Certificate of Enrollment

MOBILE HEALTHCARE PLAN

AETNA
GLOBAL
BENEFITS®

46.33.300.1-LA (3/11)

This **Certificate of Enrollment** (“certificate”) has been issued to **You** as evidence of the acceptance of **Your Application for Enrollment** in the Mobile Healthcare 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 19 December 2006. 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 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 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 most commonly used words and phrases used within this certificate have specific meaning, 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 while the **Enrolled Person**'s 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** that 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.

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**.

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

Benefits:
The insurance coverage provided by this certificate 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** that results in the **Enrolled Person's** dismemberment, disablement or other physical external injury.

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

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

Co-Insurance:
The percentage of the total value of the incurred expenses for which the **Enrolled Person** is responsible for each **Period of Coverage**, exclusive of the **Deductible**.

Commencement Date:
The date shown on the **Schedule of Coverage** on which coverage under the **Enrolled Person's** certificate, or in respect of a particular **Benefit**, commences. For the purpose of this certificate, coverage commences from 00:01 am on the date shown on the **Schedule of Coverage**.

Certificate of Enrollment:
This document, to which a copy of **Your Application for Enrollment** is attached and made a part of.

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 **Enrolled Person** holds a passport.

Country of Residence:
The country in which the **Enrolled Person** has habitual residence (residing for a period of no less than six months per **Period of Coverage**) at the **Date of Entry** of this certificate.

Date of Entry:
The date shown on the **Schedule of Coverage** on which an **Enrolled Person** was first included under the certificate.

Day-Patient:
Treatment in a **Medical Facility** where the patient is admitted to a bed but does not stay overnight.

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

Deductible:
The amount payable by an **Enrolled Person** in respect of expenses incurred for **Treatment**, before any **Benefits** are paid under the certificate for each **Period of Coverage**, exclusive of **Co-Insurance**.

Drugs and Dressings:
Essential drugs, medicines and dressings prescribed by a **Physician** or **Specialist Physician** and which are not available without prescription.

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 Person**s 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.

Expatriate:
Any persons living or working outside of the country for which they hold a passport, for a period exceeding six months per **Period of Coverage**.

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 and who provides basic nursing care. In the USA, such health care workers should be LPN or RN qualified.

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

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

Hospital:
An establishment that 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:
An **Enrolled Person** who receives **Treatment** by a **Physician** or **Specialist Physician** but 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 for Enrollment** form and **Schedule of Coverage** form part of the contract and must be read together with the **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**, the definition of **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 resident to perform 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 resident.

Reasonable and Customary Charges:
The average amount charged in respect of valid services or **Treatment** costs, as determined by the **Insurer's** 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 Persons** 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 speciality in a **Medical Facility**.

b) Currently holds a substantive consultant appointment that **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 purpose of which is the cure or relief of a **Medical Condition**.

Terminal Illness:

A medical prognosis of six months or less to live.

We/Our/Us:

Goodhealth Worldwide (Global) Limited c/o 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** that occurred, commenced or existed during the **Period of Coverage**.

The following **Benefits** are covered up to US$2,000,000 per **Enrolled Person** per **Period of Coverage** subject to any specific limits set out under each **Benefit** and subject to the payment of all **Deductible**(s) and **Co-Insurance** as set out in section headed **Deductible** and **Co-Insurance** 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 **Physician** to a **Physiotherapist**. A referral letter from a **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 **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 (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 if 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 pre-certification by **Us**. Without **Our** written consent prior to **Treatment**, **We** will not be liable to pay any **Benefit**.

d) **Hospice Care** charges:

Treatment provided by a **Hospice** for the care of an insured person with a **Terminal Illness**.

Such **Treatment** will cover:

i) **Palliative Treatment** and other **Acute** and **Chronic** symptom management.

ii) Medical social services under the direction of a **Physician** or **Specialist Physician**.

iii) Physiological and dietary counseling.

iv) Consultation or case management services by a **Physician** or **Specialist Physician**.

v) Part-time or intermittent **Home Health Care Provider** services for up to eight hours in any one day for **Out-Patient** care. **Benefits** are limited to a period of 30 days for **In-Patient Treatment** and to a maximum of US$5,000 for **Out-Patient Treatment**.

e) 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:
Drugs and Dressings, medicines and **Appliances** prescribed by a **Physician** or **Specialist Physician**.

