



UltraCare

Plan guide

For plans with a start date
on or after 1 January 2015



Archipelago

 InterGlobal
An Aetna Company

Contents

Your plan guide	3
Individual plans	3
Cooling off period	3
Individual eligibility	3
Plan start date	3
Premiums	3
Ways to pay	4
Unpaid or late premiums	4
Adding dependants	4
Removing dependants	4
Transfers	5
Making plan changes	5
Renewal	5
Automatic renewal	5
No-claims discount	5
Cancellation	6
Death	6
Group plans	6
Group eligibility	6
Group plan start date	7
Group premiums	7
Ways to pay group premiums	7
Unpaid or late group premium payments	7
Adding group members	7
Removing group members	8
Group member transfers	8
Continuing cover when leaving a group plan	8
Changing the cover and add-on plans for groups	8
Renewing the group plan	8
Cancelling the group plan	9
General conditions, benefit conditions and benefit exclusions	9
General conditions	9
Benefit conditions	10
Benefit exclusions	10
Extra benefit conditions and benefit exclusions for add-on plans	12
Extra benefit condition for the Maternity add-on plan	12
Benefit conditions for the Personal accident add-on plan	12
Benefit exclusions for the Personal accident add-on plan	12
Benefit conditions for the Travel add-on plan	12
Benefit exclusions for the Travel add-on plan	13
Data Protection	14
Complaints	14
How you can help us contain your premium	14
Fraud, let's beat it together	14
Definitions	15

Your plan guide

This Plan guide, together with your Table of benefits, explains what is, and is not, covered under the UltraCare plan and any of the following add-on plans that have been chosen:

- Maternity add-on plan;
- Personal accident add-on plan;
- Travel add-on plan.

Different terms and conditions apply to different underwriting terms. See the 'Definitions' section for more information on your underwriting terms, as shown on your Certificate of insurance. Also see benefit exclusions BE1 and BE2 for more information.

This Plan guide will also give you important information about managing these plans.

For information about how to make a claim and what to do in a medical emergency please refer to your Claims procedures.

Please spend some time reading carefully through this Plan guide to make sure that you are completely satisfied with the cover we are providing and that the cover meets your needs. If you have any questions about the information in this Plan guide or any questions you think it does not answer, please contact us and we will be more than happy to help.

Some words and phrases used in this Plan guide, your Table of benefits and your Claims procedures have specific meanings that are relevant to your plans. We have highlighted them in bold print and defined them in the 'Definitions' section of this Plan guide.

This plan is insured by Archipelago Life Insurance Limited.

Individual plans

The Individual application, Table of benefits, Certificate of insurance and this Plan guide form the contract of insurance with us and you must read them together.

The currency of your UltraCare plan and any add-on plans will be US dollars (\$). Premiums must be paid in the same currency as your plans.

We can change any of the general conditions, benefit conditions, benefit exclusions or other terms and conditions in this Plan guide at the beginning of the plan year. We can also change the premiums and any discounts or surcharges at the beginning of the plan year. We will tell the planholder about any changes before the plan renewal date.

Cooling off period

If you feel a plan does not meet your needs, the planholder may cancel it. The planholder must tell us in writing by letter, fax or email within 30 days of receiving the Table of benefits, Certificate of insurance and Plan guide, or the date of joining, whichever is later. The planholder must return the Certificate of insurance when they cancel the plan. If the UltraCare plan is cancelled all membership cards must also be returned.

As long as no claims have been made by any member on the plan, the premium received will be refunded in full.

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

If the UltraCare plan is cancelled, any add-on plans will also be cancelled.

Premiums can only be refunded to the account they were originally paid from. The planholder will be responsible for:

- any shortfall as a result of exchange rate differences; and
- any associated bank charges.

If the planholder decides to cancel a plan after the 30-day period, the cancellation will be governed by the 'Cancellation' section in this Plan guide.

Individual eligibility

Your eligibility depends on us accepting the application, including the medical questionnaire if your underwriting terms are FMU.

The UltraCare plans and add-on plans are available to people of all nationalities, including dependants, except citizens of the USA who live in the USA and people who are governed by exchange controls or local licensing regulations.

Plans may not meet specific visa requirements. Cover may also be illegal under local laws. It is the planholder's responsibility to ensure that any plans chosen meet your needs.

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

The minimum age of a planholder is 18. If none of the members to be included on the plan are 18 or above at the date of application, the application will be subject to our acceptance, and their parent or legal guardian must apply for them. The parent or legal guardian will act as the planholder, but will not have cover under the plan. UltraCare plan premiums will be based on the adult rate of 18 to 25 years for all members included on the plan. No discounts will apply.

You cannot be older than 74 at your start date.

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

Add-on plans are only valid when the UltraCare plan is in force.

The Maternity add-on plan is only available with the same area of cover as the UltraCare plan. This plan is also only available to female members aged 18 to 44 at entry. Once members reach the age of 46 during a plan year, their cover on the Maternity add-on plan will not be renewed.

The minimum age at entry for the Personal accident add-on plan is 18. The maximum age at entry is 74. This plan can cover:

- the planholder only; or
- the planholder and any dependants, aged 18 and over, who are included on their UltraCare plan.

The Personal accident add-on plan provides cover for managerial, clerical and administrative occupations only. See benefit condition BCPA1 for more information.

The Travel add-on plan can cover:

- the planholder only; or
- the planholder and all of the dependants who are included on their UltraCare plan.

Additional eligibility criteria apply to some plan types. These are shown in your Individual application and Table of benefits where applicable.

We can refuse cover on any of our plans for any reason. We may provide cover under our plans with any special terms that we may set. Any special terms will be shown on the Certificate of insurance.

Plan start date

With our agreement cover under the UltraCare plan will begin:

- as soon as we receive the Individual application; or
- on a future date given to us by the planholder;

unless your underwriting terms are CPME or FMU.

If your UltraCare plan underwriting terms are CPME, cover on the UltraCare plan will begin as soon as we receive the planholder's acceptance of the special terms offered in the quotation or on a future date the planholder has given and we have agreed, as long as there is no break in cover.

If your UltraCare plan underwriting terms are FMU, cover on the UltraCare plan will begin as soon as we receive the planholder's acceptance of the special terms offered in the quotation.

We will tell the planholder the start date in writing.

Cover under any add-on plans will begin on the same day as the UltraCare plan or any future UltraCare plan renewal date.

We cannot backdate cover under any circumstances. All plans will continue for 12 months until the next renewal date.

The premiums and benefits applied to a plan will be those in force at the plan start date.

Premiums

Each plan is a yearly contract.

The planholder must choose how often your UltraCare plan premiums are paid from the payment options available for that plan type. They must choose this at application or renewal and it will apply throughout the entire plan year. Maternity add-on plan premiums can be paid every year or as often as the UltraCare plan premium is paid. Personal accident and Travel add-on plan premiums can only be paid yearly.

UltraCare

The **planholder** is responsible for paying all premiums. Premiums must be paid in the same currency as **your plans**. The premium will be returned if payment is received in a different currency to the currency of **your plans**. The **planholder** will be responsible for:

- any shortfall as a result of exchange rate differences; and
- any associated bank charges.

UltraCare plan premiums are based on the age of the **planholder** and each **dependant** at the **plan start date**. Add-on **plan** premiums are based on:

- the age of any female **members** included on the Maternity **plan**;
- the number of units chosen for each **member** on the Personal accident **plan**;
- the **planholder** and any **dependants** included on the Travel **plan**.

All cover is subject to **our** eligibility criteria.

We must receive all premiums, including any taxes that apply, on or before the premium due dates.

Ways to pay

Premiums must be paid in the same currency as **your plans**.

For yearly payments, premiums can be paid by:

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

For payments made every month or every three months, premiums can only be paid by **card**.

Card

There are two ways to pay by **card**:

- complete and fax the Credit **card** authority form;
- complete and post the Credit **card** authority form.

Please do not send **card** details by email. Email and internet messages cannot be guaranteed to be completely secure, as personal information can be intercepted, lost or stolen. **Card** details sent by email will not be processed.

Completing the Credit **card** authority form gives authorisation for the relevant amount to be collected from the named account on or around a premium due date. This also gives authorisation to collect renewal premiums until written instructions are received from the **planholder** to change the method of payment.

The **planholder** will be told in writing if, for any reason, premiums cannot be collected. Attempts to collect the premium will continue unless the **planholder** gives alternative instructions. This may mean that more than one premium needs to be collected on the next collection date. See the 'Unpaid or late premiums' section for more information.

The **planholder** is responsible for providing up to date **card** details. The **planholder** must advise any changes to the **card** details to make sure that any premiums can be collected.

Bank transfers, cheques and banker's drafts

See the Individual application or renewal quotation for payment details. When making a payment, the **planholder** must give their full name and the quotation number or **UltraCare plan** number as the reference.

