

Certificate of Enrollment

AETNA LATIN AMERICA & CARIBBEAN PLAN
EFFECTIVE 1ST MAY 2010

AETNA
GLOBAL
BENEFITS®

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This **Certificate of Enrollment** (“Certificate”) has been issued to **You** as evidence of the acceptance of **Your Application for Enrollment** in the Aetna Latin America & Caribbean Plan, a plan established in a **Policy** of group health insurance (“**Policy**”) delivered to Butterfield Trust (Bermuda) Limited as agent of the Aetna Global Benefits Trust domiciled in Bermuda and which is effective from 1 May 2010. This Certificate, which summarizes the **Benefits**, limitations, exclusions and other terms and conditions of the **Policy**, is not a **Policy** of insurance.

Introduction

You and any of **Your Eligible Persons**, for whom the required premiums have been paid, are eligible for coverage under the Plan, and upon satisfaction of all required conditions of eligibility and submission and approval of an **Application for Enrollment** shall be considered **Enrolled Persons** entitled to the **Benefits** set forth in the **Policy**, subject to all limitations and exclusions set forth in the **Policy**. The **Insurer** of **Your** plan is Aetna Life & Casualty (Bermuda) Ltd., which is solely responsible for the payment of all covered **Benefits**. The plan is managed and administered by Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits and the persons and companies to whom Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits has delegated administrative responsibility. References to **We** and **Us** in this Certificate are to Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits, acting on behalf of Aetna Life & Casualty (Bermuda) Ltd., the **Insurer** of **Your** plan, who is identified in this Certificate as the “**Insurer**.”

Coverage is subject to the terms, conditions, exclusions, and limitations established in the **Policy**. As a Certificate, this document describes the provisions of the **Policy** but does not constitute the **Policy** nor is it a substitute for the **Policy**. In the event of a conflict between the provisions of the **Policy** and this Certificate, the provisions of the **Policy** will prevail. A copy of the **Policy** will be provided to **You** upon request. The first time that a copy is requested, the copy will be provided without charge. For subsequent requests, **You** will be charged a fee for each copy provided. A copy of the **Policy** is also available for inspection at the head office of the Butterfield Trust (Bermuda) Limited in Hamilton, Bermuda, during regular business hours.

This Certificate replaces and supersedes any Certificate, Terms and Conditions of Coverage, or any other coverage instrument previously delivered to **You**. This Certificate will in turn be superseded by any subsequent Certificates issued to **You**.

How to Use this Certificate

This Certificate should be read and re-read in its entirety. Many of the provisions of this Certificate are interrelated; therefore, just reading one or two provisions may give **You** a misleading impression.

Many words used in this Certificate have special meanings; these words will appear capitalized and are defined for **You**. By using these definitions, **You** will have a clearer understanding of this Certificate.

From time to time, the **Policy** and this Certificate may be amended. When that happens, a new Certificate or Amendment pages for this Certificate will be sent to **You**. **Your** Certificate should be kept in a safe place for **Your** future reference.

Administration

The management and administration of the **Policy** with respect to collection of premiums and handling of claims has been delegated by the **Insurer** to Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits. Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits may, in turn, delegate all or part of its administrative duties to any third party indicated by Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits, with the exception of the authority to underwrite or to decide whether all or part of a claim is covered and the amount payable for covered claims. Authority for deciding whether all or part of a claim is covered and the amount payable for a covered claim shall reside with Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits and be exercised by that entity in Bermuda. Claims, however, should be submitted to the entity and at the location indicated in this Certificate or any attachment to this Certificate.

DEFINITIONS

To help **You** understand this Certificate, the following words and phrases used anywhere within this Certificate have specific meanings, which are set out in this section. To enable **You** to recognize the defined words and phrases **We** have shown them in bold wherever they appear in this Certificate.

Accident:

An unexpected, unforeseen and involuntary external event resulting in injury occurring whilst this Certificate is in force.

Act of Terrorism:

An act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

Acute:

A **Medical Condition**, which is brief, has a definite end point and which **We**, on **Medical Advice**, determine responds to and can be cured by **Treatment**.

Advice:

Any consultation by a **Physician** or **Specialist Physician** including the issue of **Drugs and Dressings** or repeat prescriptions.

Appliances:

Devices and equipment when used as an integral part of a surgical procedure and is administered by a **Physician** or **Specialist Physician**.

Application for Enrollment:

The form completed and executed by **You** and submitted to **Us** for consideration and approval of **Your** enrollment and the enrollment of the other **Eligible Persons** listed on the **Application for Enrollment**.

Benefits:

The insurance coverage provided by this **Policy** and any extensions or restrictions shown in the **Schedule of Coverage** or in any endorsements (if and where applicable).

Bodily Injury:

Injury, which is caused solely by an **Accident** which results in the **Enrolled Person's** dismemberment, disablement or other physical external injury.

Certificate of Enrollment:

This document and **Your Schedule of Coverage** prepared from **Your Application for Enrollment**.

Chronic:

A **Medical Condition** or **Related Condition** lasting a long time with no definite end point or one which **We**, on **Medical Advice**, determine does not respond to **Treatment** or cannot be cured by **Treatment**.

Co-Insurance:

The percentage of the total value of the incurred expenses for which the **Enrolled Person** is responsible for each and every **Medical Condition** for each **Period of Coverage**.

Commencement Date:

The date shown on the **Schedule of Coverage** on which coverage under this **Policy** commences. For the purpose of this **Policy**, coverage starts from 00:01 am on the date shown on the **Schedule of Coverage**.

Congenital Anomaly:

Intrauterine development of an organ or structure that is abnormal with reference to form, structure or position.

Convalescence:

Physical, occupational or speech therapy, vocational guidance, independent living **Advice** and exercises, retraining, educational pursuits and other services given to an **Enrolled Person** following an eligible **Medical Condition**, to assist the **Enrolled Person**, as much as is reasonably possible, to readapt to life in the community and/or to restore them to the state of health they enjoyed prior to such **Medical Condition** occurring.

Convalescent Facility:

An institution licensed to provide 24-hour chargeable **Qualified Nurse** care, through supervision by a full-time **Physician**, and physical restoration services to help patients achieve self-care in daily living activities. This does not extend to any institution providing long term care for the elderly, custodial or educational care or for care of mental disorders.

Country of Nationality:

For the purpose of this **Policy**, this will be the country to which the **Enrolled Person** holds a passport.

Country of Residence:

The country in which the **Enrolled Person** has his/her habitual residence (residing for a period of no less than six months per **Period of Coverage**) at the time this **Certificate of Enrollment** is first issued or at each subsequent **Renewal Date**.

Date of Entry:

The date shown on the **Schedule of Coverage** on which an **Enrolled Person** was first included under this Certificate.

Day-Patient:

Treatment in a defined **Medical Facility** where the patient is admitted to a bed but does not stay overnight.

Deductible:

The amount payable by an **Enrolled Person** in respect of expenses incurred for **Treatment** before any **Benefits** are paid under this Certificate for each **Period of Coverage**.

Dental Practitioner:

A person who is licensed by the relevant licensing authority to practice dentistry in the country where the dental **Treatment** is given.

Drugs and Dressings:

Drugs, medicines and dressings prescribed by a **Physician** or **Specialist Physician**.

Eligible Person:

A person that satisfies the requirements for enrollment. An **Eligible Person** is one who is either **Your** spouse or adult partner, or **Your** unmarried children who are not more than 18 years old and residing with **You**, or **Your** unmarried children who are not more than 23 years old if in full time education, at the **Date of Entry** or at any subsequent **Renewal Date**. Children under the age of 18 years old not residing with **You**, will be accepted for coverage providing the application is signed by a legal parent or guardian. (The term partner shall mean husband, wife or the person permanently living with **You** (whether or not of the same sex) in a similar relationship). All **Eligible Persons** must be named as **Enrolled Persons** in the **Schedule of Coverage**.

Emergency:

A sudden, serious, unexpected and unforeseen condition or illness that causes severe symptoms requiring immediate medical care, and constituting a hazard for life, health or physical well-being.

