgery (or a written contractual agreement with an accredited hospital for the performance of surgery); and for US facilities, is accredited by the joint commission on accreditation of healthcare facilities.

"Hospital" does not include a facility, or part thereof, which is principally used as: a rest or custodial care facility; nursing facility; convalescent facility; extended care facility; or facility for the aged or for the care and treatment of drug addicts or alcoholics, unless specifically provided in this policy and/or as mandated by local law. It does not mean any institution in which the insured person receives treatment for which he is not required to pay.

Meaning of words continued

Illness means: a bodily disorder or infirmity; complications of pregnancy; and pregnancy.

Injury means a bodily injury that is: 1) sustained by a insured person while insured under this policy; and 2) caused by an accident directly and independently of all other causes. An insured person must begin receiving services, supplies or treatment within 72 hours from the time of accident in order for it to be considered an injury. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury.

Insured event means an accident or the sudden and unexpected onset of serious illness, or the sudden and unexpected death or imminent demise of a close relative, during the period of insurance within the permanent place of residence of the close relative.

Insured person means an eligible individual and his or her dependents entitled to benefit under this policy, each of whom is named or described on a completed enrolment form or subsequent notification and for whom the appropriate premium has been paid to us, and whom we have accepted for cover.

L.P.N. means a licensed practical nurse.

L.V.N. means a licensed vocational nurse.

Medical emergency means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected to result: a) in placing the patient's body in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Medically necessary means that a treatment, service, supply, drug or hospital or extended care facility confinement (or part of a confinement): a) is appropriate and essential to diagnose or treat the patient's illness or injury; b) does not exceed, in scope, duration, or intensity, the level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment; c) is prescribed by a physician; d) is consistent with widely accepted professional standards of medical practice in the jurisdiction where treatment is rendered; e) is not primarily for the personal comfort or convenience of the patient, the family, physician, or other provider of care; f) is not a part of or associated with the scholastic education or vocational training of the patient; g) is not experimental or investigative; and h) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a physician has prescribed, recommended, approved or provided a treatment, service, supply, or confinement does not, in itself, make it medically necessary. We may examine all conditions listed above in reviewing a claim for treatment, service, supply, drug or hospital or extended care facility confinement or part thereof.

Medicare means Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or subsequently amended.

Medical coordinator or **our medical coordinator** means an organisation with a staff who performs the certification processes in conjunction with consultant physician(s) qualified or specialising in the treatment of the condition (including mental illness, alcohol or drug abuse), and arrange or approve certain medical transportation.

Nurse midwife means a person: a) certified to practice as a nurse midwife; b) and licensed by a board of nurses as a registered nurse (R.N.); and c) who has completed a programme for the preparation of nurse midwives, approved by the jurisdiction in which the person is practicing.

Out of pocket means expenses that the insured person pays towards costs.

Period of insurance means the period which is shown on your certificate of insurance.

Physician/practitioner means, with respect to any medical care and service, a person: a) certified or licensed, under the laws of the jurisdiction where treatment is rendered, as qualified to perform the particular medical or surgical service for which a claim for cover under this policy is made and who is practicing within the scope of such certification or licenser; and b) any other healthcare provider if, and as, mandated by a state's or other jurisdiction's law. This term does not include: 1) an intern; or 2) a person in training.

Policy means this document, including the policyholder's enrolment, and any subsequent amendment or policy endorsement, which we issue for attachment to the policy.

Policy limit means the limit of applicable benefit shown in the table of benefits.

Policyholder: the primary insured person who has subscribed to this policy, who is responsible for paying the premium and ensuring that the policy terms and conditions are adhered to.

Preferred provider/organisation (PPO) means the hospitals, physicians, or other providers who have entered into a contractual agreement with us to provide hospital and medical services to insured persons at negotiated fees.

Reconstructive surgery means surgery which does not itself restore the function of an abnormal body structure and which is incidental to, or the result of, a previous surgery necessary due to illness, injury, or congenital defect.

R.N. means a registered nurse.

Scheduled hospitalisation or **scheduled confinement** means a hospital confinement, which has been planned in advance by an insured person's physician for a fixed future time.