Unpaid or late premiums

The **planholder** must make sure premiums are paid on or before the due date. **We** will tell the **planholder**, in writing, if payments are not made on time.

We will not approve or pay any **claims** until the payments are up to date.

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

Adding dependants

With **our** agreement the **planholder** may add **dependants** to the **UltraCare plan** after the **plan start date**. The **planholder** must make the request in writing by letter, fax or email, unless the underwriting terms are **CPME** or **FMU**. If the underwriting terms are **CPME**, see the 'Transfers' section for information about

how to apply. If the underwriting terms are **FMU** the **planholder** must send an Individual application, including the medical questionnaire.

With **our** agreement the **planholder** may also add **dependants** to any add-on **plans** at the same time they are added to the **UltraCare plan**. The **planholder** must request this in writing by letter, fax or email.

When making a request to add **dependants**, the **planholder** must also tell us all **material facts**. If there is any doubt about whether a fact is material, the **planholder** should tell us. See general condition GC2 for more information.

With **our** agreement cover will begin:

- as soon as **we** receive the request; or
- on a future date given to us by the **planholder**;

unless the **dependant's** underwriting terms on the **UltraCare plan** are **CPME** or **FMU**.

If the **dependant's** underwriting terms are **CPME** on the **UltraCare plan**, cover will begin as soon as **we** receive the **planholder's** acceptance of the special terms offered in the quotation or on a future date the **planholder** has given and **we** have agreed, as long as there is no break in cover.

If the **dependant's** underwriting terms are **FMU** on the **UltraCare plan**, cover will begin as soon as **we** receive the **planholder's** acceptance of the special terms offered in the quotation.

Cover under any add-on **plans** will begin on the same day as the **UltraCare plan**.

We will not backdate cover under any circumstances.

With **our** agreement the **planholder** may add newborn children as **dependants** during the **plan year**. When making a request the **planholder** must tell us all **material facts**.

If the **planholder** applies in writing before the newborn child is 30 days old **we** will not apply any underwriting terms to the newborn child's cover on the **UltraCare plan** and their **date of joining** will be their date of birth. **Benefit** condition BC5 and **benefit** exclusions BE1 and BE2 will not apply.

If the **planholder** applies in writing after the newborn child is 30 days old, underwriting terms will apply. If the underwriting terms on the **UltraCare plan** are:

- **moratorium** – cover will begin as soon as **we** receive the request or on a future date given to us by the **planholder**.
- **FMU** – the **planholder** must send an Individual application, including the medical questionnaire. Cover will begin as soon as **we** receive the **planholder's** acceptance of the special terms offered in the quotation.

We will not backdate cover for any requests received by us after the newborn child is 30 days old.

Premiums may change in line with any agreed requests.

When adding any **dependants**, **we** will send the **planholder** a revised Certificate of insurance and a new membership card, if this applies, showing the changes and any special terms that may apply.

Removing dependants

With **our** agreement the **planholder** may remove a **dependant** from a **plan** after the **plan start date**. The **planholder** must make the request in writing by letter, fax or email. The last day of cover will be the date that **we** receive the request, or a future date the **planholder** has given.

The **planholder** must also confirm in writing by letter, fax or email, if there are any **claims** to be made by any **member** on the **plan** for **treatment** or services received, or costs incurred, on or before the **dependant's end date**.

- If no **claims** have been made, or will be made, for any **member** on the **plan**, a pro-rata refund will be issued.
- If no **claims** have been paid, but any **member** on the **plan** has made **claims** that **we** have not yet approved, or has **claims** to be made, **we** will not approve or pay these costs unless all premiums have been received for the entire **plan year**. A pro-rata refund will be issued if the **planholder** confirms in writing by letter, fax or email that they do not want us to approve the **claim**.
- If no **claims** have been paid, but any **member** on the **plan** has made **claims** that **we** have approved, the **planholder** must confirm in writing by letter, fax or email:
 - whether any costs have been incurred; and if so
 - whether the **planholder** will pay these costs or the **planholder** expects us to pay the **claim**.

The **claim** will only be paid when all premiums have been received for the entire **plan year**. A pro-rata refund will only be issued if the **planholder** pays these costs, or no costs have been incurred.

- If any **member** on the **plan** has made any **claims** that we have approved and paid, no refund will be issued and all premiums must be paid for the entire **plan year**.

If a **dependant** is removed from an **UltraCare plan** they will also be removed from any add-on **plans**. The last day of cover on any add-on **plans** will be the same as their last day of cover on the **UltraCare plan**.

Premiums may change in line with any agreed requests.

If **dependants** are removed from more than one **plan**, any pro-rata refund or outstanding premium due on each **plan** will be combined.

If any refund is due, this can only be refunded to the account it was originally paid from. The **planholder** will be responsible for:

- any shortfall as a result of exchange rate differences; and
- any associated bank charges.

When removing any **dependants** from a **plan**, the **planholder** must return the Certificate of insurance. If a **dependant** is being removed from an **UltraCare plan**, the **planholder** must also return the **dependant's** membership card.

We will send the **planholder** a revised Certificate of insurance showing the changes and any special terms that may apply.

Transfers

If a new person wants to transfer cover from another insurer to apply for CPME underwriting terms with us, an Individual application for CPME must be completed, and we will need an original certificate of insurance from their previous insurer, which shows:

- their original start date with that insurer;
- their underwriting terms; and
- any special terms that may have applied.

If there is a break in cover between the end date of the previous insurance plan and the application to us, we will not offer a transfer of previous underwriting terms.

If we accept the application we may charge an increased premium. Cover will begin as soon as we receive the **planholder's** acceptance of any special terms offered in the quotation or on a future date they have given and we have agreed, as long as there is no break in cover.

Our **plan** terms, conditions and **benefits** may be different to those of the previous insurer.

Making plan changes

When making any request for changes to a **plan**, including add-on **plans**, the **planholder** must also tell us all **material facts**. If there is any doubt about whether a fact is material, for your own protection, the **planholder** should tell us. See general condition GC2 for more information.

If you change your address the **planholder** must tell us in writing by letter, fax or email. If your new address is in a different country, we will consider this to be the **country where you live** unless the **planholder** tells us otherwise.

If the **planholder** wants to change the **area of cover** on the **UltraCare plan** and any Maternity add-on **plan**, they must tell us in writing by letter, fax or email giving the reason for the change in circumstances. With our agreement this change can be made at any time during the **plan year**. We will make this change from the date the **planholder** tells us or any future date they have given.

We will send the **planholder** a revised Certificate of insurance if your new address is in a different country or your **area of cover** changes. If your **area of cover** changes, we will also send a new membership card. The Certificate of insurance and membership card will show the changes and any special terms that may apply. Premiums, taxes and **benefit** limits may change in line with any agreed requests.

The **planholder** cannot make changes to:

- the **UltraCare plan** type;
- **deductibles** or how often the premiums are paid on the **UltraCare plan** or Maternity add-on **plan**; or
- the number of units on a Personal accident add-on **plan**;

during the **plan year**. With our agreement these changes can be made at the next **plan renewal date**. The **planholder** must tell us about the changes in writing by letter, fax or email before the **plan renewal date**. Premiums, taxes and **benefit** limits may change in line with any agreed requests.

Add-on **plans** cannot be added during the **plan year**. With our agreement these can be included from the next **plan renewal date**. The **planholder** must apply in writing by letter, fax or email before the **plan renewal date**. When making the application the **planholder** must also tell us all **material facts**. If there is any doubt about whether a fact is material, for your own protection, the **planholder** should tell us.

Renewal

With our agreement the **planholder** may renew the **UltraCare plan** and any add-on **plans** each year.

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

The **planholder** must tell us all **material facts** before the **renewal date**. If there is any doubt about whether a fact is material, for your own protection, the **planholder** should tell us. See general condition GC2 for more information.

We may change the definitions, **benefits**, general conditions, **benefit** conditions and **benefit** exclusions that apply to the **UltraCare plan** and any add-on **plans**. Any changes will be sent to the **planholder** together with the renewal quotation at least six weeks before the **renewal date**. Renewal premiums must be paid on or before the **renewal date**.

UltraCare plan renewal premiums are based on the age of the **planholder** and each **dependant** at the **renewal date**, the countries where they live, increases in medical inflation and the **plan** type chosen.

Maternity add-on **plan** renewal premiums are based on the age of any female **members** included at the **renewal date**, the countries where they live and increases in medical inflation.

Personal accident add-on **plan** renewal premiums are based on the number of units chosen for each **member** at the **renewal date**.

Travel add-on **plan** renewal premiums are based on the **planholder** and any **dependants** included at the **renewal date**.

All cover is subject to our eligibility criteria.

A child will no longer be eligible as a **dependant** under any **plan** at the next **renewal date** if any one or more of the following apply:

- they marry;
- they are not in continuous full-time education and they are 18 to 24; or
- they reach the age of 25.