4. 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**.

5. Newborn Care:
In-Patient Treatment of a **Medical Condition** being suffered by a newborn baby which manifests itself within first 30 days of life. Coverage is limited to US$250,000 per lifetime for any and all conditions under this **Benefit**.

6. 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.

7. 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 pre-certification 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 pre-certification.

8. 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.

9. 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.

10. 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 have not been coordinated by **Us**, are limited to US$2,000 per incident.

11. 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** 18 – 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 coverage the costs for one other person to travel with the **Enrolled Person**, as 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 **You** will be evacuated.

12. 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 **Your 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**.

13. 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**.

14. External Prostheses:
The costs of any artificial eyes and 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**.

15. Organ Transplants:
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

Benefits 16 through 21 available only on the Mobile Healthcare Plan – Basic Plus.

16. Dental Treatment
Benefit is limited to US$1,500 for each **Enrolled Person** in each **Period of Coverage** with a **Co-Insurance** of 25 percent.
i) Routine dental.

Subject to a waiting period of six months from the **Commencement Date** of this certificate, or the **Date of Entry**, whichever is the later.

Fees of a **Dental Practitioner** carrying out routine dental **Treatment**.

Routine dental **Treatment** is defined as:

Examinations, tooth cleaning, normal compound fillings, simple or non-surgical extractions.

ii) Major restorative dental subject to a waiting period of nine months from the **Commencement Date** of this certificate, or the **Date of Entry**, whichever is the later.

Fees of a **Dental Practitioner** and associated costs for the following specified procedures:

a) Removal of impacted, buried or un-erupted teeth

b) Removal of roots, removal of solid odontomes

c) Apicectomy, new or repair of bridge work, new or repair of crowns

d) Root canal **Treatment**, and new or repair of upper or lower dentures.

17. Maternity Coverage:

This **Benefit** is available to any **Enrolled Person** of 18 years of age or older.

Costs associated with pregnancy and childbirth and any **Related Condition** incurred after the first 12 months following the **Commencement 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 costs for caesarean section required on medical grounds. **Benefit** is limited to US$5,000 for each pregnancy or to a limit of US$9,500 for caesarean sections required on medical grounds.

18. 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 **Commencement Date** or the **Date of Entry**, whichever is the later.

19. 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.

20. Newborn Accommodation:

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

21. Wellness Benefit:

Benefit is payable up to an annual limit of US$250 subject to the sub-limits shown below per **Enrolled Person**. This **Benefit** is not available within the first 12 months from the **Commencement Date** of this **Benefit** or the **Date of Entry**, whichever is the later, and is not subject to **Deductible** or **Co-Insurance**.

Routine wellness checks: up to US$150 per visit

Well baby checks: up to US$50 per visit

Vaccinations: up to **Reasonable and Customary Charges**

DEDUCTIBLE AND CO-INSURANCE

1. Deductible:

Your Schedule of Coverage will show the amount of **Deductible** and **Co-Insurance You** will be obliged to pay before receiving any **Benefits** under the **Policy**.

A **Deductible** of US$100, $250, $500, $1,000 or $2,500 per **Enrolled Person** per **Period of Coverage**, as indicated on **Your Schedule of Coverage**. **You** will be required to meet the costs of all eligible **Treatment** up to the amount set out as **Your Deductible**. Once the cost of **Your Treatment** exceeds the amount of the **Deductible**, the **Policy** will begin paying **Benefits** for eligible **Treatment**.

2. Co-Insurance:

For the **Period of Coverage**, and where a **Co-Insurance** applies (except in respect of **Benefit** 16 – Dental **Treatment**), **We** will pay 80 percent of the next US$5,000 of eligible **Treatment** expenses after the **Deductible**. The **Enrolled Person** shall be obligated for the remaining 20 percent. Thereafter **We** will pay 100 percent of the eligible **Treatment** expenses up to applicable limits. Eligible **Treatment** requiring pre-certification that is not pre-certified will be subject to 50 percent **Co-Insurance** without 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 Benefits/Limits:

The full schedule of **Benefits**/limits for all applicable coverage options are outlined in the Schedule of **Benefits**/limits section of this document. The coverage option **You** have purchased is incorporated in **Your Schedule of Coverage** and should be referred to 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 involved simultaneously in an **Accident**, a maximum of two individual **Deductibles** will be applied to the total cost of the claims for the family members.