Enrolled Person:

You and/or the **Eligible Persons** identified in the **Schedule of Coverage** as an "Enrolled Person."

Evacuation:

Costs incurred in moving an **Enrolled Person** from the place of incident to the nearest appropriate **Medical Facility**, as determined by the attending **Physician** in conjunction with **Our** medical advisors in the event of an **Emergency**. All airline tickets will be limited to economy class.

Hereditary:

Transmitted from parents to offspring, inherited and which presents symptoms at birth.

Home Health Care:

Treatment made in the home of the **Enrolled Person**.

Home Health Care Provider:

A health care worker with sufficient training and qualifications to comply with any relevant regulation within the country in which the **Treatment** is undertaken who provides basic nursing care. In the USA, such health care workers should be LPN or RN qualified.

Hospice:

A **Medical Facility** providing **In-Patient Hospice Care** to patients with **Terminal Illness**.

Hospice Care:

Palliative Treatment and supportive care given to patients diagnosed by a **Physician** or **Specialist Physician** as having a **Terminal Illness**.

Hospital:

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

In-Patient:

An **Enrolled Person** who is admitted to a bed in a **Medical Facility** for one or more nights solely to receive **Treatment**.

Insurer:

Aetna Life & Casualty (Bermuda) Ltd.

Medical Advice:

Notice from the relevant professional body as to established medical practice and/or established medical opinion in relation to any **Medical Condition** or **Treatment**.

Medical Condition:

Any injury, illness or disease including psychiatric illness.

Medical Facility:

A **Hospital**, **Hospice** or **Convalescent Facility** that:

- a) Provides 24 hour nursing care by **Qualified Nurses**.
- b) Is supervised full-time by a **Physician**.
- c) Has at least one **Physician** on call at all times.
- d) Keeps a complete medical record of each patient.
- e) Has a full-time administrator.
- f) Meets any licensing or certification standards of the country where it is situated.
- g) Is a fee-charging establishment.

Medically Necessary:

A medical service or **Treatment** which in the opinion of a qualified **Physician** is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the **Enrolled Person's** condition or the quality of medical care rendered.

Out-Patient Treatment:

Treatment of an **Enrolled Person** by a **Physician** or **Specialist Physician**, but where the **Enrolled Person** is not admitted to a bed in a **Medical Facility**.

Palliative Treatment:

Any **Treatment**, which is, on **Medical Advice**, for the purpose of offering temporary relief of symptoms and where it is not given to cure the **Medical Condition** causing the symptoms.

Period of Coverage:

The **Period of Coverage** set out in the **Schedule of Coverage**. This will be a twelve month period starting from the **Commencement Date** or any subsequent **Renewal Date**.

Physician:

A person who has attained primary degrees in medicine or surgery by attending a medical school recognized by the World Health Organization and who is licensed by the relevant authority to practice medicine in the country where the **Treatment** is given.

Physiotherapist:

A person who is registered as a **Physiotherapist** and licensed to practice in the country in which **Treatment** is given.

Policy:

Our contract of insurance with **You** providing coverage as detailed in this **Certificate of Enrollment**. The application form and **Schedule of Coverage** form part of the contract and must be read together with this **Policy**.

Preferred Care Provider:

A health care provider that has contracted to supply services for a pre-agreed charge and is included in **Our** directory of **Medical Facilities** named as **Preferred Care Providers**. **You** are entitled to ask **Us** for a list of **Preferred Care Providers**.

Prosthesis:

An artificial body part. Under this **Policy**, prosthesis will be limited to an artificial limb or eye.

Psychiatric Physician:

A **Physician** specializing in psychiatry or who has the training or experience recognized in the country in which they are a resident to do the required evaluation and **Treatment** of psychiatric illness.

Qualified Nurse:

A qualified and licensed resident or daily nurse whose name is on any register or roll of nurses, maintained by any statutory registration body within the country in which they are a resident.

Reasonable and Customary Charges:

The average amount charged in respect of valid services or **Treatment** costs, as determined in **Our** experience in a particular country, area or region and substantiated by an independent third party, being a practicing **Physician**, **Specialist Physician** or Government Health Department.

Related Condition:

Any **Medical Condition** is a **Related Condition** if **We**, on **Medical Advice**, determine that one is the direct result of the other or if each is a result of the same injury, illness or disease.

Renewal Date:

The annual anniversary of the **Commencement Date**.

Room and Board:

Charges made by a **Medical Facility** for the provision of a room, bed and other necessary services made on a daily or weekly standard-private room rate.

Schedule of Coverage:

The schedule giving details of the **Enrolled Person** eligible for coverage, the **Benefits** applicable and any extensions, restrictions or endorsements applicable.

Specialist Physician:

A registered **Physician** who:

- a) Currently holds a substantive consultant appointment in that specialty in a **Medical Facility**;
- b) Currently holds a substantive consultant appointment which **We** on professional **Advice** or **Medical Advice** accept as being of equivalent professional status, or
- c) Is recognized as such by the statutory bodies of the relevant country.

Treatment:

Surgical, medical or other procedures, the sole purposes of which are the cure or relief of a **Medical Condition**.

Terminal Illness:

A medical prognosis of six months or less to live.

We/Our/Us:

Aetna Life & Casualty (Bermuda) Ltd, trading as Aetna Global Benefits.

You/Your:

The person identified in the **Schedule of Coverage** as the **Enrolled Person** who applied for enrollment in the **Policy**.

BENEFITS

The **Insurer** will provide insurance within the terms of the **Policy**, in respect of a **Medical Condition** (including those as a result of an **Accident**) that first manifests itself during the **Period of Coverage**.

The **Policy** provides for medical expenses insurance only and is not insurance for the disease or injury itself. No **Benefits** are payable for medical expenses before the **Date of Entry**, after the **Period of Coverage** has expired or after the coverage has terminated, even if the expenses were incurred as a result of an **Accident** or **Medical Condition** which occurred, commenced or existed during the **Period of Coverage**.

The following **Benefits** are covered up to US\$1,000,000 under the Silver/Gold Option and US\$2,000,000 under the Platinum Option per **Enrolled Person** per **Period of Coverage**, subject to any specific limits set out under each **Benefit** and subject to the payment of all **Co-Insurance** and **Deductible(s)** as set out in section headed **Limits of Coverage** in this Certificate and/or as stated in **Your Schedule of Coverage**. All **Benefits** are subject to all medical expenses covered being no more than **Reasonable and Customary Charges**.

1. Physician and Specialist Physician Fees:

- a) **Physician** and **Specialist Physician** fees including consultations.
- b) Diagnostic and surgical procedures, including pathology, X-rays, MRI and CT scans.
- c) Anaesthetist fees.
- d) **Physiotherapy** on referral by a **Specialist Physician** to a **Physiotherapist**. A referral letter from a **Specialist Physician** must be submitted with the first claim for such **Treatment**. **Benefits** will be restricted to 10 sessions without a written report. After this time a written report must be produced and submitted to **Us** for review by the **Specialist Physician** before **Treatment** can continue. Any **Benefits** for such **Treatment** of more than 10 sessions will be at **Our** absolute discretion.
- e) **Treatment** administered by registered chiropractors, osteopaths, homeopaths and acupuncturists under the direct control of and following referral by a **Specialist Physician**. This **Treatment** is limited to 10 sessions in aggregate per **Medical Condition**. A referral letter by a **Specialist Physician** must be submitted with the first claim for such **Treatment**.

2. Medical Facility and Home Health Care Charges:

- a) **Hospital** charges:
 - i) Operating room fees and other charges incurred for the **Treatment** of a **Medical Condition**.
 - ii) **Room and Board** costs, limited to a standard private room rate, and associated charges, including admittance to the intensive care unit, and charges for nursing by a **Qualified Nurse**.
 - iii) Charges for applicable service and supplies as set out in 2(a)(i) and (ii) above for **Day-Patient** and **Out-Patient Treatment**.