With our agreement they can apply to have their own **UltraCare plan** and add-on **plans** by completing an Individual application. As long as there is no break in their cover with us, their **date of joining** will stay the same. Their application will be governed by the definitions, **benefits**, general conditions, **benefit** conditions and **benefit** exclusions in force at their new **plan start date**.

Automatic renewal

If the premiums are paid by **card**, we will automatically renew the **UltraCare plan** and any add-on **plans**, unless we tell the **planholder** otherwise. Renewal premiums will be taken from the named account as long as the payment details are still valid at the **renewal date**.

If the **card** details provided previously are not valid for at least three months after the **renewal date**, then new **card** details must be provided by completing, and faxing or posting, the Credit **card** authority form.

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

No-claims discount

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

UltraCare

The following discounts will apply to the **UltraCare plan** after it has been **claim free** for the amount of time shown.

- For less than one **plan year**: no discount.
- For one **plan year**: 10% discount.
- For two **plan years**: 15% discount.
- For three **plan years**: 20% discount.
- For four or more **plan years**: 25% discount.

The maximum no-claims discount is 25%.

Any **claims** made for the Wellness or Hospital cash **benefits**, or on any add-on **plans**, will not affect the no-claims discount.

If a **claim** relating to a previous **plan year** is made on the **UltraCare plan** after we have given a no-claims discount, the full premium will be due for the **plan year** to which the discount was given. We will also recalculate the amount of no-claims discount that applies to the following **plan years** and any additional premiums that become due as a result of this will be charged.

The no-claims discount does not apply to the premiums of any add-on **plans**.

Cancellation

Please see the 'Cooling off period' section if a **plan** is being cancelled within 30 days of receiving the Table of **benefits**, Certificate of insurance and **Plan** guide, or the **date of joining**, whichever is later.

If the **planholder** is cancelling a **plan** at any other time, they must confirm in writing by letter, fax or email if there are any **claims** to be made by any **member** on the **plan**. The last day of cover will be the date that we receive the written confirmation, or on a future date given to us.

- If no **claims** have been made, or will be made, for any **member** on the **plan**, a pro-rata refund will be issued.
- If no **claims** have been paid, but any **member** on the **plan** has made **claims** that we have not yet approved, or has **claims** to be made, we will not approve or pay these costs unless all premiums have been received for the entire **plan year**. A pro-rata refund will be issued if the **planholder** confirms in writing by letter, fax or email that they do not want us to approve the **claim**.
- If no **claims** have been paid, but any **member** on the **plan** has made **claims** that we have approved, the **planholder** must confirm in writing by letter, fax or email:
 - whether any costs have been incurred; and if so
 - whether the **planholder** will pay these costs or the **planholder** expects us to pay the **claim**.The **claim** will only be paid when all premiums have been received for the entire **plan year**. A pro-rata refund will only be issued if the **planholder** pays these costs, or no costs have been incurred.
- If any **member** on the **plan** has made any **claims** that we have approved and paid, no refund will be issued and all premiums must be paid for the entire **plan year**.

If the **UltraCare plan** is cancelled, any add-on **plans** will also be cancelled. The last day of cover on any add-on **plans** will be the same as the last day of cover on the **UltraCare plan**.

No **claims** will be paid on a **plan** after it is cancelled.

An administration fee of \$170 will be charged for cancelling your **UltraCare plan**, depending on the currency of your **plan**. We reserve the right to make an additional charge if we incur any further or unexpected costs as a result of the cancellation.

If more than one **plan** is cancelled, any pro-rata refund or outstanding premium due on each **plan** will be combined.

If any refund is due, this can only be refunded to the account it was originally paid from. The **planholder** will be responsible for:

- any shortfall as a result of exchange rate differences; and
- any associated bank charges.

The **planholder** must return the Certificate of insurance when they cancel a **plan**. They must also return all membership cards if the **UltraCare plan** is cancelled.

Death

If the **planholder** dies we will offer their **dependants** continued cover if we receive a signed Individual application from them within four weeks of the date of death.

If the **planholder's dependants** do not want to continue cover, they must tell us in writing by letter, fax or email. We will then cancel the **plan** and a pro-rata refund will be issued in line with the instructions received from the **planholder's** personal representative, as long as no **claims** have been made and accepted by us. If we have accepted a **claim**, no refund will be paid.

We will ask to see a certified copy of the death certificate before any refund is issued.

Group plans

The **plan** terms apply to you and the **planholder**.

You must read the Group **member** application (if this applies), Table of **benefits**, Certificate of insurance, membership cards and this **Plan** guide.

The Group application, Group **member** applications (if these apply), Group declaration of health (if this applies), Group membership census, Corporate agreement, Table of **benefits**, Certificates of insurance and this **Plan** guide form the contract of insurance between us and the **planholder**. The **planholder** must read these together.

The currency of the **UltraCare plan** and any add-on **plans** will be US dollars (\$). Premiums must be paid in the same currency as the **plans**.

We can change any of the general conditions, **benefit** conditions, **benefit** exclusions or other terms and conditions in this **Plan** guide at the beginning of the **plan year**. We can also change the premiums and any discounts or surcharges at the beginning of the **plan year**. We will tell the **planholder** about any changes before the **plan renewal date**.

Group eligibility

Eligibility depends on us accepting the Group application, Group **member** applications if the underwriting terms are moratorium or CPME, previous certificates of insurance if the underwriting terms are CPME, Group **member** applications including the medical questionnaires if the underwriting terms are FMU, Group declaration of health (if this applies) and a complete Group membership census.

Plans must be made up of a group of employees of the same company or members of an existing affinity group. The size of a group **UltraCare plan** at the **start date** must be at least three **main members** (employees or affinity members). If there are less than three **main members** at the **start date** or at a **renewal date**, the group cannot continue and we will offer individual **plans** to the remaining **members**.

The **UltraCare plans** and add-on **plans** are available to people of all nationalities, including **dependants**, except citizens of the USA who live in the USA and people who are governed by exchange controls or local licensing regulations.

Plans may not meet specific visa requirements. Cover may also be illegal under local laws. It is the **planholder's** responsibility to ensure that any **plans** chosen meet your needs.

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

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

Main members and their **dependants** must have the same **area of cover**.

Add-on **plans** are only valid when the **UltraCare plan** is in force.

The minimum age at entry for the Personal accident add-on **plan** is 18. The maximum age at entry is 74. This **plan** can cover:

- the **main member** only; or
- the **main member** and all of their **dependants**, aged 18 and over, who are included on the **UltraCare plan**. All **dependants** must have the same level of cover as the **main member**.

The Personal accident add-on **plan** provides cover for managerial, clerical and administrative occupations only. See **benefit** condition BCPA1 for more information.

The Travel add-on **plan** can cover:

- the **main member** only; or
- the **main member** and all of their **dependants** who are included on the **UltraCare plan**.

Additional eligibility criteria apply to some **plan** types. These are shown in the Group **member** application and Table of **benefits** where applicable.

We can refuse cover on any of our plans for any reason. We may provide cover under our plans with any special terms that we may set. Any special terms will be shown on the Certificate of insurance.

Group plan start date

With our agreement cover under the UltraCare plan will begin immediately or on a future date the planholder has given and we have agreed, as long as we accept the application, and as soon as we have received the:

- Group application;
- Group member applications if the underwriting terms are moratorium or CPME;
- Group member applications including the medical questionnaires if the underwriting terms are FMU;
- previous certificates of insurance if the underwriting terms are CPME;
- acceptance of all special terms offered in the quotation if the underwriting terms are CPME or FMU;
- Group declaration of health if this applies; and
- Group membership census.

We will tell the planholder the start date in writing.

Cover under any add-on plans will begin on the same day as the UltraCare plan or any future UltraCare plan renewal date.

We cannot backdate cover under any circumstances. All plans will continue for 12 months until the next renewal date or until they are cancelled or extended for any reason.

Group premiums

Each plan is a yearly contract.

The premiums in the quotation accepted by the planholder will apply for the plan year.

The planholder must choose how often the UltraCare plan premiums are paid from the payment options available for that plan type. They must choose this at application or renewal and it will apply throughout the entire plan year. Personal accident and Travel add-on plan premiums can only be paid yearly.

The planholder is responsible for paying all premiums. Premiums must be paid in the same currency as the plans. The premium will be returned if payment is received in a different currency to the currency of the plans. The planholder will be responsible for:

- any shortfall as a result of exchange rate differences; and
- any associated bank charges.

We must receive all premiums, including any taxes that apply, on or before the premium due dates.

Premiums may change as a result of adding or removing members. The planholder must pay any extra premiums when the next reconciliation statement is sent, in accordance with the credit terms. Any refund due to the planholder will be carried forward to the next reconciliation statement.

Ways to pay group premiums

Premiums must be paid in the same currency as the plans.

Premiums can be paid by:

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

Bank transfers, cheques and banker's drafts

See the Group application or invoice for payment details. When making a payment, the planholder must give the group name and the quotation number or UltraCare plan number as the reference.