EXCLUSIONS

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

1. Any **Medical Condition** or **Related Condition** for which **You** have received **Treatment**, had symptoms of or sought **Advice** for prior to **Your Date of Entry** (pre-existing **Medical Condition**), except where such **Medical Conditions** have been declared to **Us** and accepted in writing. **Benefits** for a pre-existing **Medical Condition** and/or **Related Condition** may be eligible after two years of continuous coverage provided that **You** have not consulted a **Physician** or **Specialist Physician** for **Treatment** or **Advice**, experienced further symptoms or taken medications.
2. **Treatment** that **We** determine on **Medical Advice** is either experimental or unproven.
3. No coverage will be provided under the **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.
4. Birth injuries, **Congenital Anomalies**, genetic deformities and **Hereditary Medical Conditions** with symptoms present prior to the **Date of Entry**. Coverage is extended to newborn care under **Benefit** 5 of the **Policy**, to a lifetime maximum of US$250,000.
5. Routine physical examination by a **Physician**, including gynecological investigations, routine tests, newborn neo-natal care, inoculations, vaccinations (except where **Benefit** 21 – Wellness **Benefit** has been purchased) 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.
6. **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**.
7. **Treatment** received in health hydros, 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.
8. 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.
9. Alternative medicines, including, but not limited to, chiropodists, optometrists, lactation examiners and podiatrists. Coverage is extended to include chiropractors, osteopaths, homeopaths and acupuncturists only, as provided for under **Benefit** 1(e) of the **Policy**.
10. 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.
11. 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.
12. Voluntary caesarean section costs.
13. Pregnancy terminations on non medical grounds, antenatal classes, midwifery costs when not associated with delivery or a recognized **Medical Condition**, and cost associated with amniocentesis (or associated/similar procedure).
14. Any pregnancy or complications of pregnancy whatsoever incurred in the first 12 months following the **Commencement Date** of this **Benefit** or the **Date of Entry**, whichever is the later.
15. **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**.
16. **Treatment** of impotence or any **Related Condition** or consequence thereof.
17. **Treatment** directly or indirectly associated with a sex change and consequence thereof.
18. Venereal disease or any other sexually transmitted diseases or any **Related Condition** other than HIV/AIDS as provided for under **Benefit** 8 of the **Policy**.
19. Corrective surgery for sight defects not incurred as a result of an **Accident**.
20. Routine or restorative dental **Treatment**, whether or not performed by a **Physician**, **Specialist Physician** or **Dental Practitioner**, or an oral and maxillofacial surgeon (except where **Benefit** 16 - Dental **Treatment** has been purchased).
21. Orthodontic **Treatment**, gingivitis and periodontitis or any **Related Condition**.
22. Costs in respect of a psychotherapist, psychologist, family therapist or bereavement counselor.
23. **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.
24. **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.
25. 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.
26. 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 outpatient.

27. Costs and expenses incurred where an **Enrolled Person** has traveled against **Medical Advice**.
28. The fees of a religious practitioner in respect of **Benefit** 13 of the coverage.
29. **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** while an innocent bystander resulting from an **Act of Terrorism**, only up to a maximum amount US$50,000 per **Enrolled Person** per incident.
30. Regardless of any contributory clause(s), this insurance does not cover **Treatment** of a **Medical Condition** which 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 this insurance the burden of proving the contrary shall be upon **You**.
31. **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**.
32. **Treatment** received in connection with insomnia, sleep disorders, sleep apnea, fatigue, jet lag or work related stress or any **Related Condition**.
33. Dietary supplements and substances that are available naturally, including but not limited to, vitamins, minerals and organic substances.
34. Home visits by a **Physician**, **Specialist Physician** or **Qualified Nurse** unless specifically agreed by **Us** in writing prior to consultation.
35. Any **Treatment** not prescribed, recommended or approved by **Your** attending **Physician** or **Specialist Physician**.
36. Costs for **Treatment** that **You** are not legally obliged to pay.
37. Costs, as determined by **Us**, to be for custodial care.
38. Any **Treatment** for mental disorders of whatever nature (to include **Chronic** Brain Syndrome) other than those covered under **Benefit** 7 of the **Policy**.