- b) **Convalescent Facility** charges:

Admission to a **Convalescent Facility** must follow **Treatment** for a **Medical Condition** where the **Enrolled Person** was confined to a **Hospital** as an **In-Patient** for at least three consecutive days, and where a **Physician** confirms in writing that **Convalescence** is required. Admission to a **Convalescent Facility** must be made within 14 days of discharge from **Hospital**.

Such **Treatment** would cover:

- i) Use of special **Treatment** rooms.
- ii) Physical, occupational or speech therapy fees.
- iii) Other services usually given by a **Convalescent Facility** including **Qualified Nurse** care but not including private or special nursing or **Specialist Physician** services. **Benefit** is limited to 30 days for each **Medical Condition** or **Related Condition**.

- c) **Home Health Care** charges:

Treatment made in the home of the **Enrolled Person**. Such **Treatment** will cover:

- i) Part-time or intermittent care by a **Qualified Nurse**.
- ii) Part-time or intermittent services of a **Home Health Care Provider**.
- iii) Laboratory services.

Home Health Care Benefits are limited to 30 visits. Each visit by a **Qualified Nurse** or **Home Health Care Provider** of up to four hours duration is classed as one visit. Each visit of more than four hours duration will be classed as two or more visits, each visit being deemed to compose of four hours of services provided. All **Treatment** under this **Benefit** is conditional upon precertification by **Us**. Without **Our** written consent prior to **Treatment**, the **Insurer** will not be liable to pay any **Benefit**.

- d) General charges applicable to all **Medical Facilities**:
 - i) **Room and Board** costs, limited to a standard private room rate and associated charges.
 - ii) **Drugs and Dressings**.
 - iii) Diagnostic x-ray and laboratory work.
 - iv) Anaesthetics.
 - v) Oxygen and gas therapy.

3. **Drugs and Dressings:**

Limited to US\$2,000 (Gold Option) or US\$3,000 (Platinum Option) per **Enrolled Person** per **Period of Coverage** for any **Drugs and Dressings** prescribed for **Out-Patient Treatment**.

(Note: This limit does not apply to the **AIDS Benefit 6**.)

4. **Reconstructive Surgery:**

Reconstructive surgery following an **Accident** or following surgery for an eligible **Medical Condition**, provided such surgery is carried out at a medically suitable stage after the **Accident** or surgery has occurred. Surgery, in any event, must be carried out within 365 days from the date of the **Accident** or **Medical Condition** subject to **Policy** coverage being maintained throughout such period.

5. **Psychiatric Illness:**

- i) **Out-Patient Treatment**, including **Psychiatric Physician** and **Specialist Physician** consultations.
- ii) **In-Patient Treatment** in a recognized psychiatric unit of a **Hospital**, limited to 28 days per **Period of Coverage**.

All **Treatment** under this **Benefit** is conditional upon precertification from **Us** and must at all times be administered under the direct control of a registered **Psychiatric Physician**. Without **Our** written confirmation prior to such **Treatment**, **Insurer** will not be liable to pay any **Benefit**. However, initial consultation with a **Physician** (not a **Psychiatric Physician**), which results in a psychiatric referral, is covered without the requirement for precertification.

6. **AIDS:**

Medical expenses that arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof. Expenses are limited to pre- and post-diagnosis consultations, routine check-ups for this condition, **Drugs and Dressings** (except experimental or those unproven), **Room and Board** and **Qualified Nurse** fees. The **Benefit** provided in respect of AIDS is not for an **Acute Medical Condition** and this is provided solely and purely as an extension of coverage only in relation to AIDS.

Limited to US\$40,000 in the lifetime of the **Enrolled Person** and subject to **Policy** coverage being maintained throughout such period.

7. **Accidental Damage to Teeth:**

Treatment received in an **Emergency** room in a **Hospital** within seven days of incurring accidental damage caused to sound, natural teeth that were firmly attached to the jaw bone at the time of injury, when given by a **Physician** or **Dental Practitioner**.

Coverage is limited to:

- i) The first denture or fixed bridgework to replace lost teeth.
- ii) The first crown needed to repair each damaged tooth.

8. **Chronic Conditions:**

Coverage under this Certificate is extended to include routine management incurred in connection with a **Chronic Medical Condition**.

Expenses are limited to routine check-ups associated with the **Chronic** condition, **Physician** fees, **Drugs and Dressings** prescribed for management of the condition (limited to US\$2,000 (Gold Option) or US\$3,000 (Platinum Option) per annum in the aggregate with **Benefit 3**), nursing, surgery and **Palliative Treatment**. Coverage is restricted to new **Medical Conditions** that have not been previously suffered from, whether or not diagnosed, occurring after the **Date of Entry** of this Certificate.

9. **Maternity Coverage:**

Costs associated with pregnancy and childbirth and any **Related Condition** incurred after the first 12 months following the purchase date of this **Benefit** or the **Date of Entry**, whichever is the later. **Benefits** are limited to childbirth, pre- and post-natal check-ups and delivery costs, including caesarean section costs required on medical grounds. All costs relating to a pregnancy and/or childbirth following assisted conception will be limited to this **Benefit**. The **Benefit** is limited to US\$5,000 (Gold Option) or US\$7,500 (Platinum Option) for each pregnancy or to a limit of US\$9,500 (Gold Option) or US\$12,000 (Platinum Option) for caesarean sections required on medical grounds. This **Benefit** is available to all **Enrolled Persons** of 18+ years of age. The **Co-Insurance** applicable for this **Benefit** is 20% when care is received within the United States at facility that is not a **Preferred Care Provider** and is not subject to the **Co-Insurance** maximum limits on the **Policy**.

10. **Complications of Pregnancy:**

Treatment of a **Medical Condition** that arises during the antenatal stages of pregnancy, or a **Medical Condition** that arises during childbirth and requires a recognized obstetric procedure (excluding caesarean sections required on medical grounds). This **Benefit** is not available within the first 12 months from the purchase date of this **Benefit** or the **Date of Entry**, whichever is the later.

11. **Newborn Care:**

In-Patient Treatment of a **Medical Condition** being suffered by a newborn baby born from a covered maternity, which presents symptoms at birth or whose symptoms can be traced to birth. Coverage is limited to US\$250,000 per lifetime for any and all conditions under this **Benefit**.

12. **Parent Accommodation:**

Room and Board in respect of a Parent or Legal Guardian staying with an **Enrolled Person** who is under 18 years of age and is admitted as an **In-Patient** in a **Hospital**.

13. **Hormone Replacement Therapy:**

Physician or **Specialist Physician** consultations and the cost of prescribed implants, patches or tablets when **Treatment** is prescribed solely for the purpose of hormone imbalance. Coverage is provided for female menopause that has been induced artificially and/or through early onset (by early onset **We** mean prior to age 40 years). Coverage does not extend to **Treatment** of hormone imbalance due to naturally occurring menopause.

14. Newborn Accommodation:

Hospital accommodation costs relating to a newborn baby to accompany its mother (being an **Enrolled Person**) whilst she is receiving **Treatment** as an **In-Patient** in a **Hospital**.

15. Emergency Transportation:

Transportation costs to and from a **Hospital** by the most appropriate transport method (including licensed air ambulance but excluding all other forms of air transportation) in the event of an **Emergency** where considered **Medically Necessary** by a **Physician** or **Specialist Physician**. Costs for air ambulance, which has not been pre-certified by **Us**, are limited to US\$2,000 per incident.

16. Evacuation:

Evacuation costs of an **Enrolled Person** in the event of **Emergency Treatment** not being readily available at the place of the incident, to the nearest appropriate **Medical Facility**, for the purpose of admission to a **Medical Facility** as an **In-Patient** or **Day-Patient** (excluding normal maternity or childbirth costs, but extended to include **Benefit 10 – Complications of Pregnancy**). **Evacuation** is subject to pre-certification by **Us** prior to travel and certified instructions from the attending **Physician** or **Specialist Physician**, including confirmation that the required **Treatment** is unavailable in the place of incident. Extended to cover the costs for one other person to travel with the **Enrolled Person**, as an escort, if **Medically Necessary**. Our medical advisors will decide the most appropriate method of transportation for the **Evacuation** and the most appropriate **Medical Facility** to which the **Enrolled Person** will be evacuated.