Card

There are two ways to pay by card:

- complete and fax the Credit card authority form;
- complete and post the Credit card authority form.

Please do not send card details by email. Email and internet messages cannot be guaranteed to be completely secure, as personal information can be intercepted, lost or stolen. Card details sent by email will not be processed.

Completing the Credit card authority form gives authorisation for the relevant amount to be collected from the named account on or around a premium due date. This also gives authorisation to collect renewal premiums until written instructions are received from the planholder to change the method of payment.

The planholder will be told in writing if, for any reason, premiums cannot be collected. Attempts to collect the premium will continue unless the planholder gives alternative instructions. This may mean that more than one premium needs to be collected on the next collection date. See the 'Unpaid or late group premium payments' section for more information.

The planholder is responsible for providing up to date card details. The planholder must advise any changes to the card details to make sure that any premiums can be collected.

Unpaid or late group premium payments

The planholder must make sure premiums are paid on or before the due date. We will tell the planholder, in writing, if payments are not made on time.

We will not approve or pay any claims until the payments are up to date.

We will cancel a plan if payment is not received within 30 days of the premium due date. If we cancel a plan, the planholder will have to apply for a new plan. The premiums may change and the cover may have new terms.

We reserve the right to charge commercial interest on any overdue premium at the Bank Negara Malaysia base rate, plus 5%. Interest will accrue on a daily basis from the premium due date until full payment is made for the overdue premium.

Adding group members

With our agreement the plan administrator may add members to the UltraCare plan after the plan start date. The plan administrator must make the request as follows, depending on the underwriting terms.

- MHD – the plan administrator must make the request in writing by letter, fax or email.
- Moratorium – if a new dependant is being added the plan administrator must make the request in writing by letter, fax or email. If a new main member is being added the plan administrator must send a group application for the main member, and any dependants to be included.
- CPME – see the 'Group member transfers' section.
- FMU – the plan administrator must send a Group member application, including the medical questionnaire.

With our agreement the plan administrator may also add members to any add-on plans at the same time they are added to the UltraCare plan. The plan administrator must request this in writing by letter, fax or email.

When making a request to add members, the plan administrator must also tell us all material facts. If there is any doubt about whether a fact is material, the plan administrator should tell us. See general condition GC2 for more information.

With our agreement cover will begin as follows, depending on the underwriting terms.

- MHD – as soon as we receive the request or on a future date given to us by the plan administrator.
- Moratorium – as soon as we receive the request or on a future date given to us by the plan administrator.
- CPME – as soon as we receive acceptance of the special terms offered in the quotation or on a future date the plan administrator has given and we have agreed, as long as there is no break in cover.
- FMU – as soon as we receive acceptance of the special terms offered in the quotation.

Cover under any add-on plans will begin on the same day as the UltraCare plan.

We will not backdate cover under any circumstances.

With our agreement the plan administrator may add newborn children as dependants during the plan year. When making a request the plan administrator must tell us all material facts.

If the plan administrator applies in writing before the newborn child is 30 days old we will not apply any underwriting terms to the newborn child's cover on the UltraCare plan and their date of joining will be their date of birth. Benefit condition BC5 and benefit exclusions BE1 and BE2 will not apply.

If the plan administrator applies in writing after the newborn child is 30 days old, underwriting terms will apply. If the underwriting terms on the UltraCare plan are:

UltraCare

- **MHD** – cover will begin as soon as we receive the written request or on a future date given to us by the **plan administrator**.
- **Moratorium** – cover will begin as soon as we receive the written request or on a future date given to us by the **plan administrator**.
- **FMU** – the **plan administrator** must send a **Group member** application, including the medical questionnaire. Cover will begin as soon as we receive acceptance of the special terms offered in the quotation.

We will not backdate cover for any requests received by us after the newborn child is 30 days old.

Premiums may change in line with any agreed requests.

When adding any **dependants**, we will send the **plan administrator** a revised Certificate of insurance and a new membership card, if this applies, showing the changes and any special terms that may apply.

When adding any new **main members** we will send the **plan administrator** a Certificate of insurance for the **main member** and any **dependants** included, showing any special terms that may apply. We will also send membership cards for the **main member** and their **dependants**.

Removing group members

With our agreement the **plan administrator** may remove a **member** from a **plan** after the **plan start date**. The **plan administrator** must make the request in writing by letter, fax or email. The last day of cover will be the date that we receive the request, or a future date the **plan administrator** has given. If a **main member** is removed from a **plan**, all of their **dependants** will also be removed.

When **members** are removed, the **plan administrator** is responsible for collecting and destroying their Certificates of insurance and membership cards on or by the **end date**. If the **plan administrator** does not collect and destroy the Certificates of insurance and membership cards and a removed **member** uses these to obtain **treatment** at a direct billing facility, the **planholder** will be responsible for paying any costs to the **treatment** provider. We will not be responsible for any costs after cover has ended.

If a **member** is removed from an **UltraCare plan** they will also be removed from any **add-on plans**. The last day of cover on any **add-on plans** will be the same as their last day of cover on the **UltraCare plan**.

Premiums may change in line with any agreed requests.

When removing any **dependants**, we will send the **plan administrator** a revised Certificate of insurance showing the changes and any special terms that may apply.

Group member transfers

If a new person wants to transfer cover from another insurer to apply for **CPME** underwriting terms with us, a **Group member** application for **CPME** must be completed, and we will need an original certificate of insurance from their previous insurer, which shows:

- their original start date with that insurer;
- their underwriting terms; and
- any special terms that may have applied.

If there is a break in cover between the end date of the previous insurance plan and the application to us, we will not offer a transfer of previous underwriting terms.

If we accept the application we may charge an increased premium. Cover will begin as soon as we receive acceptance of any special terms offered in the quotation or on a future date the **plan administrator** has given and we have agreed, as long as there is no break in cover.

Our **plan** terms, conditions and **benefits** may be different to those of the previous insurer.

Continuing cover when leaving a group plan

If **your** cover is coming to an end, with our agreement **you** can be transferred to an individual **UltraCare plan**, as long as there is no break in **your** cover with us and **you** meet our individual eligibility criteria.

You must send us **your** application before **you** leave the group **plan**. If we accept **your** application to continue cover, we may charge an increased premium and **your** underwriting terms may change. The application will be governed by the definitions, **benefits**, general conditions, **benefit** conditions and **benefit** exclusions in force at **your** new **plan start date**.

The **start date** of **your** new individual **plan** will be the first day after **you** leave the group **plan**.

Changing the cover and add-on plans for groups

When making any request for changes to a **plan**, including **add-on plans**, the **plan administrator** must also tell us all **material facts**. If there is any doubt about whether a fact is material, for **your** own protection, the **plan administrator** should tell us. See general condition GC2 for more information.

If **you** change **your** address the **plan administrator** must tell us in writing by letter, fax or email. If **your** new address is in a different country, we will consider this to be the **country where you live** unless the **plan administrator** tells us otherwise.

If a **main member** needs to change their **area of cover** on the **UltraCare plan**, the **plan administrator** must tell us in writing by letter, fax or email giving the reason for the change in circumstances. With our agreement this change can be made at any time during the **plan year**. We will make this change from the date the **plan administrator** tells us or any future date they have given. Their **dependants** will also change to the new **area of cover** on the same day.

If there is a change to the **country where a member lives** or their **area of cover** changes, we will send the **plan administrator** a revised Certificate of insurance. If the **area of cover** changes we will also send new membership cards for the **main member** and any **dependants**. The Certificate of insurance and membership cards will show the changes and any special terms that may apply. Premiums, taxes and **benefit** limits may change in line with any agreed requests.

The **planholder** cannot make changes to:

- the **UltraCare plan** type;
- the **UltraCare plan** **benefits**;
- **deductibles** or how often the premiums are paid on the **UltraCare plan**;
- the number of units on a **Personal accident** **add-on plan**; or
- the currency of any **plan**;

during the **plan year**. With our agreement these changes can be made at the next **plan renewal date**. The **planholder** must tell us about the changes in writing by letter, fax or email before the **plan renewal date**. Premiums, taxes and **benefit** limits may change in line with any agreed requests.

Add-on plans cannot be added during the **plan year**. With our agreement these can be included from the next **plan renewal date**. The **planholder** must apply in writing by letter, fax or email before the **plan renewal date**. When making the application the **planholder** must also tell us all **material facts**. If there is any doubt about whether a fact is material, for **your** own protection, the **planholder** should tell us.

Renewing the group plan

With our agreement the **planholder** may renew the **UltraCare plan** and any **add-on plans** each year.

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

The **planholder** must tell us all **material facts** about all **members** before the **renewal date**. If there is any doubt about whether a fact is material, for **your** own protection, the **planholder** should tell us. See general condition GC2 for more information.