Serious illness means any sudden and detrimental alteration in health as duly diagnosed by a physician, which necessitates the close relative being admitted to a hospital bed on the advice of a physician for a minimum of three consecutive nights.

Skilled nursing care means services provided by, and which require the special skills of, a registered nurse (R.N.), Licensed practical nurse (L.P.N.), Or licensed vocational nurse (L.V.N.).

Usual, reasonable and customary charge/allowable charge means the lower of: a) the provider's usual charge for furnishing the treatment, service or supply; or b) the charge which we determine to be the general rate charged by others who render or furnish such treatments, services or supplies to persons: 1) who reside in the same area; and 2) whose injury or illness is comparable in nature and severity. (We will determine the usual, reasonable and customary charge for a treatment, service or supply that is unusual, or not often provided in the area, or that is provided by only a small number of providers in the area. We will consider such factors as: 1) complexity; 2) degree of skill needed; 3) type of specialist required; 4) range of services or supplies provided by a facility; and 5) the prevailing charge in other areas. The term "area" means a city, a county or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment.)

We, us, our means MGEN.

You, **your** means an insured person.

Complaints procedure

We trust you will be satisfied with your policy, but in the event that you do have any cause for complaint, the most important thing for us is to help resolve your concerns as quickly as possible. Upon receipt of your complaint, we will do all we can to resolve your complaint by the end of the next business day. However, if we can't do this, we will contact you within five working days to acknowledge your complaint and explain the next steps. Letting us know when you are unhappy with our service gives us the opportunity to put things right for you and improve our service for everybody.

You can call our claims administrators on:
+(33) 184 780 368

email to:
integra@medical-administrators.com

or write to:
Medical Administrators International, 37, rue Anatole France, 92532 Levallois Perret, France.

If the Insured persons are not satisfied by MAI's response, they can send a standard letter or email to:
MGEN International Benefits, 7 Square Max Hymans, 75748 Paris Cedex 15, France or **clients@vyv-ib.com.**

In the event of disagreement with a decision by the Insurer and having exhausted all means of appeal offered by the Insurer, the Insured person may contact the MGEN ombudsman at **MGEN – Monsieur le Médiateur - 3, Square Max Hymans - 75748 Paris Cedex 1** or email **mediation@mgen.fr**.

The Ombudsman's opinion is not binding on the parties in dispute and they retain the right to bring proceedings before the competent court. The Ombudsman is not authorised to give an opinion on insurance admissibility conditions. The terms and conditions of the Ombudsman's intervention can be consulted on the website www.mgen.fr (mediation section) or obtained on request from the postal address above.

To help us resolve your complaint, please supply the following information:

- your name and membership details
- a contact telephone number
- a description of your complaint
- any relevant information relating to your complaint that we may not have already seen.

Data protection notice

We collect and maintain personal information in order to underwrite and administer the policies of insurance that we issue. All personal information is treated with the utmost confidentiality and with appropriate levels of security. We will not keep your information longer than is necessary. Your information will be protected from accidental or unauthorised disclosure. We will only reveal your information if it is allowed by law, authorised by you, to prevent fraud or in order that we can liaise with our agents in the administration of this policy.

Where personal information is collected about individuals in connection with the arranging of insurance, this information will be collected and processed in accordance with our Privacy Policy which can be viewed on our website: www.integraglobal.com/ig/privacy-policy. Alternatively, you can contact us for a copy.

You have the right to ask for a copy of any information we hold on you and to require a correction of any incorrect information held. Any inaccurate or misleading data will be corrected as soon as possible. The above principles apply whether we hold your information on paper or in electronic form.

Enquiries in relation to data held by MGEN should be directed to Data Protection, MGEN, Centre de gestion de la Verrière, Gestion CNIL, Cs 10601 La Verrière 6 bis avenue Joseph Rollo, 78321 Le Mesnil Saint Denis Cedex, France, enclosing a photocopy of both sides of a valid identity card.