17. Additional Travel Expenses Following Evacuation:

Travel costs:

- i) To and from medical appointments when **Treatment** is being received as a **Day-Patient** up to a daily limit of US\$25.00.
- ii) For an accompanying person to travel to and from the **Hospital** to visit the **Enrolled Person** following admission as an **In-Patient** up to a daily limit of US\$25.00.
- iii) Up to US\$50.00 per day per person for non-**Hospital** accommodation only for immediate pre- and post-**Hospital** admission periods provided that the **Enrolled Person** is under the care of a **Specialist Physician**. Economy class airline ticket to return the **Enrolled Person** and one other person who has traveled as an escort to **Enrolled Person's Country of Residence** or to the country where **Evacuation** occurred. All additional travel costs under this section are limited to total of US\$10,000 per **Evacuation**.

18. Mortal Remains:

In the event of death from an eligible **Medical Condition**:

- i) Costs of transportation of body or ashes of an **Enrolled Person** to his/her **Country of Nationality** or **Country of Residence**.

or

- ii) Burial or cremation costs at the place of death in accordance with reasonable and customary practice. This **Benefit** is limited to US\$10,000 per **Enrolled Person**.

19. External Protheses:

The costs of any artificial eyes or limbs following **Treatment** for an eligible **Medical Condition** or as a result of an **Accident**.

Coverage is limited to a lifetime **Benefit** of US\$5,000 per **Enrolled Person**.

20. Organ Transplant

Benefit is limited to US\$250,000 per covered transplant.

Covered transplants are:

- a) Heart
- b) Heart/lung
- c) Lung
- d) Kidney
- e) Kidney/pancreas
- f) Liver
- g) Allogenic bone marrow
- h) Autologous bone marrow

21. Wellness Benefit:

(Platinum Plan Only) The cost of one annual routine medical checkup (limited to US\$250 per **Policy** year) and associated tests and the cost of **Medically Necessary** vaccinations or inoculations. Such routine check-ups/tests to include:

- a) Blood and cholesterol checks
- b) Height/weight body mass index
- c) Resting blood pressure
- d) Urine analysis
- e) Cardiac examination
- f) Bilateral mammogram/breast examination
- g) Testicular/prostate examination/PSA/DRE Tests
- h) Exercise electrocardiogram (ECG)
- i) Well-baby checks including physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as **Hereditary** and metabolic screening at birth, immunizations, urine analysis, tuberculin tests and hematocrit, hemoglobin and other blood tests, including tests to screen for sickle hemoglobinopathy; all as recommended by a **Physician** or **Specialist Physician**. Limited to a maximum of six (6) consultations per newborn per annum from birth until the dependent child reaches the age of two years.
- j) Routine gynecological tests, including Pap tests.
- k) Vaccinations, including those **Medically Necessary** for travel.

22. Gold and Platinum plans only:

Medical expenses that arise from or are in any way related to End Stage Renal Disease (ESRD), including dialysis. Expenses are limited to pre- and post-diagnosis consultations, routine check-ups for this condition, **Drugs and Dressings** (except experimental or those unproven), **Room and Board** and **Qualified Nurse** fees. The **Benefit** provided in respect of ESRD is not for an **Acute Medical Condition** and this is provided solely and purely as an extension of coverage only in relation to ESRD.

Limited to US\$20,000 in the lifetime of the **Enrolled Person** and subject to **Policy** coverage being maintained throughout such period.

EXCLUSIONS

This **Policy** does not cover expenses arising from:

1. Any **Medical Condition** or **Related Condition** for which the **Enrolled Person** has received **Treatment**, had symptoms of, or sought **Advice** for prior to the **Enrolled Person's Date of Entry** (pre-existing **Medical Condition**), unless it had been declared as a material fact at the time of application and accepted in writing by **Us**.
2. Any **Medical Condition** arising within the first 90 days from the **Date of Entry**, where such a **Medical Condition** had not been as a result of an **Accident** or disease of infectious origin.
3. **Treatment** that **We** determine on **Medical Advice** is either experimental or unproven.
4. **Chronic** supportive **Treatment** of renal failure, including dialysis. **We** will, however, pay for the cost of renal dialysis incurred: (Exclusion applies only to the Silver Plan)
 - a) Immediately pre- and post-operatively.
 - b) In connection with **Acute** secondary failure when dialysis is part of intensive care.
5. No coverage will be provided under this **Policy** where **Treatment** or **Advice** of any **Medical Condition** whatsoever, whether related or not, was as a result of autotherapy (self administered) or where such **Treatment** or **Advice** had been given by a relative, including but not limited to, spouse, partner, parent, grandparent, child or guardian.
6. Birth injuries, **Congenital Anomalies**, genetic deformities or **Hereditary Medical Conditions** with symptoms present prior to the **Date of Entry**. Coverage is extended to newborn care under **Benefit 11** of this Certificate, to a maximum of US\$250,000.
7. Routine physical examination by a **Physician**, including gynecological investigations, routine tests, newborn neo-natal care, inoculations, vaccinations (with the exception of **Benefit 20, Wellness Benefit**) and preventative medicines, normal eye tests, normal hearing tests, non-medical/natural degenerative eye defects including, but not limited to, myopia, presbyopia and astigmatism, and any corrective surgery for non-medical/natural degenerative hearing defects.
8. **Convalescence** unless it forms an integral part of **Treatment** received as an **In-Patient** and is under the control or supervision of a **Specialist Physician** and is undertaken in a recognized **Convalescent Facility** or as **Home Health Care**.
9. **Treatment** received in health spas, nature cure clinics, spas or similar establishments or private beds registered as a **Medical Facility** or nursing home attached to such establishments or a **Medical Facility** where the **Medical Facility** has effectively become the **Enrolled Person's** home or permanent abode or where admission is arranged wholly or partly for domestic or social reasons.
10. Cosmetic **Treatment** or any consequences thereof and/or **Treatment** for weight loss or weight problems whether or not for psychological purposes and any associated **Treatment** costs consequent of cosmetic surgery or arising as a result of an eating disorder or weight problem.
11. Alternative medicines including, but not limited to, chiropractors, optometrists, lactation examiners and podiatrists. Coverage is extended to include chiropractors, osteopaths, homeopaths and acupuncturists only, as provided for under **Benefit 1(e)** of this Certificate.
12. Costs incurred in connection with locating a replacement organ or any costs incurred for removal of the organ from the donor, transportation costs of same and all associated administration costs.
13. Any second or subsequent medical opinions from a **Physician** or **Specialist Physician** for the same **Medical Condition** unless it has been authorized by **Us** in writing.
14. Voluntary caesarean section costs.
15. Pregnancy terminations on non medical grounds, antenatal classes, midwifery costs when not associated with delivery or a recognized **Medical Condition**, and costs associated with amniocentesis (or associated/similar procedure).
16. Any pregnancy or complications of pregnancy expenses whatsoever incurred in the first 12 months following the purchase date of this **Benefit** or the **Date of Entry**, whichever is the later.
17. Any pregnancy costs whatsoever relating to unmarried children under 18 years of age qualifying as an **Eligible Person**.
18. **Treatment** directly or indirectly arising from or required in connection with male and female birth control, infertility, contraception, sterilization (or its reversal) and any form of assisted reproduction or any complication or pregnancy arising as a result of assisted pregnancy or fertility **Treatment**.