We may change the definitions, **benefits**, general conditions, **benefit** conditions and **benefit** exclusions that apply to the **UltraCare plan** and any **add-on plans**. Any changes will be sent to the **planholder** together with the renewal quotation at least six weeks before the **renewal date**. Renewal premiums must be paid on or before the **renewal date**.

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

All cover is subject to our eligibility criteria.

A child will no longer be eligible as a **dependant** under any **plan** at the next **renewal date** if any one or more of the following apply:

- they marry;
- they are not in continuous full-time education and they are 18 to 24; or
- they reach the age of 25.

With our agreement they can apply to have their own **UltraCare plan** and **add-on plans** by completing an Individual application. As long as there is no break in their cover with us, their **date of joining** will stay the same. Their application will be governed by the definitions, **benefits**, general conditions, **benefit** conditions and **benefit** exclusions in force at their new **plan start date**.

We will not renew the group plan automatically.

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

Canceling the group plan

If the planholder wants to cancel a plan, they must confirm in writing by letter, fax or email. The last day of cover will be the date that we receive the written confirmation, or on a future date given to us.

If the UltraCare plan is cancelled, any add-on plans will also be cancelled. The last day of cover on any add-on plans will be the same as the last day of cover on the UltraCare plan.

As each plan is a yearly contract the planholder must pay any premium owed for the rest of the plan year. No refunds will be issued and the planholder may have to pay a cancellation charge.

The plan administrator must destroy all Certificates of insurance when they cancel a plan.

The plan administrator must also destroy all membership cards if the UltraCare plan is cancelled. If a membership card is used to obtain treatment at a direct billing facility after the plan has been cancelled, the planholder will be responsible for paying any costs to the treatment provider. We will not be responsible for any costs after cover has been cancelled.

General conditions, benefit conditions and benefit exclusions

The UltraCare plan and all add-on plans, are governed by the general conditions shown below. The UltraCare plan, Maternity and Travel add-on plans are governed by the benefit conditions shown below. Some of these benefit conditions also apply to the Personal accident add-on plan. See the 'Extra benefit conditions and benefit exclusions for add-on plans' section for more information. Claims will only be paid under a plan if you meet these general conditions and benefit conditions.

Extra benefit conditions also apply to the Maternity, Personal accident and Travel add-on plans. See the 'Extra benefit conditions and benefit exclusions for add-on plans' section for more information.

General conditions

GC1 The planholder or plan administrator must tell us immediately in writing by letter, fax or email about any important change that affects information given in connection with the application for cover under a plan, for example:

- you change your name or occupation;
- there is a change to planholder details;
- you plan to engage in any hazardous pursuits; or
- you change your address.

If your new address is in a different country, we will consider this to be the country where you live unless the planholder or plan administrator tell us otherwise.

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

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

GC2 The planholder or plan administrator must tell us all material facts before we accept an application, make changes to a plan or renew a plan. The planholder and plan administrator must check that any material facts are correct. You must check that any material facts about you are correct.

If there is any doubt about whether a fact is material, for your own protection, the planholder or plan administrator should tell us. Where applicable the 24-month moratorium will still apply even if the planholder or plan administrator tells us about any pre-existing medical conditions you may have.

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

GC3 If you make a claim that you know is false or fraudulent, we will refuse the claim. If any payment has already been made, we will recover any costs from the planholder. We will cancel cover from a date given by us.

GC4 We will send all correspondence about a plan to the planholder.

GC5 When handling your claim we will always:

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

unless you or your personal representative give us explicit consent to contact any other individual about your claim in accordance with our data protection policy.

GC6 If you need to make a claim, you must follow your Claims procedures and send all the information we ask for as soon as possible.

GC7 If we ask for more information to support a claim, this must be provided or your claim may not be paid. We also have the right to instruct a specialist of our choice to examine you as often as we feel is necessary to support a claim.

GC8 If we reject a claim under a plan, for any reason, you will have to prove that the claim is covered under the plan.

GC9 If an eligible claim is submitted at any time and it relates to a plan year for which a no-claims discount was previously given, the no-claims discount amount must be returned before your claim can be paid.

GC10 If you attend a hospital, clinic or any other facility where direct billing or cashless arrangements are in place, and the claim for this is subsequently found to be ineligible, we have the right to recover the full amount of the claim from you or the planholder. Payment of a claim is not an indication of our acceptance of liability for the claim or confirmation that further costs for the same medical condition or any related medical condition will be met.

GC11 If there are other insurance plans or policies that cover a claim, including any reciprocal health insurance arrangements, and they have any of the same, or equivalent benefits, only our share of the claim will be paid under your plan with us, after:

- you have paid any deductibles that apply on any of the other plans or policies; and
- you have paid any deductible on your plan with us.

GC12 We will not return the original claim documents to you after payment has been made to you or the provider.

GC13 If more than one currency is shown on your Table of benefits, the benefit limit shown in the same currency as your plans will apply to you.

GC14 If the country where you live is in an area where we have to collect any taxes, we will charge these on top of the premium due.

GC15 If your area of cover is Area 3 and you are a citizen of the USA, we will cancel your cover if you have spent more than 180 continuous days in the USA in any one plan year.

GC16 We can make an administration charge to replace or reissue plan documents or membership cards.

GC17 If there is a break in your cover with us, for any reason, we can change any plan terms and apply any special conditions.

GC18 The planholder or plan administrator must tell us immediately in writing by letter, fax or email about any proceedings or right of action against any other party, due to any circumstances which led to a claim under a plan. The planholder or plan administrator must continue to keep us informed in writing and take all steps we reasonably need, for us to take proceedings against the other party.

GC19 The planholder or plan administrator must tell us about any negotiations or settlement discussions that you enter into with any other party about any action which leads to a claim under a plan. You must not agree to a settlement with any party before we give our written agreement.

GC20 We are entitled to take proceedings in your name for our own benefit to recover the costs of any eligible claim under a plan. We will decide how we handle any proceedings.

GC21 If you want to take legal action against us in respect of a plan, you must do so within three years from the date the relevant event took place.

GC22 (a) APPLICABLE LAW The applicable law for our contract of insurance shall be the Laws of Malaysia governing Labuan IBFC legal and regulatory framework. (b) ARBITRATION Any dispute, controversy or claim arising out of or relating to this contract, or the breach, termination or invalidity thereof shall be settled by arbitration in accordance with the Rules of Arbitration of the Kuala Lumpur Regional Center for Arbitration.

GC23 Any translated versions of our documents that we issue are for your information only. In the case of any dispute or discrepancy of wording or interpretation, the English version will apply.

Benefit conditions

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

BC2 You or your personal representative must request pre-authorisation for any in-patient treatment, daycare treatment, medical evacuation, compassionate emergency visit, or preparation or transportation of your body or mortal remains, before it takes place. Once you or your personal representative have received our approval, we will settle all covered costs directly with the providers. If you or your personal representative do not receive our approval before it takes place, we will only approve the costs we would have negotiated if we had been involved and given our approval.

BC3 Hospital accommodation will be paid up to the cost of a standard single room with a private bathroom. This will include your hospital meals.

BC4 If a local situation makes it impossible, dangerous or not practical to enter a specific location or country, we may be unable to arrange a medical evacuation.

BC5 If we have not been given details of your medical practitioner on your application and a claim is made that we believe is for a pre-existing medical condition:

- we will reject the claim if your underwriting terms are moratorium or CPME previously moratorium;
- we will reject the claim if your underwriting terms are FMU or CPME previously FMU and you did not tell us about the medical condition when we asked about it on the application, or we have not accepted it.

This benefit condition does not apply if your underwriting terms are MHD.

BC6 Only reasonable costs will be paid for claims. Any costs above the relevant limits shown in your Table of benefits will not be paid. If the costs are not reasonable, or are above the limits shown in your Table of benefits, you will have to pay the difference.

BC7 If you choose to use a visiting doctor instead of an in-house doctor, in a hospital, clinic or any other facility where direct billing or cashless arrangements are in place, only reasonable costs will be paid. If the visiting doctor's costs are not reasonable and not in line with the in-house doctor's costs, you will have to pay the difference.

BC8 If you move to a plan where a lifetime limit applies to a benefit, any amount previously paid under the same, or equivalent benefit:

- on any one or more plans;
- regardless of any previous benefit limit; and
- whether or not there has been a break in your cover;

will be deducted from the current lifetime limit on the benefit.

BC9 Physiotherapy must be referred by a medical practitioner or specialist. If more than six physiotherapy sessions are needed for any medical condition, your therapist must provide the reasons in the Claim form so we can consider cover.

BC10 Complementary treatment must be referred by a medical practitioner or specialist. If more than four osteopathic, chiropractic, homeopathic, podiatry, Chinese traditional medicine or acupuncture sessions are needed for any medical condition, your therapist must provide the reasons in the Claim form so we can consider cover.

BC11 All psychiatric treatment and psychotherapy must be given by medical practitioners, psychiatrists or qualified and registered psychotherapists or psychoanalysts.