GENERAL CONDITIONS

1. **Subrogation Clause:**
   If the **Insurer** pay **Benefits** under the **Policy** for covered medical expenses incurred and if it is found that **You** were repaid for all or some of those expenses by another source including any other insurance **Policy** as outlined in General **Condition** 16, 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 void from the **Commencement Date**, without a refund of premium. Other than with the written consent of the **Insurer**, **You** have no entitlement to admit liability for any eventuality or give promise of any undertaking which is binding upon **You**, **Your** dependents or any other **Enrolled Person** named in this certificate.
2. **Family/Dependent Coverage:**
   You and all **Enrolled Persons** are required to be covered under the same **Policy** with identical **Benefits**. Where **We** find 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** enrollment and that of all **Enrolled Persons**.
3. **Acceptance Clause:**
   The **Insurer** is entitled to refuse to accept an application 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 form or declare to **Us** as a material fact.
4. **Eligibility:**
   The **Policy** is designed for **Expatriate**s. Local nationals can only be considered subject to **Our** approval. New applicants will be eligible for coverage until the age of 65. Individuals over the age of 65 are not eligible for coverage unless the **Enrolled Person's Date of Entry** was prior to their 65th 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.
5. **Compliance with Policy Terms:**
   The **Insurer** shall not be 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 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 **You** move 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 generally introduced 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 (12 months) and **You** are responsible for the whole year's premium even if **We** have agreed that **You** may pay by installments.

8. Break In Coverage:

Where there is a break in coverage, for whatever reason, **We** reserve the right to reapply Exclusion 1 in respect of pre-existing **Medical Condition**s.

9. Children:

Newborn children will be accepted for coverage from birth. Acceptance of newborn babies is subject to receipt of an application form 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 Entry** or at any annual **Renewal Date**, will be accepted for coverage. Children under the age of 18 years will be accepted for coverage as the primary **Enrolled Person**, 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 will be valid unless it is in writing from the **Insurer** or from **Us** acting on behalf of the **Insurer** and signed by an authorized representative of the **Insurer**.

11. Waiver:

Waiver by the **Insurer** or **Us** acting on behalf of the **Insurer** in any instance of any term or condition of this **Policy** will not prevent the **Insurer** or **Us** acting on behalf of the **Insurer** 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.

While 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 **Us** 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.

13. Applicable Law:

The law applicable to the **Policy**, 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, 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** or 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. 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.

16. 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.

17 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 shall upon the date of **Your** death become responsible for paying the premium and the receipt and giving of notices.

18. Entire Contract – Changes:

The **Policy**, including the **Schedule of Coverage** and application for the **Policy** and **Your Application for 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 or the **Schedule of Coverage**. No agent or broker can change the **Policy** or this certificate or waive the terms of either.

SCHEDULE OF **BENEFITS**/LIMITS

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

Plan Features	Reimbursement Levels/ Wait Periods (per person per **Period of Coverage** unless specified otherwise)	Worldwide
Maximum annual aggregate limit	**Policy Benefit** limit	US$2,000,000
In-Patient and **Day-Patient Treatment** charges	Pre-certified reimbursement percentage	100%**
Convalescence	**Benefit** limit	
	In-Patient/Day-Patient Treatment	30 Days
Hospice Care	Time limit of **In-Patient Benefit**	30 Days
	Monetary limit of **Out-Patient Benefit**	US$5,000
Home Health Care	Maximum number of visits	
	- per **Medical Condition**	30 Days
Psychiatric **Treatment** (**In-Patient**)	Maximum limit of **Treatment**	28 Days
Newborn care	**Benefit** limit per lifetime	US$250,000
Organ transplant	**Benefit** limit per transplant	US$250,000
AIDS	**Benefit** limit per lifetime	US$40,000
Prosthesis	**Benefit** limit per lifetime	US$5,000
Room and Board	Level of room rate	Private
	Room rate limit	**Reasonable and Customary**
ICU	Room rate limit	**Reasonable and Customary**
Medical **Evacuation**	Reimbursement percentage	
	- per **Medical Condition**	100%
Mortal remains	**Benefit** limit	US$10,000
Out-Patient Treatment charges	Reimbursement percentage	100%**
Out-Patient Drugs and Dressings	Reimbursement percentage	100%
Non pre-certified **Treatment**	**In-Patient/Day-Patient** and	
	Emergency Treatment	50%
Non-**Emergency Care** in **Emergency** room	Reimbursement percentage	
	– per **Medical Condition**	50%