19. **Treatment** of impotence or any **Related Condition** or consequence thereof.
20. **Treatment** directly or indirectly associated with a sex change and consequence thereof.
21. Venereal disease or any other sexually transmitted diseases or any **Related Condition** other than HIV/AIDS as provided for under **Benefit 6** of this Certificate.
22. Corrective surgery for sight defects not incurred as a result of an **Accident**.
23. Routine or restorative dental **Treatment**, whether or not performed by a **Physician, Specialist Physician** or **Dental Practitioner** or an oral and maxillofacial surgeon.
24. Orthodontic **Treatment**, gingivitis, and periodontitis or any **Related Condition**.
25. Costs in respect of a psychotherapist, psychologist, family therapist or bereavement counselor.
26. **Treatment** for learning difficulties in children, hyperactivity, attention deficit disorder, speech therapy (except as specified in **Benefit 2(b)** of the **Policy**), developmental and behavioral problems.
27. **Treatment** for alcoholism, drug or substance abuse or any addictive condition of any kind and any injury or illness arising directly or indirectly from such abuse or addiction.
28. Suicide or attempted suicide, willfully self-inflicted **Bodily Injury** or illness or injury sustained directly or indirectly as a result of the **Enrolled Person** committing a criminal offense.
29. Travel and accommodation costs unless specifically agreed by **Us** in writing prior to travel. No travel and accommodation costs are payable where **Treatment** is obtained solely as an **Out-Patient**.
30. Costs and expenses incurred where an **Enrolled Person** has traveled against **Medical Advice**.
31. The fees of a religious practitioner in respect of **Benefit 18** of the coverage.
32. **Treatment** and expenses directly or indirectly arising from or required as a consequence of: war, invasion, acts of foreign enemy hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege or attempted overthrow of government or any **Act of Terrorism**, unless the **Enrolled Person** sustains **Bodily Injury** whilst an innocent bystander resulting from an **Act of Terrorism** only up to a maximum amount US\$50,000 per **Enrolled Person** per incident.
33. Regardless of any contributory clause(s), this insurance does not cover **Treatment** of a **Medical Condition** that is in any way caused or contributed to by an **Act of Terrorism** involving the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent. If **We** allege that by reason of this exclusion any claim is not covered by the insurance the burden of proving the contrary shall be upon **You**.
34. **Treatment** directly or indirectly arising from or required as a result of chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel, asbestosis or any **Related Condition**.
35. **Treatment** received in connection with insomnia, sleep disorders, sleep apnea, fatigue, jet lag or work related stress or any **Related Condition**.
36. Dietary supplements and substances that are available naturally including, but not limited to, vitamins, minerals and organic substances.
37. **Treatment** required due to medical malpractice.
38. Home visits by a **Physician, Specialist Physician** or **Qualified Nurse** unless specifically agreed by **Us** in writing prior to consultation.
39. Any **Treatment** not prescribed, recommended or approved by the **Enrolled Person's** attending **Physician** or **Specialist Physician**.
40. Costs for **Treatment** that the **Enrolled Person** is not legally obliged to pay.
41. Costs, as determined by **Us**, to be for custodial care.
42. Any **Treatment** for mental disorders of whatever nature (to include **Chronic Brain Syndrome**) other than those covered under **Benefit 5** of this Certificate.
43. Costs, as determined by **Us**, to be for **Hospice Care**.

LIMITS OF COVERAGE

1. Deductibles:

The **Schedule of Coverage** will show the amount of **Co-Insurance** and **Deductible** the **Enrolled Person** will be obliged to pay before receiving any **Benefits** under this **Policy**. Any **Co-Insurance** will not apply towards meeting the **Deductible**.

a) Preferred Care Deductible (to include Treatment outside of the USA):

All costs for eligible **Treatment** received outside of the USA and any eligible **Treatment** carried out by a **Preferred Care Provider** within the USA will be considered as expenses properly incurred for the purpose of the **Deductible**. The **Enrolled Person** will be required to meet the costs of this **Treatment** up to the amount set out as the **Preferred Care Deductible**. Once the cost of the **Enrolled Person's Treatment** exceeds the amount of the **Preferred Care Deductible** then the **Policy** will begin paying **Benefits** for eligible **Treatment** outside of the USA and eligible **Treatment** by a **Preferred Care Provider** within the USA.

b) Non-Preferred Care Deductible:

Only costs for eligible **Treatment** in the USA carried out by a non-**Preferred Care Provider** will be considered as expenses properly incurred for the purpose of the **Non-Preferred Care Deductible**. **You** will be required to meet the costs of this **Treatment** up to the amount set out as the **Non-Preferred Care Deductible**. Once the cost of **Your Treatment** exceeds the amount of the **Non-Preferred Care Deductible** then the **Policy** will begin paying **Benefits** for eligible **Treatment** by non-**Preferred Care Providers** within the USA. Each **Deductible** stands separately and will be accrued separately. Eligible **Treatment** requiring pre-certification that is not pre-certified will count towards a **Deductible** only after application of the reduced reimbursement percentage.

2. Co-Insurance Limits:

Where **Treatment** occurs inside the USA — or in any event in the case of all and any expenses incurred under the maternity coverage **Benefit** — the **Enrolled Person** is required to pay a percentage of the total value of any incurred expenses for each **Medical Condition** for each **Period of Coverage**. This is called **Co-Insurance** and the percentage can be found in the **Schedule of Limits/Maximums** section of this document. The maximum amount each **Enrolled Person** will have to pay as **Co-Insurance** per **Period of Coverage** is called the **Co-Insurance Limit** and can also be found in the **Schedule of Limits/Maximums**. Each **Enrolled Person** has a separate **Co-Insurance** limit for pre-certified **Treatment** undertaken by **Preferred Care Providers** and non-**Preferred Care Providers** in this **Policy**. After this maximum, for which **You** are liable, is reached, the **Policy** will pay **Benefits** at 100%. **Deductible** payments do not contribute to these limits. Eligible **Treatment** requiring pre-certification that is not pre-certified will not be subject to the **Co-Insurance** limit.

3. Application of Limits:

Any overall **Benefit** limits (per visit, number of days, monetary limit, etc.) will be applied before the application of any **Deductibles**.

4. Schedule of Limits/Maximums:

The full **Schedule of Limits/Maximums** for all applicable coverage options are outlined overleaf. The coverage option **You** have purchased is incorporated in **Your Schedule of Coverage** and should be referred to in order to determine how the limits will be applied to the coverage and **Benefits** as described.

5. Accumulation:

Where a family with three **Enrolled Persons** or more are all involved simultaneously in an **Accident**, a maximum two (2) individual **Deductibles** will be applied to the total cost of the claims for the family members.

SCHEDULE OF LIMITS/MAXIMUMS

The table below summarizes the product choices available and the features, coverage limits, wait periods and **Co-Insurance** applicable to each option.

SILVER OPTION

Plan Features	In USA In-Network	In USA Out-of-Network	Outside USA
Maximum Annual Aggregate Limit Policy Benefit limit	US\$1,000,000	US\$1,000,000	US\$1,000,000
Co-Insurance Maximum The maximum amount of Co-Insurance payable	N/A	US\$4,000	N/A
In-Patient and Day-Patient Treatment Charges Pre-authorized reimbursement percentage	100%	80%*	100%
Convalescence Benefit limit – In-Patient/Day-Patient Treatment	30 Days	30 Days	30 Days
Home Health Care Maximum number of visits – per Medical Condition	30	30	30
Reconstructive Surgery Reimbursement percentage Treatment must take place within set time period from date of Accident or Medical Condition . Within 365 days.	100%	80%	100%
Psychiatric Treatment (In-Patient) Maximum limit of Treatment	28 Days	28 Days	28 Days
Out-Patient Psychiatric Reimbursement percentage	No Coverage	No Coverage	No Coverage
Newborn Illnesses Benefit limit per lifetime	No Coverage	No Coverage	No Coverage
Oncology Reimbursement percentage	100%	80%	100%
Organ Transplant Benefit limit per organ/transplant operation per lifetime	US\$250,000	US\$250,000	US\$250,000
Accidental Damage to Teeth Reimbursement percentage	100%	80%	100%
AIDS Benefit limit per lifetime	US\$40,000	US\$40,000	US\$40,000
Prosthesis Benefit limit per lifetime	US\$5,000	US\$5,000	US\$5,000
Room and Board Level of room rate	Private	Private	Private
Room rate limit	No Limit	No Limit	No Limit
ICU Room rate limit	US\$2,000	US\$1,800	US\$2,000
Emergency Transportation	When considered Medically Necessary	When considered Medically Necessary	When considered Medically Necessary