Life Cover lump sum in case of death

A lump sum is paid in case of death (all causes) of an adult Insured Person depending on the plan chosen and as listed in your Table of Benefits.

Unless you have designated a particularly beneficiary, the benefit in the case of the Insured's death is attributed by order of preference:

- to the spouse not legally separated from the Insured,
- failing him/her, to the civil union partner
- in the absence of the latter, to the Insured's children born or to be born equally shared between them, the share of the predeceased going to his own children or to his brothers and sisters if he has no children
- in the absence of the latter, to the mother and father, equally shared between them, or to the surviving parent in the case of predecease
- in the absence of the latter, to the heirs.

The Insured can modify the above order at any time and designate any natural or legal person of his choice by sending a registered letter to the Insurer with request for acknowledgement of receipt.

When the beneficiary is specifically named, the Insured must indicate the contact details of the beneficiary so that the Insurer can use them in the event of death. Where the personal designation lapses, the above standard designation shall apply.

The designation of a beneficiary becomes irrevocable by the acceptance of the beneficiary. Acceptance by authentic deed or private deed signed by the Insured and the beneficiary must be notified to the Insurer in order to take effect.

In the case of death of an Insured and one or more designated beneficiaries during the same event without it being possible to determine the order of death, or when the beneficiary who died before the Insured, did not have time to accept the benefit of the payment, the Insured is assumed to have survived when determining the beneficiaries of the payment.

Sums due under this benefit, which are not the subject of a request for payment, are deposited to the 'Caisse des Dépôts' after a period of 10 years from the date on which the Insurer becomes aware of the Insured's death. Six months prior to the transfer of the sums due to 'Caisse des Dépôts', the Insurer shall inform the beneficiary(s) of the transfer. For 20 years from the transfer of the sums due to the 'Caisse des Dépôts', the beneficiaries can approach the latter to claim their sums. The lump sum paid to natural persons is revalued "post-mortem" in accordance to a rate in accordance with French Decree.

Specific exclusions

The coverage excludes in any case:

- the consequences of a civil or non-civil war, an insurrection, a riot, an attack, a commotion or acts of terrorism, whatever the place of these events and their protagonists, except if the insured person does not take an active part in such event
- the consequences of an illness or accident intentionally provoked by the covered person, intentional self-injuries or suicide attempt, the participation in any sport as a professional.

Accidental death and disablement (AD&D)

Specific accidental death and disablement definitions

The following additional definitions apply to this section:
Annual salary means the total remuneration from your primary employer as declared. It excludes bonuses, overtime, commissions and any other financial incentives or benefits.

Bodily injury means physical injury resulting from an accident to your body resulting in your death, loss of sight or loss of limb being incurred.

Loss of hand/hands/arm/arms means loss by physical separation of a hand at or above the wrist and includes total and irrecoverable loss of use of the hand or arm.

Loss of limb means loss by physical separation of a hand at or above the wrist or of a foot at or above the ankle and includes total and irrecoverable loss of use of hand, arm, foot or leg.

Loss of foot/feet/leg/legs means loss by physical separation of a foot at or above the ankle and includes total and irrecoverable loss of use of the foot or leg.

Loss of sight of one eye means total and permanent loss of sight in one eye.

Loss of sight of both eyes eyes means total and permanent loss of sight in both eyes.

Accidental death and disablement cover

If during the period of insurance an insured person sustains bodily injury resulting from an accident we will pay to the insured person the benefit specified in the certificate of insurance attached to and forming part of this policy subject to:

1 payment of the premium specified; and
2 the terms, conditions and exclusions of this policy.