Mobile Healthcare Plan – Basic Plus – Optional Benefits

Routine dental	6 months waiting period	75% of the expenses Up to US$1,500
Major restorative dental	9 months waiting period	
Maternity	12 months waiting period	
	Monetary limit of benefit	
	– normal delivery	US$5,000
	Monetary limit of benefit	
	– caesarean section on medical grounds	US$9,500
Newborn accommodation	Reimbursement percentage	100%**
Wellness benefit	Monetary limit per year	US$250
	Monetary limit per visit	US$150
	Vaccinations	**Reasonable and Customary**
Hormone replacement therapy	Reimbursement percentage	100%

** Subject to 20% co-insurance, out-of-network only.

CLAIMS PROCEDURE

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. Planned In-Patient/Day-Patient Treatment undertaken without pre-certification from Us will only be eligible for reimbursement at a rate of 50 percent of the costs incurred. A verbal confirmation does not constitute pre-approval. Please ensure that Treatment is not undertaken until We have agreed such Treatment by fax, e-mail or in writing. If in doubt, please contact the International Member Service Center.**

INTERNATIONAL MEMBER SERVICE CENTER

All insured 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. All **Enrolled Persons** under this **Policy** shall at all times take reasonable precautions to prevent any **Accident** or illness and shall comply with recommended vaccination schedules and/or take appropriate malaria and other drug prophylaxis. All expenditure for which **Benefit** is claimed must be subject be **Reasonable and Customary Charges** and be necessarily incurred wholly and exclusively for the purpose of **Treatment**. 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** and any **Enrolled Person** 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 re-imbursed at 50 percent of the costs incurred unless **You** follow these procedures.

i) Contact **Our** 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 International Member Service Center will advise **You** if they have sufficient information to confirm **You** are 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 Goodhealth Worldwide (Global) Limited c/o 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 re-imbursed at 50 percent of the costs incurred within the terms of the **Policy**. 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 Goodhealth c/o Aetna Global Benefits claims department with all substantiating proof of **You** are the **Enrolled Person's** claim, including, but not limited to, the original invoice and proof of payment, prescription and a written diagnosis from the **Physician**.

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 which 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 CLAIM FORMS SHOULD BE SENT TO:

Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits
P.O. Box 30545
Tampa, FL 33630-3548
USA

If **You** require non-**Emergency Treatment** in the USA, pre-certification for **Treatment** in the USA or wish to obtain details of providers included in **Our** US network, please contact the below numbers:

TF 1 866 545 3252
T +1 813 775 0220
F +1 813 775 0625
E AmericasServices@aetna.com

In the event that **You** need **Emergency** medical assistance, please contact **Our** medical hotline on one of the numbers listed below:

London:	+44 (0) 208 762 8129
Hong Kong:	+852 2970 3045
Jakarta:	+6221 7591 2847

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:

Aetna Global Benefits
PO Box 30545
Tampa, FL 33630

TF 1-866-545-3252

T 1-813-775-0220

F 1-860-262-9111

E AmericasServices@aetna.com

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Policies issued in Latin America and the Caribbean are issued and administered by Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits.

No warranty or representation is given, whether expressed or implied, as to the completeness and/or accuracy of the information contained in this document and accordingly the information given is for guidance purposes only. You are requested to verify the above information before you act upon it. You should not rely on such information and should seek your own independent legal advice. We will not be liable for any loss and damage, whether direct or indirect, from your use of the information and the materials contained therein.

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.aetnainternational.com**.

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