Medical Evacuation Reimbursement percentage – per Medical Condition	100%	100%	100%
Additional Travel Expenses following Evacuation Benefit limit	US\$10,000	US\$10,000	US\$10,000
Mortal Remains Benefit limit	US\$10,000	US\$10,000	US\$10,000
Maternity Wait period before eligible for Benefit	No Coverage	No Coverage	No Coverage
Monetary limit of Benefit – normal delivery	No Coverage	No Coverage	No Coverage
Monetary limit of Benefit – caesarean section on medical grounds	No Coverage	No Coverage	No Coverage
Reimbursement percentage	No Coverage	No Coverage	No Coverage
Complication of Pregnancy Reimbursement percentage	100%	80%	100%
Wait period before eligible for Benefit	12 Months Waiting Period	12 Months Waiting Period	12 Months Waiting Period
Out-Patient Treatment Charges Reimbursement percentage	No Coverage	No Coverage	No Coverage
Out-Patient Drugs and Dressings Monetary limit of Benefit	No Coverage	No Coverage	No Coverage
Hormone Replacement Therapy	No Coverage	No Coverage	No Coverage
Routine Management of Chronic Conditions Reimbursement percentage	No Coverage	No Coverage	No Coverage
End Stage Renal Disease Coverage, including Dialysis coverage Benefit limit per lifetime	No Coverage	No Coverage	No Coverage
Non Pre-authorized Treatment** In-Patient/Day-Patient and Emergency Treatment	50%	50%	50%
Non-Emergency Care in Emergency Room** Reimbursement percentage – per Medical Condition	50%	50%	50%

GOLD OPTION

Plan Features	In USA In-Network	In USA Out-of-Network	Outside USA
Maximum Annual Aggregate Limit Policy Benefit limit	US\$1,000,000	US\$1,000,000	US\$1,000,000
Co-Insurance Maximum The maximum amount of Co-Insurance payable	N/A	US\$4,000	N/A
In-Patient and Day-Patient Treatment Charges Pre-authorized reimbursement percentage	100%	80%*	100%
Convalescence Benefit limit – In-Patient/Day-Patient Treatment	30 Days	30 Days	30 Days
Home Health Care Maximum number of visits – per Medical Condition	30	30	30
Reconstructive Surgery Reimbursement percentage Treatment must take place within set time period from date of Accident or Medical Condition. Within 365 days.	100%	80%	100%
Psychiatric Treatment (In-Patient) Maximum limit of Treatment	28 Days	28 Days	28 Days

Out-Patient Psychiatric Reimbursement percentage	Full Refund	Full Refund	Full Refund
Newborn Illnesses Benefit limit per lifetime	US\$250,000	US\$250,000	US\$250,000
Oncology Reimbursement percentage	100%	80%	100%
Organ Transplant Benefit limit per organ/transplant operation per lifetime	US\$250,000	US\$250,000	US\$250,000
AIDS Benefit limit per lifetime	US\$40,000	US\$40,000	US\$40,000
Prosthesis Benefit limit per lifetime	US\$5,000	US\$5,000	US\$5,000
Accidental Damage to Teeth Reimbursement percentage	100%	80%	100%
Room and Board Level of room rate	Private	Private	Private
Room rate limit	No Limit	No Limit	No Limit
ICU Room rate limit	US\$2,000	US\$1,800	US\$2,000
Emergency Transportation	When Considered Medically Necessary	When Considered Medically Necessary	When Considered Medically Necessary
Medical Evacuation Reimbursement percentage – per Medical Condition	100%	100%	100%
Additional Travel Expenses following Evacuation Benefit limit	US\$10,000	US\$10,000	US\$10,000
Mortal Remains Benefit limit	US\$10,000	US\$10,000	US\$10,000
Maternity Wait period before eligible for Benefit	12 Months Waiting Period	12 Months Waiting Period	12 Months Waiting Period
Monetary limit of Benefit – normal delivery	US\$5,000	US\$5,000	US\$5,000
Monetary limit of Benefit – caesarean section on medical grounds	US\$9,500	US\$9,500	US\$9,500
Reimbursement percentage	100%	80%	100%
Complication of Pregnancy Reimbursement percentage	100%	80%	100%
Wait period before eligible for Benefit	12 Months Waiting Period	12 Months Waiting Period	12 Months Waiting Period
Out-Patient Treatment Charges Reimbursement percentage	100%	80%	100%
Out-Patient Drugs and Dressings Monetary limit of Benefit	US\$2,000	US\$2,000	US\$2,000
Hormone Replacement Therapy	100%	80%	100%
Routine Management of Chronic Conditions Reimbursement percentage	Full Refund	Full Refund	Full Refund
End Stage Renal Disease Coverage, including Dialysis coverage Benefit limit per lifetime	US\$20,000	US\$20,000	US\$20,000
Non Pre-authorized Treatment** In-Patient/Day-Patient and Emergency Treatment	50%	50%	50%
Non-Emergency Care in Emergency Room** Reimbursement percentage – per Medical Condition	50%	50%	50%

PLATINUM OPTION

Plan Features	In USA In-Network	In USA Out-of-Network	Outside USA
Maximum Annual Aggregate Limit Policy Benefit limit	US\$2,000,000	US\$2,000,000	US\$2,000,000
Co-Insurance Maximum The maximum amount of Co-Insurance payable	N/A	US\$4,000	N/A
In-Patient and Day-Patient Treatment Charges Pre-authorized reimbursement percentage	100%	80%*	100%
Convalescence Benefit limit – In-Patient/Day-Patient Treatment	30 Days	30 Days	30 Days
Home Health Care Maximum number of visits – per Medical Condition	30	30	30
Reconstructive Surgery Reimbursement percentage Treatment must take place within set time period from date of Accident or Medical Condition. Within 365 days.	100%	80%	100%
Psychiatric Treatment (In-Patient) Maximum limit of Treatment	28 Days	28 Days	28 Days
Out-Patient Psychiatric Reimbursement percentage	Full Refund	Full Refund	Full Refund
Newborn Illnesses Benefit limit per lifetime	US\$250,000	US\$250,000	US\$250,000
Oncology Reimbursement percentage	100%	80%	100%
Organ Transplant Benefit limit per organ/transplant operation per lifetime	US\$250,000	US\$250,000	US\$250,000
AIDS Benefit limit per lifetime	US\$40,000	US\$40,000	US\$40,000
Prosthesis Benefit limit per lifetime	US\$5,000	US\$5,000	US\$5,000
Accidental Damage to Teeth Reimbursement percentage	100%	80%	100%
Room and Board Level of room rate	Private	Private	Private
Room rate limit	No Limit	No Limit	No Limit
ICU Room rate limit	US\$3,000	US\$3,000	US\$3,000
Emergency Transportation	When Considered Medically Necessary	When Considered Medically Necessary	When Considered Medically Necessary
Medical Evacuation Reimbursement percentage – per Medical Condition	100%	100%	100%
Additional Travel Expenses following Evacuation Benefit limit	US\$10,000	US\$10,000	US\$10,000
Mortal Remains Benefit limit	US\$10,000	US\$10,000	US\$10,000
Maternity Wait period before eligible for Benefit	12 Months Waiting Period	12 Months Waiting Period	12 Months Waiting Period
Monetary limit of Benefit – normal delivery	US\$7,500	US\$7,500	US\$7,500
Monetary limit of Benefit – caesarean section on medical grounds	US\$12,000	US\$12,000	US\$12,000
Reimbursement percentage	100%	80%	100%

Complication of Pregnancy Reimbursement percentage	100%	80%	100%
Wait period before eligible for Benefit	12 Months Waiting Period	12 Months Waiting Period	12 Months Waiting Period
Out-Patient Treatment Charges Reimbursement percentage	100%	80%	100%
Out-Patient Drugs and Dressings Monetary limit of Benefit	US\$3,000	US\$3,000	US\$3,000
Hormone Replacement Therapy	100%	80%	100%
Routine Management of Chronic Conditions Reimbursement percentage	Full Refund	Full Refund	Full Refund
Non Pre-authorized Treatment** In-Patient/Day-Patient and Emergency Treatment	50%	50%	50%
End Stage Renal Disease Coverage, including Dialysis coverage Benefit limit per lifetime	US\$20,000	US\$20,000	US\$20,000
Non-Emergency Care in Emergency Room** Reimbursement percentage – per Medical Condition	50%	50%	50%

*80% if outside of Network area.