Specific accidental death and disablement exclusions

The following additional exclusions apply to this section:

1 From the insured person('s):
   a. engaging in:
      i. riding or driving in any kind of race,
      ii. horse riding,
      iii. riding on a motorcycle as a driver or passenger,
      iv. rock climbing or mountaineering of any type,
      v. hang-gliding, paragliding, parachuting or bungee jumping,
      vi. snow skiing or snowboarding whilst away from prepared and marked runs and/or against the advice of the local ski school or local authoritative body;
      vii. sub aqua pursuits involving underwater breathing apparatus unless PADI/NAUI certified, accompanied by a certified instructor, and at depths of less than 10 meters; or
      viii. aviation except when traveling by air as a fare paying passenger;
   b. bodily injury resulting from any occupation not declared to and accepted by us.
   c. being a member of the police or armed forces of any nation or international authority or a member of any reserve forces;
   d. being under the influence of alcohol or drugs, otherwise than under the direction of a registered medical practitioner provided that such direction is not for treatment for drug addiction or dependence;

2 Sickness or disease not directly resulting from bodily injury;

3 From or is traceable to or is caused by any gradually developing deterioration whatever the cause of that deterioration;

4 Work related accidents other than from normal crew activities;

5 War, hostilities (whether war be declared or not), terrorist activity, revolution, military or usurped power, civil commotion or any similar event;

6 Radiation or contamination or the effects of radiation;

7 After the expiry of the period of insurance during which the insured person attains the age of 65 years; or

8 From any injury arising more than 12 months after the accident giving rise to bodily injury.

Specific accidental death and disablement conditions

1 The insured must declare to us all facts which are likely to affect this cover. Failure to do so may prejudice a claim. If there is doubt whether or not a fact is material it should be declared to us.

2 Any benefit payable under this policy will be payable to the insured unless otherwise specified in writing and agreed by us.

3 The insured person must take all reasonable steps to avoid or minimise any claim and must avoid needless self-exposure to peril unless attempting to save human life.

4 The maximum sum payable under this policy in respect of any one accident to any one insured person shall not exceed the largest of any one benefit specified in the schedule applicable to that insured person.

5 The maximum benefit payable in respect of any one Accident resulting in bodily injury to more than one insured person shall not exceed the aggregate limit specified in the table of benefits and in any case shall not exceed two times annual salary.

6 Written notice must be given to us as soon as practicable in the event of any change in an insured person's occupation or country of residence involving increased personal hazard. Bodily injury arising from such changed occupation will not be covered hereunder until our agreement has been obtained and any additional premium that may be required has been paid. We reserve the right to withhold such agreement.

7 Cover shall not apply where the period of insurance is less than two complete months.

8 In the event of a claim under this section notice must be sent to us as soon as practicable. The insured person will permit our own appointed medical adviser or advisers to examine them as often as may be deemed necessary.

Life Cover lump sum in case of death

A lump sum is paid in case of death (all causes) of an adult Insured Person depending on the plan chosen and as listed in your Table of Benefits.

Unless you have designated a particularly beneficiary, the benefit in the case of the Insured's death is attributed by order of preference:

- to the spouse not legally separated from the Insured,
- failing him/her, to the civil union partner
- in the absence of the latter, to the Insured's children born or to be born equally shared between them, the share of the predeceased going to his own children or to his brothers and sisters if he has no children
- in the absence of the latter, to the mother and father, equally shared between them, or to the surviving parent in the case of predecease
- in the absence of the latter, to the heirs.

The Insured can modify the above order at any time and designate any natural or legal person of his choice by sending a registered letter to the Insurer with request for acknowledgement of receipt.

When the beneficiary is specifically named, the Insured must indicate the contact details of the beneficiary so that the Insurer can use them in the event of death. Where the personal designation lapses, the above standard designation shall apply.

The designation of a beneficiary becomes irrevocable by the acceptance of the beneficiary. Acceptance by authentic deed or private deed signed by the Insured and the beneficiary must be notified to the Insurer in order to take effect.

In the case of death of an Insured and one or more designated beneficiaries during the same event without it being possible to determine the order of death, or when the beneficiary who died before the Insured, did not have time to accept the benefit of the payment, the Insured is assumed to have survived when determining the beneficiaries of the payment.

Sums due under this benefit, which are not the subject of a request for payment, are deposited to the 'Caisse des Dépôts' after a period of 10 years from the date on which the Insurer becomes aware of the Insured's death. Six months prior to the transfer of the sums due to 'Caisse des Dépôts', the Insurer shall inform the beneficiary(s) of the transfer. For 20 years from the transfer of the sums due to the 'Caisse des Dépôts', the beneficiaries can approach the latter to claim their sums. The lump sum paid to natural persons is revalued "post-mortem" in accordance to a rate in accordance with French Decree.