BC12 The normal pregnancy and childbirth benefit covers no more than one routine antenatal 2D ultrasound scan in each trimester of a normal uncomplicated pregnancy. If any more ultrasound scans are needed, your medical practitioner must confirm the reasons in the Claim form so we can consider cover. The benefit also covers 12 routine antenatal visits during a normal uncomplicated pregnancy. If any more antenatal visits are needed your medical practitioner must provide the reasons in the Claim form so we can consider cover.

The benefit covers the following for the newborn child:

- one physical examination;
- vitamin K, hepatitis B and BCG vaccinations;
- routine blood tests for PKU, congenital hypothyroidism and G6PD;
- one hearing examination; and
- reasonable accommodation costs for no more than four nights, if the mother is admitted and not suffering any complications.

BC13 If we receive new information that shows a claim we have already approved is not eligible, no costs will be paid. If any costs have already been paid, we will recover these from you or the planholder and no further costs will be paid. Any approval we have given during the pre-authorisation process may also be withdrawn.

Benefit exclusions

The UltraCare plan and Maternity add-on plan do not cover claims for, arising from or connected with the following benefit exclusions unless shown on your Table of benefits, or agreed by us in writing.

Some of these benefit exclusions also apply to the Personal accident and Travel add-on plans. See the 'Extra benefit conditions and benefit exclusions for add-on plans' section for more information.

Extra benefit exclusions also apply to the Personal accident and Travel add-on plans. See the 'Extra benefit conditions and benefit exclusions for add-on plans' section for more information.

BE1 (This benefit exclusion applies if your underwriting terms are moratorium or CPME previously moratorium, as shown on your Certificate of insurance. See benefit exclusion BE2 if your underwriting terms are FMU or CPME previously FMU, as benefit exclusion BE1 does not apply to these underwriting terms. Benefit exclusions BE1 and BE2 do not apply if your underwriting terms are MHD.)

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

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

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

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

If you have:

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

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

BE2 (This benefit exclusion applies if your underwriting terms are FMU or CPME previously FMU, as shown on your Certificate of insurance. See benefit exclusion BE1 if your underwriting terms are moratorium or CPME previously moratorium, as benefit exclusion BE2 does not apply to these underwriting terms. Benefit exclusions BE1 and BE2 do not apply if your underwriting terms are MHD.)

A medical condition or symptom that you were aware of before your start date unless we were given all the information we asked for in the application and we have not specifically excluded the medical condition or symptom as shown on your Certificate of insurance.

BE3 Costs that exceed a limit shown on your Table of benefits.

BE4 A benefit not included on your plan.

BE5 A benefit not included on your plan at the time the costs are incurred, even if the benefit was included in any previous plan year.

BE6 A benefit included on your plan, if you have not completed the waiting period shown on your Table of benefits.

BE7 Pregnancy, childbirth or postnatal costs, whether complicated or not.

BE8 Any journey made specifically for the purpose of receiving medical treatment, unless you have requested pre-authorisation and we have given our approval.

BE9 Non-emergency transportation.

BE10 Burial, cremation, or the costs of moving **your** body or mortal remains, if you die in **your home country**.

BE11 Any journey, activity, action or pursuit carried out against the advice of a **medical practitioner, specialist, nurse or therapist**.

BE12 **Treatment** given, or referrals made by, a **medical practitioner, specialist, nurse or therapist** who is in any way related to **you**, and self-prescribed **treatment** or self-referral if you are a **medical practitioner, specialist or therapist**.

BE13 Alcohol, drug or any other intoxicating substance **abuse**, any addictive condition of any kind and any **medical condition** arising directly or indirectly from any such **abuse** or addictive condition.

BE14 You being under the influence of alcohol, drugs or any other intoxicating substance.

BE15 Male to female or female to male gender reassignment.

BE16 Tests or **treatment** for, or because of, sexually transmitted infections.

BE17 Experimental or unproven **treatment**, unless you have requested **pre-approval** and we have given our approval.

BE18 Bone marrow transplants, the costs of finding and obtaining an organ, costs as a result of removing an organ from a donor, any costs related to the transplant of an organ that is not obtained in accordance with the World Health Organisation's guidelines, costs of removing an organ from you to transplant it into another person, and any resulting complications.

BE19 Cryopreservation, implantation or re-implantation of living cells or living tissue, whether taken from **your** own body or provided by a donor. Costs of removing living cells or living tissue from you to implant or re-implant into another person, and any resulting complications.

BE20 Foetal **treatment**.

BE21 Terminating a pregnancy.

BE22 Congenital abnormalities or birth defects.

BE23 Suicide, attempted suicide or any deliberate, self-inflicted **medical condition**.

BE24 Putting yourself in needless danger, except in an attempt to save human life.

BE25 Any **medical condition** suffered by military, naval or air force personnel engaging in any military, naval or air force operation or exercise.

BE26 Any **medical condition** you suffer as a result of taking part in, or engaging in, any one or more of the following:

- an illegal or criminal act;
- military activity, war, riot, revolution, strike, lock-out or civil commotion;
- terrorism, usurped power; or
- any similar event.

BE27 Contamination from biological, chemical or nuclear materials, including waste products from the combustion of nuclear fuel. Any biological, chemical or nuclear weapon of mass destruction, whether or not as the result of an explosion.

BE28 **Treatment** received and costs incurred outside **your area of cover**.

BE29 You engaging in **professional sports** or using a weapon or firearm for any purpose.

BE30 Sleep apnoea, sleep-related breathing disorders, snoring or insomnia.

BE31 Developmental disorders of the brain, learning disorders, learning difficulties, speech problems and voice problems.

BE32 The costs of:

- cosmetic, reconstructive or remedial **treatment**; or
- replacing any implant;

including any related complications, whether or not the **treatment**, replacement or complications are for psychological reasons.

We will pay these costs if an in-patient or daycare surgical operation is needed as the result of an eligible **medical condition** that first occurred after **your date of joining**.

BE33 Removing fat from any part of the body, breast reduction or breast enlargement.

BE34 **Treatment** in a quarantine, isolation ward or unit, nursing home, hydro spa, spa, health farm or similar facility.

BE35 Charges incurred for overdue payment of invoices.

BE36 Myopia, hypermetropia, astigmatism, natural or non-medical degenerative sight or hearing disorders, aids to help with **your** sight or hearing, contact lens solutions, eye drops, sunglasses or prescription sunglasses. **Preventative services** and examinations for sight or hearing.

BE37 **Treatment** needed as a result of tattooing or piercing any part of the body.

BE38 Costs of:

- precious crowns;
- **dental** implants;
- removable bridges;
- dentures; or
- false teeth,

preventative dental services, including but not limited to:

- sealants;
- fluoride **treatment**; or
- scraping, cleaning and polishing, or

orthodontic treatment.

BE39 Compulsive or addictive eating disorders or homesickness.

BE40 Obesity, special diet or weight control.

BE41 Costs of:

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

BE42 Supplying, fitting or maintaining any external prostheses, appliance or device. The cost of renting or buying wheelchairs or other equipment, medical or otherwise. We will pay for a spinal support, knee brace or air cast boot if it is part of a surgical operation or part of the **treatment** of an eligible **medical condition**. We will also pay for crutches if medically necessary for the **treatment** of an eligible **medical condition**.

BE43 Costs of:

- completing Claim forms;
- completing or obtaining any other documents;
- hospital administration fees; or
- any registration fees.

BE44 Any **consequential loss**.

BE45 Costs incurred before **your start date** or after **your end date**.

BE46 Any costs relating to **in-patient, daycare or out-patient treatment** in a hospital:

- received at the time of **your start date**; or
- that you were aware of at **your start date**;

whether the **treatment** was planned or not, unless you have told us about it and we have accepted it.

BE47 Drugs or dressings that:

- are not recognised by the pharmaceutical regulator in the country where **treatment** is provided;
- are available without prescription; or
- are prescribed for a **medical condition** that is different to the one that you are claiming for.

BE48 Costs as a result of proven medical negligence or malpractice.

BE49 Any **deductible** that applies to **your plan**.

BE50 Costs of:

- contraception or sterilisation;
- **treatment** for sexual problems, including impotence, whatever the cause;
- fertility or infertility tests or **treatment**;
- assisted reproduction; or
- surrogacy.

BE51 Any **treatment** needed for a newborn child if the pregnancy was the result of assisted conception.

BE52 Invoices, Claim forms, medical reports or any other documents that have been altered or amended.

BE53 Travelling in, or on, a motorised vehicle as a driver or passenger:

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

BE54 Antenatal 3D or 4D ultrasound scans.

BE55 Health education programmes or services including, but not limited to, family planning, antenatal classes and parenting classes.

BE56 Treatment of birthmarks.

Extra benefit conditions and benefit exclusions for add-on plans

The following extra benefit conditions and benefit exclusions apply to the add-on plans. If you have an add-on plan you will receive an additional Certificate of insurance for this plan.