**The Co-Insurance maximum does not apply.

GENERAL CONDITIONS

1. Subrogation Clause:

If the **Insurer** pays **Benefits** for covered medical expenses incurred and if it is found that any **Enrolled Person** was repaid for all or some of those expenses by another source including any other insurance **Policy**, as outlined in **General Condition 17**, the **Insurer** will have the right to a refund from **You**. Where necessary the **Insurer** retains the right to deduct such refund from any impending or future claim settlements or to cancel **Your Enrollment** and that of all **Enrolled Persons** void from commencement, without a refund of premium. Other than with the written consent of the **Insurer**, no **Enrolled Person** has any entitlement to admit liability for any eventuality or give promise of any undertaking which is binding upon **You, Eligible Persons** or any other **Enrolled Person** named in the **Schedule of Coverage**.

2. Family/Dependent Coverage:

You and all **Enrolled Persons** are required to be covered under the same **Policy** with identical **Benefits**. Where the **Insurer** finds that this is not the case, **You** will be asked to comply with this request at **Your** next **Renewal Date**. Failure to comply with this condition will result in the termination of **Your** coverage and that of all **Enrolled Persons**.

3. Acceptance Clause:

The **Insurer** is entitled to refuse to accept an **Application for Enrollment** from any person without giving a reason. The **Insurer** maintains the right to ask **You** to provide proof of age and/or state of health of any person included in **Your** application. The **Insurer** reserves the right to apply additional endorsements, exclusions or premium increases to reflect any circumstances **You** advise in **Your Application for Enrollment** form or declare to the **Insurer** as a material fact.

4. Eligibility:

New applicants will be eligible for coverage up to and including the age of 74*. Individuals over the age of 74 are not eligible for coverage unless the **Enrolled Person's Date of Entry** was prior to their 75th birthday. Eligibility will not extend in any event to any applicants whose **Country of Residence**, at the time of **Application for Enrollment** or at the **Renewal Date**, is the USA or Bermuda, and all coverage shall terminate for **You** if **You** reside or come to reside during any **Period of Coverage** in either Bermuda or the United States.

*Subject to certain **Deductible** options only.

5. Compliance with Policy Terms:

The **Insurer** shall not be liable for any claim in the event of any failure by an **Enrolled Person** to comply with its terms and conditions, except where the circumstances of any claim are unconnected with such failure and no fraud is involved.

6. Change of Risk:

You must inform **Us** as soon as reasonably possible of any material changes relating to any **Enrolled Person** that affects information given in connection with **Your Application for Enrollment**. The **Insurer** reserves the right to alter the terms of this **Certificate of Enrollment** or cancel coverage for an **Enrolled Person** following a change of risk.

7. Policy Duration and Premiums:

- a) The coverage provided is for one year and is renewable for successive one year periods, subject to the terms in force at the time of each **Renewal Date** and to payment of the premium.
- b) The premium payable may be changed by the **Insurer** from time to time. If the **Insurer** moves into a higher age band, the premium will increase at the next **Renewal Date**. However, coverage will not be subject to any alteration in premium rates until the next **Renewal Date**.
- c) All premiums are payable in advance of any coverage under this **Policy** being provided.
- d) The **Policy** is an annual contract and **You** are responsible for the whole year's premium even if the **Insurer** has agreed that **You** may pay by installments.

8. Break In Coverage:

Where there is a break in coverage, for whatever reason, the **Insurer** reserves the right to reapply Exclusion 1 in respect of pre-existing **Medical Conditions** and Exclusion 2.

9. Children:

Newborn children will be accepted for coverage from birth. Acceptance of newborn babies is subject to written notification within 30 days of birth and receipt of the full premium within a further 30 days following notification. Children who are not more than 18 years old residing with **You**, or 23 years old if in full-time education, at the date of joining or at any annual **Renewal Date** will be accepted for coverage. Children under the age of 18 years old not residing with **You**, will be accepted for coverage providing the application is signed by a legal parent or guardian. The premium applicable will be the 18 – 21 age band rate.

10. Alterations:

- a) **We** may alter the terms and conditions of enrollment at any **Renewal Date**. A copy of the amended **Certificate of Enrollment** will be sent to **You** at such time. **You** may cancel enrollment within 15 days following any **Renewal Date**, and provided **You** have not made a claim, **We** will refund **Your** premium. **We** will give **You** reasonable notice of such alterations. **We** will send details of such alterations to **Your** last address on file with **Us**. However, the alterations will take effect even if **You** do not receive them for any reason.
- b) No alteration or amendment to the **Policy** or this **Certificate of Enrollment's** terms will be valid unless it is in writing from **Us** and signed by an authorized representative of the **Insurer**.

11. Waiver:

Waiver by **Us** in any instance of any term or condition of this **Policy** will not prevent **Us** from relying on such term or condition in other instances.

12. Cancellation:

In the event of any non-payment of premium, the **Insurer** shall be entitled to cancel the enrollment of all **Enrolled Persons**. Cancellation will be automatic. The **Insurer** may at its sole discretion reinstate the coverage if the premium is subsequently paid.

Whilst the **Insurer** shall not cancel this **Policy** because of eligible claims made by any **Enrolled Person**, the **Insurer** may at any time terminate an **Enrolled Person's** coverage if he/she has at any time:

- a) Misled the **Insurer** by misstatement.
- b) Knowingly claimed **Benefits** for any purpose other than as are provided for under this **Policy**.
- c) Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the **Insurer's** detriment.
- d) Otherwise failed to observe the terms and conditions of this **Policy** or failed to act with utmost good faith.
- e) Changed **Country of Residence** so that, for the purposes of the **Policy**, the **Country of Residence** becomes the USA or Bermuda.

13. Applicable Law:

The law applicable to the **Policy**, to this **Certificate of Enrollment**, and to any and all causes of action arising out of, in connection with, or relating to the **Policy** or to this **Certificate of Enrollment** shall be the substantive laws of Bermuda, without regard or application of the conflict of laws rules of that jurisdiction.

14. Arbitration:

Any and all disputes, controversies and claims arising out of or in connection with the **Policy**, this **Certificate of Enrollment**, the application or solicitation process for either, or any service provided in connection with the subject matter of this document, shall be resolved exclusively by resort to private and confidential arbitration. Included within the scope of this agreement to arbitrate shall be any and all disputes, controversies and claims involving the **Insurer**, **Us**, **You** or any **Enrolled Person** on anyone acting on behalf of any of them. The location of the arbitration shall be Hamilton, Bermuda at the municipal address selected by a majority of the arbitral panel (which shall consist

of three arbitrators, one selected by each party and the third by the two arbitrators so selected). The arbitrators shall each have at least five years experience in the field of life and/or health insurance, and may not have (or have had for the past five years) any affiliation with either of the parties.

The decision of a majority of the arbitrators shall be binding and final and not be subject to appeal. The cost of the arbitration proceedings shall be borne as assigned by the arbitrators. To the extent permitted by the law of Bermuda the arbitration shall be conducted in accordance with the UNCITRAL RULES for Arbitral Procedure. In all other aspects, the law of Bermuda shall govern the arbitration. In the event of an impasse regarding the selection or appointment of an arbitrator, the International Court of Arbitration of the International Chamber of Commerce shall be the appointing authority, as permitted under the UNCITRAL Rules.