Specific exclusions

The coverage excludes in any case:

- the consequences of a civil or non-civil war, an insurrection, a riot, an attack, a commotion or acts of terrorism, whatever the place of these events and their protagonists, except if the insured person does not take an active part in such event
- the consequences of an illness or accident intentionally provoked by the covered person, intentional self-injuries or suicide attempt, the participation in any sport as a professional.

Dental insurance option endorsement

Dental insurance: description of benefits

The expenses described in the three dental classes following are reimbursed at the indicated percentage subject to the annual deductible and annual maximum as listed in your per Table of Benefits

Class I dental services are not subject to the deductible. Class III services are not covered during the first six (6) months of insurance cover.

Class I dental services

Benefits are paid at 100% of usual, reasonable and customary cost with no deductible for necessary diagnostic examinations and preventive treatment subject to the annual maximum.

Covered expenses include:

1 oral exams but not more than twice in any one period of insurance
2 X-rays
a. full mouth X-rays but not more than once every five years
b. bitewing X-rays but not more than once in a calendar year
3 preventative treatment
a. cleaning and scaling of teeth (oral prophylaxis) but not more than twice in any one period of insurance
b. topical fluoride treatment for a covered child under 19 years of age but no more than once in any one period of insurance
4 space maintenance for a covered child under 19 years of age.

Class II dental services

Benefits are paid as per table of benefits of usual, reasonable and customary cost after the deductible for basic restoration, endodontic, peridontal treatments and oral surgery subject to the annual maximum.

Covered expenses include:

1 fillings – amalgam, silicate, acrylic, synthetic porcelain or composite fillings
2 extractions
3 root canal treatment
4 treatment of periodontal disease and other diseases of the gums and tissues of the mouth
5 oral surgery except procedures covered under any medical plan.
6 administration of general anesthesia, when medically necessary in connection with oral surgery
7 emergency palliative treatment
8 injections of antibiotic drugs

Class III dental services

Benefits are paid as per table of benefits of usual, reasonable and customary cost after the deductible for necessary crowns, bridges and dentures subject to the annual maximum.

Covered expenses include necessary supplies and services of a physician for installation or replacement of:

1 those services needed to replace one or more natural teeth that are lost while dental expense benefits for the insured person are in effect for:
   a. installation of fixed bridgework done for the first time
   b. installation for the first time of:
      i. a partial removable denture; or
      ii. a full removable denture
   c. replacing an existing removable denture or fixed bridgework if:
      i. it is needed because of loss of one or more natural teeth after the existing denture or bridgework was installed; or
      ii. it is needed because the existing denture or bridgework can no longer be used and was installed at least five years prior to its replacement
   d. replacing an existing immediate temporary full denture by a new permanent full denture when:
      i. the existing denture cannot be made permanent; and
      ii. the permanent denture is installed within 12 months after the existing denture was installed
   e. adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed
2 inlays and onlays
3 crowns and their replacements, but not more than one replacement per crown every five years
4 repair or re-cementing of:
   a. crowns; or
   b. inlays or onlays; or
   c. dentures; or
   d. bridgework.

Medical concierge services

Complimentary access to the following exclusive services is available as a benefit to premier health plan members.

Diagnosis verification and treatment programme – remote second opinion

A dedicated diagnosis verification and treatment planning care management programme. In the event that you are diagnosed with a specified critical illness, the programme provides access to an appropriate specialist from a top rated hospital who will remotely review your medical reports to confirm your diagnosis and advise, in conjunction with your treating physician on your treatment options, to provide the best outcome.

Covered conditions: a remote second opinion will be available for:

- narrowed or blocked coronary arteries and valvular abnormalities
- interventional cardiology procedures (coronary angioplasty) to correct narrowing of two or more coronary arteries by means of dilating or opening the vessels
- major vascular procedures to repair one or more of the aorta, carotid, iliac, femoral and cerebral arteries
- cancer treatment for all forms of cancer except non-invasive skin cancer and cancer in the presence of human immuno-deficiency virus (HIV)
- intracranial neurosurgical procedures performed to remove a tumour or to repair an intracranial blood vessel (conditions related to trauma or injury are excluded)
- major organ transplants, from a living donor, of the lung, liver, kidney, pancreas or bone marrow.