Extra benefit condition for the Maternity add-on plan

Claims will only be paid under the plan if you meet the benefit conditions listed in the 'Benefit conditions' section and the extra benefit condition listed below.

BCM1 The co-insurance chosen will apply for the first 24 months' continuous cover under this plan.

Benefit conditions for the Personal accident add-on plan

Claims will only be paid under the plan if you meet benefit condition BC13 in the 'Benefit conditions' section and the extra benefit conditions listed below.

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

BCPA2 No amount above the maximum accumulation limit shown on the Table of benefits will be paid for claims arising from any one event in any one location or vehicle, if they are made by multiple members on the same Personal accident add-on plan. If the total value of claims exceeds the maximum accumulation limit, the amount paid for each claim will be reduced proportionately to the amount each member is due, up to the maximum accumulation limit.

BCPA3 You will not be paid more than the overall maximum limit for each unit shown in the Table of benefits for any one or more accidents.

BCPA4 If you suffer one or more permanent total or permanent partial disablements within 12 months of an accident, you will only be paid up to the benefit limits shown on your Table of benefits that applied in the plan year when you had the accident. You will not be paid any more than the overall limit shown on your Table of benefits.

BCPA5 If you die within 12 months of an accident, payment will only be made up to the benefit limit shown on your Table of benefits that applied in the plan year when you had the accident, in line with the instructions received from your personal representative. If you die before any disablement benefit is paid, only the accidental death benefit will be paid.

If any disablement benefit has already been paid under this plan for any accident that happened in the same plan year, the accidental death benefit amount paid will be reduced by the value of any claims already paid.

No payment will be made for any more than the overall limit shown on your Table of benefits.

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

BCPA7 Cover is not provided for sickness or disease.

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

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

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

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

An example of this is:

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

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

Benefit exclusions for the Personal accident add-on plan

The Personal accident add-on plan does not cover claims for, arising from or connected with the benefit exclusions, BE3 to BE4, BE11 to BE14, BE23 to BE27, BE29, BE43, BE44, BE47, BE52 and BE53 listed in the 'Benefit exclusions' section and the extra benefit exclusions listed below.

BEPA1 Aviation other than as a fare-paying passenger in a fully-certified passenger carrying aircraft, flown in the course of licensed operation for transporting passengers by licensed crew.

BEPA2 Engaging in manual or dangerous occupations or hazardous pursuits.

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

Benefit conditions for the Travel add-on plan

Claims will only be paid under the plan if you meet the benefit conditions listed in the 'Benefit conditions' section and the extra benefit conditions listed below.

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

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

BCT3 You must take care of your property at all times and take all practical steps to recover any item or items lost or stolen. If you do not do this, it may affect your claim.

BCT4 Any loss of, or damage to, an item or items when in the custody of an airline or other carrier:

- must be reported to the airline or other carrier immediately upon discovering the loss or damage; and
- must be supported by a written report from the airline or other carrier.

BCT5 Any theft, suspected theft or loss must be reported to the local police within 24 hours of discovery and supported by a police report.

BCT6 You must keep any damaged items that you want to claim for and, if we ask, send them to us at your own cost. If a claim is paid for the full value of an item, it will become our property.

BCT7 We may discharge any of our legal responsibilities under this plan by replacing or repairing any item or items lost or damaged.

BCT8 If you want to change your original plans for returning home and claim any extra costs, you must tell us. If you do not tell us, it may affect your claim.

BCT9 When making a claim for a delayed departure or delayed baggage you must provide us with a written report from your carrier giving the details.

BCT10 When making a claim for a missed departure you must have planned to arrive at your departure point before your earliest scheduled check-in time and give us a written report from the carrier at the place of departure, police or relevant public transport authority, confirming the delay and stating its cause.

BCT11 When making a claim because your transport was hijacked you must provide us with a police report giving the details.

Benefit exclusions for the Travel add-on plan

Section A of the Travel add-on plan does not cover claims for, arising from or connected with benefit exclusions BE3 to BE5, BE9 to BE27, BE29 to BE45, BE47 to BE53 and BE56 listed in the 'Benefit exclusions' section and the extra benefit exclusions below.

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

BET2 A medical condition that:

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

within the 24-month period before:

- the date of booking a trip; or
- your date of joining as shown on your Certificate of insurance;

whichever is later.

BET3 A pregnancy when:

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

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

Sections B to I of the Travel add-on plan do not cover claims for, arising from or connected with benefit exclusions BE3 to BE5, BE11 to BE17, BE22 to BE35, BE37, BE39, BE43 to BE49, BE52, BE53, BE56, BET2 and the benefit exclusions listed below.

BET5 Leaving your baggage:

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

BET6 Unauthorised use of your traveller's cheques or credit cards.

BET7 An aircraft or sea vessel being withdrawn from service, whether temporary or otherwise, on the recommendation of a relevant port authority, the civil aviation authority or any similar organisation.

BET8 Strike or industrial action taking place, or publicly declared on, or before, the date the trip is booked.

BET9 Neglect, or failure to act, by the provider of transport or accommodation, or any agent the travel arrangements were made through.

BET10 Expenses payable by, or to, the travel agent, tour operator, accommodation provider, airline or other carrier.

BET11 Proceedings taken against a tour operator, travel agent or carrier.

BET12 Any person, organisation or company becoming insolvent or being unable or unwilling to fulfil any part of their obligation to you.

BET13 Shortages due to loss of value, omission, exchange or mistakes.

BET14 Changes in exchange rates.

BET15 Any costs you have to pay for visas needed in connection with your trip.

BET16 Any costs you would normally have to pay in connection with your trip.

BET17 More than the cost of the original trip.

BET18 Government regulations or acts and currency restrictions.

BET19 Loss, damage or expense, as a result of travelling to an area that the government of the country where you live, or the government of your home country, has advised against travelling to.

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

BET20 You deciding not to travel, not enjoying your trip, or not travelling because you could not afford it.

BET21 Cancellation due to terrorist acts or the threat of a terrorist act, unless the government of the country where you live, or the government of your home country, has advised against travelling to the area.

BET22 Unused accommodation, activities or travel arrangements, or any administration costs that your travel agent, tour operator or provider charge for refunds in relation to these.

BET23 Extra charges made by the travel agent, tour operator, accommodation provider, airline or other carrier.

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

BET25 Cancellation or curtailment of your trip if you knew that you may need to do so at your date of joining this plan or when booking your trip, whichever is later.

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

BET26 Any extra value an item may have had because it formed part of a pair or set.

BET27 Costs of:

- damage due to moth, vermin, atmospheric conditions or climatic conditions;
- wear and tear, or gradual deterioration;
- loss of value;
- mechanical or electrical breakdown;
- damage caused by any process of cleaning, repair or restoration; or
- damage caused by leaking powder or fluid carried within your baggage.

BET18 Government regulations or acts and currency restrictions.

BET28 Breakage of fragile items, including, but not limited to china, glass and sculptures.

BET29 Damage to clothing or sports equipment when in use.

BET30 Loss due to customs or any other authority legally taking or destroying your belongings.

BET31 Loss of, or damage to, stamps, documents, deeds, manuscripts or securities of any kind.

BET32 Loss of, or damage to, goods, samples or tools hired or held in trust by you, that you do not own.

BET33 Loss of, or damage to, jewellery or photographic equipment carried in your baggage unless with you at all times.

BET34 Loss of, or damage to, contact or corneal lenses.

BET35 Loss or theft of cash, traveller's cheques, postal or money orders, passports, travel documents, or any valuables not personally carried by you, unless held in a safety deposit box or safe that is not in your room or apartment.

Data Protection

We are committed to protecting your personal data and privacy. Any personal information that we collect will be kept confidential and will be processed in accordance with relevant legislation and our own strict internal policy.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to law enforcement or other legal agencies, governmental or judicial bodies, or to regulators.

Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.

If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

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

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

Complaints

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

Archipelago Life Insurance Limited
B-08-06 Gateway Corporate Suites
Gateway Kiaramas
No 1 Jalan Desa Kiara
Mont Kiara
50480 Kuala Lumpur
Malaysia

Telephone: +603 620 108 99

Fax: +603 620 104 81

Email: customerservice@archipelagolife.com

Your complaint will be handled in a fair and timely manner and in accordance with relevant regulation.

Please give your plan number and claim number (if this applies) with as much information as you can about your complaint, as well as your full contact details.

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

How you can help us contain your premium

Fraud, let's beat it together

Healthcare fraud increases premiums for our customers and we do our very best to eliminate it.

There may only be a relatively small number of individuals or providers who engage in medical insurance related fraud, but maladministration, including innocent and careless overcharging for treatments and services, also raises the cost of medical insurance.

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

Fraud is a crime

Examples of fraud include:

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

Examples of maladministration include:

- duplicate billing;
- incorrect billing for treatments or services; and
- providing unnecessary treatments or services.