15. Other Insurance:

If there is any other insurance covering any of the same **Benefits**, **You** must disclose or ensure that the relevant **Enrolled Person** discloses the same to the **Insurer**, and the **Insurer** shall not be liable to pay or contribute more than its rateable proportion.

16. Fraudulent/Unfounded Claims:

If any claim under this **Policy** is in any respect fraudulent or unfounded, all **Benefits** paid and/or payable in relation to that claim shall be forfeited and (if appropriate) recoverable. In addition, all coverage in respect of the **Enrolled Person** shall be cancelled void from the **Commencement Date** without refund of premiums.

17. Liability:

The **Insurer's** liability shall cease immediately upon termination of enrollment under this Certificate for whatever reason, including, without limitation, non-renewal and non-payment of premium.

18. Premium Refunds:

After the first 30 days of coverage from **Your Date of Entry** (cooling off period), or 15 days from any subsequent **Renewal Date**, **You** will not be entitled to any refund of premium, either in full or in part, for whatever reason.

19. Transfer:

If there is more than one **Enrolled Person** over the age of 18 and **You** die, the oldest **Enrolled Person** over the age of 18 years shall upon the date of **Your** death become responsible for paying the premium and the receipt and giving of notices.

20. Entire Contract – Changes:

The **Policy**, including the **Schedule of Coverage**, **Application for Enrollment** and **Certificate of Enrollment** constitute the whole contract and cannot be changed by anyone other than the **Insurer**. Such approval must be endorsed or attached to this **Certificate of Enrollment** or the **Schedule of Coverage**. No agent or broker can change the **Policy** or this **Certificate of Enrollment** or waive the terms of either.

CLAIMS PROCEDURES

IMPORTANT

**** NOTE **** Please ensure that any and all costs for non-Emergency In-Patient/Day-Patient Treatment, MRI and CT scans are pre-certified by Us, in writing (fax/e-mail/letter) before ANY planned Treatment is undertaken. Notification of any elective non-Emergency In-Patient/Day-Patient Treatment should be notified to Us as soon as reasonably possible.

International Member Service Center:

All **Enrolled Persons** have access to the International Member Service Center, which is available 24 hours a day, 365 days a year, and is staffed by multilingual operators who can answer **Your** questions about claims, **Benefits** and coverage levels and can process claims in many different languages. The International Member Service Center also gives **You** direct access to the International Health Advisory Team, who can arrange for **Hospital** admissions, ambulance transfers and air **Evacuation** where necessary. To obtain assistance from the International Member Service Center, please use the contact details as shown on **Your** AGB membership ID card. **You** will need to provide **Your** name, reference number, telephone and/or fax number, location and **Medical Condition**. In any given situation, if **You** are unsure what to do, contact the International Member Service Center. In the event of a true medical **Emergency** or **Evacuation**, **You** may also contact the **Emergency** Assistance Medical Helpline using the contact details found on **Your** AGB membership ID card.

Claims paid in a local currency will be converted at the rate of exchange quoted on www.oanda.com, at the time all covered invoices for **Treatment** are assessed by **Us**.

To safeguard **You** against the possibility of being faced with expenses that are not covered under **Your Policy**, **We** have developed the following procedures:

Planned In-Patient and Day-Patient Treatment:

In the event of a planned admission on an **In-Patient** or **Day-Patient** basis to a **Medical Facility**, the following steps are to be taken. Payment of all expenses incurred by the **Enrolled Person** will only be reimbursed at 50% of the costs incurred unless **You** follow these procedures.

- i) Contact the International Member Service Center (toll free or collect) as soon as reasonably possible prior to admission, giving full details of the condition, proposed **Treatment** (including dates and name of procedure, if known) together with the name of the **Specialist Physician** and details of the **Medical Facility**. (The telephone number is provided on the back of **Your** membership card.)

- ii) The the International Member Service Center will advise **You** if they have sufficient information to confirm the **Enrolled Person's** coverage. If not, they will advise **You** what further information is required.
- iii) The International Member Service Center will verbally confirm the **Enrolled Person's** coverage and will dispatch written confirmation to **You**.
- iv) The International Member Service Center will attempt at all times to make arrangements with the **Medical Facility** for all eligible bills to be settled directly when using a **Preferred Care Provider**. Where this has been arranged, **You** should send the original claim form and the unpaid invoices (if given to **You** by the **Medical Facility**) to the Aetna Global Benefits Claims Department.

Emergency Admissions:

In the event of **Emergency** admissions, **You** should contact the International Member Service Center as soon as possible after admission and follow the steps described earlier for **In-Patient Treatment**. Failure to contact the International Member Service Center will result in **Treatment** or any **Evacuation** cost only being reimbursed at 50% of the costs incurred within the terms of this Certificate. Please do not delay obtaining **Emergency Treatment**.

Out-Patient Treatment:

If the **Enrolled Person** receives medical **Treatment** as an **Out-Patient**, **Treatment** must be paid for in full by **You** at the time of the appointment and re-claimed from **Us**. In such instances, please ensure that a claim form is completed by **You** and the **Physician** or **Specialist Physician**. Please remit this to the Aetna Global Benefits Claims Department with all substantiating proof of the **Enrolled Person's** claim, including, but not limited to, the original invoice and proof of payment, prescription and written diagnosis from the **Physician**.

Guarantee of Payment (GOP)/Pre-Certifications:

The below information/documents are required in order to process a GOP/Pre-certification in a timely manner:

- Diagnosis
- **Treatment**
- Date of Service
- Provider's name and contact person
- Provider's phone and fax number or e-mail
- Medical records/medical notes
- Cost estimate
- Release of Medical Information Form
- Pre-certification Medical Form

GOPs/Pre-certifications requests may take up to five business days to approve once all of the required information is received.

Some cases may take longer to approve based on the the types of request; for example, translations of medical records, transplants, etc.

General Claims Information:

We reserve the right to reject any claim that is not submitted within 180 days of the date **Treatment** took place. All documents and materials (including, but not limited to, original accounts, certificates and x-rays) that **We** require to support a claim, an application for coverage or change in coverage shall be provided without expense to **Us** (including if requested by **Us** a medical report from **Enrolled Person's Physician** or **Specialist Physician** and details of the **Enrolled Person's** medical history prior to any claim. In cases where medical information is required by **Us** for consideration of a claim but it is not available to **Us**, it is **Your** responsibility to obtain such information from **Enrolled Person's** current or previous **Physician**, as appropriate. Claims may only be made for **Treatment** actually given during a **Period of Coverage** and **Benefit** will be available only for expenditure incurred prior to expiry or termination of such coverage.

An **Enrolled Person** must, without delay, give **Us** written notification of any claim or right of action against any third party arising out of circumstances that gave rise to a claim under this **Policy** and must continue to keep **Us** fully informed in writing and take all steps **We** reasonably require in making a claim upon that other party. **We** shall be entitled to take legal action in any **Enrolled Person's** name for **Our** own **Benefit** and claim for indemnity or damages or otherwise which relates to any **Benefits** and costs paid or payable under this **Policy**. **We** shall have full discretion in the conduct of any such proceedings and in the settlement of any such claim.

All claims should be sent to:

Aetna Global Benefits
P.O. Box 30545
Tampa, FL 33630-3548
USA

TF 1 866 545 3252

T +1 813 775 0220

F 1 860 262 9211

E AmericasServices@aetna.com

Complaints Procedure:

Our aim is at all times to provide a first class standard of service. However, there may be occasions when **You** feel that this objective has not been achieved. Should **You** have any complaint regarding this insurance **Policy**, please contact in writing:

Goodhealth Worldwide (Global) Limited
c/o Aetna Global Benefits
P.O. Box 30545
Tampa, FL 33630
USA

TF 1 866 545 3252

T +1 813 775 0220

F 1 860 262 9211

E AmericasServices@aetna.com

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Aetna does not provide care or guarantee access to health services. Not all health services are covered. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to **www.goodhealthamericas.com**.