Conditions/diagnoses/situations which are excluded:

- cosmetic reconstruction/plastic surgery
- first diagnosis, which is, the initiation of physical assessment and diagnostic testing to determine an initial diagnosis; and

Traditional medicine and therapy is the focus of the opinion; not holistic, homeopathic, and/or alternative medicine.

Initiating a remote second opinion

1 the insured person must have an initial diagnosis

2 we will then ask you to complete a consultation request form

3 you will then be provided with contact details of the appropriate specialist

4 the appropriate specialist will then liaise with your physician(s) and treating hospital(s) to gathers relevant clinical data

5 you will be provided with the second opinion or consultation report within 15 working days.

6 you will then be able to liaise with us in relation to the information provided

Travel for family emergency

If the insured person needs to make an unscheduled journey to the permanent place of residence of the close relative during the period of insurance as a result of an insured event and within one month of the insured event taking place:

a. we will pay reasonable and necessary costs, up to the amount listed in the table of benefits for one return trip, by economy/tourist class air travel for the insured person to travel from their country of residence to the location where the close relative is situated in their permanent place of residence
b. in the event of the insured person needing to make more than one unscheduled journey to the close relative's permanent place of residence as a result of separate, unrelated and subsequent insured events, we will arrange and pay for up to a maximum of three return trips or an overall maximum as listed in the table of benefits in total under this policy during any one period of insurance.

Specific exclusions to travel for family emergency

The policy will not pay charges:

a. for any trip which is not taken within one month of the date of insured event occurring
b. for any claims arising directly or indirectly as a result of any pre-existing medical condition(s)
c. for any claim in respect of any close relative aged 75 or over
d. for any illness claim arising within the first three months after the commencement date
e. for any claim where we have not received all medical evidence we consider necessary from the close relative's physician(s)
f for the close relative's failure to seek or follow medical advice
g. for any claim arising or resulting directly or indirectly from suicide, attempted suicide, or intentional self-injury
h. for any claim resulting directly or indirectly from provoked assault, fighting (except in genuine self-defence), or whilst engaged in or taking part in civil commotion or riot, or from the close relative's own criminal act
i. for any claim resulting from the following:
   – sexually-transmitted diseases, including HIV or any related condition
   – any psychiatric, mental or nervous disorder, including stress or depression
   – pregnancy, childbirth or any related medical complication
j. for any claim if we have not been contacted prior to travel arrangements being made
k. for any claim arising from being under the effects or influence of alcohol or non prescribed drugs.

eHealth records account in partnership with, and powered by Medelinked

The eHealth records account is available to all adults covered under our yourLife, yourFamily, premierLife and premierFamily plans. We have teamed up with Medelinked, a leading online electronic health records storage service, to keep your health records secure and accessible from anywhere, 24-hours-a-day.

The unique system enables you to build your health picture online which you can then share securely with your trusted health partners. Bringing your records together is easy, you update your known information and connect with your health providers such as your doctor, specialist or optician to request them to upload records and contribute to your health picture.

Your eHealth records account empowers you to have greater control over your health by having your information available when you need it. It enables your health providers to make more informed health decisions based on your essential medical information. All of your health plan documentation has been conveniently loaded onto your account for easy access in times when you might not have access to your member ID card or plan documents.

For further questions and information please contact Integra Global by phone, email or visit www.integraglobal.com

Our insurance partner
Your Integra Global health plan number. MGENIB1100231 SAP is underwritten by MGEN, SIREN number 775 685 399, regulated by the provisions of Tome II of the French mutual insurance companies code – 3-7 Square Max Hymans, 75748 Paris Cedex 15 France. Under the supervision of the ACPR, 61 rue Taibout, 75436 Paris Cedex 09, France.

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