Here are some simple steps you can take to help protect yourself and keep premiums down:

- Compare invoices with your records. Check the dates are correct and the treatments or services were actually provided to you.
- Ask questions if you do not understand, or if there are any discrepancies.
- Liaise closely with us in the event of a claim.
- Contact us if you are concerned that your medical practitioner is providing treatment that is not necessary for you.
- Carefully complete any Claim forms. If there is anything you do not understand or are unsure of, please ask us.
- Look after your insurance details and documentation.
- Make sure you understand any documentation before you sign.
- Keep copies of any documentation and correspondence.
- Report suspected fraud to us.

We are committed to protecting you against fraud and also have statutory responsibilities to prevent our products from being used as a vehicle for financial crime.

We operate strict controls to deter, prevent, detect and investigate fraud.

We work closely with others to prevent fraud

We work with InterGlobal, a member of the Health Insurance Counter Fraud Group (HICFG), to prevent and detect fraud.

We also work in conjunction with other insurance providers and the following organisations to prevent and detect fraud;

- International Insurance bodies;
- International Police and Investigative agencies; and
- Governmental departments.

Suspect fraud?

Fraud and Investigation referrals:

fraudgovernance@interglobalpmi.com

Fraud and Investigation Confidential telephone line:

+44 (0)1252 745 990 (ext 5990)

Definitions

Abuse – the excessive use of alcohol, drugs or any other intoxicating substance. This includes use of drugs in a manner or in quantities other than as directed or prescribed on medical authority or for a reason other than that for which it was originally prescribed.

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

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

Area of cover – the geographic area of the world in which your plan applies. This is shown on your Certificate of Insurance.

Benefit – the cover provided by your plan and any extensions or restrictions shown in your Plan guide, Certificate of insurance or Table of benefits.

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

Bodily injury – any physical harm or damage to you.

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

Card – Visa or MasterCard.

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

- needs ongoing or long-term monitoring through consultations, examinations, checkups or tests;
- needs ongoing or long-term control or relief of symptoms;
- needs rehabilitation or special training to cope with it;
- continues indefinitely;
- has no known cure;
- comes back or is likely to come back.

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

Close family member – a son, daughter, stepson, stepdaughter, legally adopted son, legally adopted daughter, husband, wife, partner, parent, step-parent, legally adoptive parent, parent-in-law, grandparent, grandchild, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law or legal guardian.

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

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

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

Continuation of Personal Medical Exclusions – continuation of the same underwriting terms, including any special exclusions, that applied to you with a previous insurer. The underwriting terms with us can be CPME previously moratorium or CPME previously FMU. You will not be subject to any new personal underwriting terms. Cover will still be governed by the benefits, terms and conditions of your plan with us. See the 'Transfers' or 'Group member transfers' section and the CPME previously moratorium and CPME previously FMU definitions in this Plan guide for more information.

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

CPME – see Continuation of Personal Medical Exclusions.

CPME previously FMU – continuation of your full medical underwriting terms with a previous insurer. You will not be subject to any new personal underwriting terms. Cover will still be governed by the benefits, terms and conditions of your plan with us, including benefit exclusion BE2. Benefit exclusion BE1 will not apply.

CPME previously moratorium – continuation of your moratorium start date if you had moratorium underwriting terms with a previous insurer. You will not be subject to any new personal underwriting terms. Cover will still be governed by the benefits, terms and conditions of your plan with us, including benefit exclusion BE1. Benefit exclusion BE2 will not apply.

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

Curtailed, curtailment – you abandon a trip.

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

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

Deductibles – any co-insurance or excess that applies to your plan.

Dental – that which affects the teeth and gums.

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

- husband, wife or partner;
- unmarried child, stepchild or legally adopted child under the age of 18;
- unmarried child, stepchild or legally adopted child aged 18 to 24 who is in continuous full-time education. We may need written proof from the educational facility where they are enrolled.

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

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

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

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

- **Excess for each visit** - you must pay this excess for each consultation with a medical practitioner or specialist, no matter how many medical conditions are treated by them during one consultation.
- **Excess for each medical condition** - this excess applies to each medical condition claimed in each plan year. For example, if you make four claims for two medical conditions, you must pay two excesses in the plan year.
- **Excess for each member** - this excess applies to you once every plan year, no matter how many claims you make in each plan year.
- **Excess for each claim** - you must pay this excess for each claim you make.

FMU – see Full Medical Underwriting.

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

Full Medical Underwriting – the process that we use to assess your medical history and decide the special terms we offer you. Cover will still be governed by the benefits, terms and conditions of your plan with us except for benefit exclusion BE1.

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

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

Hospital – a legally licensed facility providing treatment under the laws of the country in which it is located.

Immediate family – a blood relative.

Inherited – a **medical condition** which is hereditary.

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

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

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

Lifetime limit – the total amount that will be paid for any eligible costs incurred during any time you are covered on any one or more plans with the same, or equivalent benefit, even if there is a break in your cover. See benefit condition BC8 for more information.

Main member – the person who is named first on a valid Certificate of insurance.

Material fact – information, as follows, which is likely to influence us in the assessment, acceptance or renewal of a plan or in making any changes to it:

- about you, your lifestyle, health or medical conditions, that we have asked you questions about;
- about the planholder and any members, including dependants, where we have asked the planholder or plan administrator questions;
- that you, the planholder or plan administrator have chosen to give to us; or

- that we have not asked the **plan administrator** or **planholder** of a group **plan** any questions about, but which the **plan administrator** or **planholder** must disclose to us.

If there is any doubt about whether a fact is material, for **your own protection**, you must tell us.

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

Medical History Disregarded – we will cover **pre-existing medical conditions** suffered by you, subject to the **benefits**, terms and conditions of **your plan**. **Benefit** condition BC5 and **benefit** exclusions BE1 and BE2 will not apply.

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

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

Member – see you, your, yourself.

MHD – see **Medical History Disregarded**.

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

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

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

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

Our – see us.

Out-patient treatment – **treatment** in a **hospital**, consulting room or clinic when you do not need a bed.

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

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

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

Plan – the contract between the **planholder**, you and us.

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

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

Plan start date – the date the **plan** begins each year.

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

Pre-authorise, pre-authorised, pre-authorisation – the process you must follow to obtain approval from us before receiving **treatment** or services, or incurring costs.

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

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

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

Professional sports – any sport that you are paid to engage in and where any payment received is the main source of your income.

Psychiatric – that which affects your mind, mental function or emotions, whether the cause is organic, traumatic or reactive.

Public transport – any paid and licensed form of transport.

Reasonable – the average cost of **treatment**, expertise or services given by similar types of provider:

- within the same country or geographical region; and
- based on our experience and knowledge.

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

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

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

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

Specialist – a **medical practitioner** who is practising and has a recognised:

- certificate of higher specialist training;
- consultant appointment or equivalent;

in the relevant field of medicine in the country where **treatment** is provided.

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

Terminal – the end stages of a **medical condition** where life expectancy is considered to be days or weeks and only **palliative treatment** is given.

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

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

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

UltraCare plan – the healthcare plan.

Us – the insurer as shown on the **Certificate of insurance**.

Valuables – photographic, audio, video, computer or electrical equipment of any kind, mobile phones, glasses, sunglasses, binoculars, telescopes, musical instruments, antiques, fine art, furs, leather goods, animal skins, watches, jewellery, and any items made of, or containing, gold, silver, precious metals, precious or semi-precious stones.

Vehicle – any mode of transport that carries people on land, water or by air.

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

We – see us.

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

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Archipelago

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An Aetna Company

Whenever coverage provided by any insurance policy would be in violation of any US, UN or EU economic or trade sanctions, such coverage shall be null and void. For example, we cannot pay for health care services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Asset Control (OFAC) license. Learn more on the US Treasury's website at: www.treasury.gov/resource-center/sanctions.

Archipelago Life Insurance Limited. Registered in Labuan. Licence No. IS2013141. Company No. LL09829. B-08-07 Gateway Corporate Suites, Gateway Kiaromas, No. 1 Jalan Desa Kiara, Mont Kiara, 50480 Kuala Lumpur, Malaysia. Tel. +603 6201 0899 F. +603 6201 0481 Email customerservice@archipelagolife.com

All plans are underwritten by Archipelago Life Insurance Limited and administered by Aetna Global Benefits (UK) Limited, registered in England (Company Registration No. 03554885), which is authorised and regulated by the Financial Conduct Authority (Firm Reference No. 312279), Woolmead House East, The Woolmead, Farnham, Surrey, GU9 7TT, United Kingdom.

Archipelago Life Insurance Limited is licensed by Labuan FSA, Company No. LL09829, Licence No. IS2013141. Registered office address: Level 1, Lot 7, Block F, Saguking Commercial Building, Jalan Patau-Patau, 87000 Labuan FT, Malaysia.

InterGlobal Limited has changed its name to Aetna Global Benefits (UK) Limited. The company will continue to trade under the 'InterGlobal' brand until further notice.

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