



# **Essential Health Plan Agreement for Individuals & Families**

For customers with an Essential Health plan  
whose period of cover starts on or after  
**01 January 2018**

**William Russell<sup>o</sup>**

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# Welcome to William Russell

Thank you for choosing a William Russell Essential Health **plan**. We want to provide **you** with an insurance policy **you** can rely on, so it is important that **you** fully understand the scope of the cover **we** provide. This **agreement** explains what is and what is not covered by **your plan**, and how **your claims** will be administered.

Please take time to read this **agreement** along with **your certificate of insurance** and **application form**. Together, these documents form the contract between **you** and **us**.

Certain words **we** use within this **agreement** have a special meaning to which **we** would like to draw **your** attention. For example:

- **'We, us, our'** – means William Russell Ltd., on behalf of the **insurer**
- **'You, your'** – means **you** and all **insured persons** on this **plan**, as shown on **your certificate of insurance**

These words appear in **bold** type, and we provide their precise meanings in the 'Definitions' section of this **agreement**.

All web addresses in this **agreement** are live. Simply click on a link and **you** will be taken directly to **our** website. **We** are, of course, always at the end of a telephone to answer queries or deal with **your claim**. **You** can find **our** contact details below.

## William Russell Ltd.

William Russell Ltd. is the administrator of **your plan**. William Russell Ltd. is authorised and regulated by the UK Financial Conduct Authority under reference number 309314.

## Allianz

Allianz (AWP Health & Life S.A., registered address at Eurosquare 2, 7 rue Dora Maar, 93400 Saint Ouen, France) is the **insurer** of **your plan**.

## Your right to cancel within 30 days

If **you** decide **your plan** does not meet **your** needs, simply contact **us** and advise **us** that **you** wish to cancel. Provided **we** receive **your** written instruction within 30 days of **your date of entry**, and provided no **claims** have been made, **we** will refund **your premium** in full.

If **we** receive **your** instruction to cancel **your plan** more than 30 days after **your date of entry**, the terms of **our** cancellation policy will apply.

## Contact details

If you have an enquiry about your plan or insurance	Tel +44 1276 486 455 Fax +44 1276 486 466 Email <a href="mailto:enquiries@william-russell.com">enquiries@william-russell.com</a>
If you need to make a claim	Tel +44 1276 486 460 Fax +44 1276 486 476 Email <a href="mailto:claims@william-russell.com">claims@william-russell.com</a> Web <a href="http://william-russell.com/making-a-claim">william-russell.com/making-a-claim</a>
If you need to contact our 24-hour emergency medical Assistance Service	Tel +44 1232 621 155 Email <a href="mailto:william.russell@cegagroup.com">william.russell@cegagroup.com</a> Web <a href="http://william-russell.com/emergency-contact">william-russell.com/emergency-contact</a>
If you'd like to write to us	William Russell Ltd. William Russell House The Square, Lightwater Surrey, GU18 5SS, UK

# Your plan agreement

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This **agreement**, together with **your application form** and **your certificate of insurance**, make up the contract between **you** and **us**. The terms of this **agreement** apply to **you** and to all of **your eligible dependants** as stated in the schedule of **insured persons** on **your certificate of insurance**.

## The purpose of your plan

**Your plan** provides **you** with cover for treating eligible medical conditions which arise after **your date of entry**.

We will pay for the **reasonable and customary** cost of **medically necessary treatment** for medical conditions covered by **your plan**. We will only pay for such **treatment** if it is received during **your period of cover**, and provided **your premium** payments have been kept up to date.

Any reimbursement **we** make may be subject to an **excess** and/ or **co-insurance**, and certain benefits are subject to a benefit limit. **Your excess** amount will be stated on **your certificate of insurance**. Any **co-insurance** and benefit limits will be as stated in the **table of benefits** for **your plan type**.

## Your obligation to provide information relating to you and your dependants' medical history

We rely on the information **you** supply to **us** in **your application form** when **we** decide whether or not to accept **your application**, and whether or not **we** need to apply **special terms**.

If **your application form** omits facts or contains materially incorrect or incomplete facts, **we** have the right to declare **your plan** void. Alternatively **we** may impose **special terms** on **your** particular **plan** which will apply from **your date of entry**.

If **your** state of health, or the state of health of any of **your eligible dependants** changes between the time **you** complete **your application form** and **your date of entry**, **you** must tell **us** in writing about the change, and **we** may only be able to accept **your application** with **special terms**.

## Pre-existing medical conditions and related conditions

Unless **we** have agreed otherwise, **your plan** will not cover any **pre-existing medical conditions** or **related conditions**.

## Age limits

**You** must be under 70 years of age at the commencement date of **your plan**. **You** may apply for cover on behalf of **your** spouse or partner (provided they are under 70 years of age), and/or on behalf of **your** unmarried children, provided they are aged less than 18 years old, or less than 25 years old if in continuous full-time education.

## Commencement of your cover

**Your** cover will commence from the **date of entry** stated on **your certificate of insurance**. We will not commence **your** cover until **we** have accepted **your application** and **we** have received payment of **your** full annual, half-yearly, quarterly or monthly

**premium**.

## If you take up residence in an excluded country and/or region

Under the terms of this **agreement** cover is not available to **you** if **you** take up residence in an excluded or restricted country or region, irrespective of **your** nationality.

These countries and/or regions are as follows: USA, Canada, any Caribbean country or island, all countries within the European Union, Andorra, Channel Islands, Gibraltar, Greenland, Iceland, Liechtenstein, Monaco, Norway, San Marino, Switzerland, Australia, Bali, China, Hong Kong, Japan, Macau, New Zealand, Singapore and Taiwan.

If **you** take up residence in an excluded or restricted country and/ or region **you** must tell **us**. **Your** cover will automatically terminate from the date on which **you** take up residence in the excluded or restricted country and/or region.

# Area of cover

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The cover provided by **your plan** is worldwide, subject to the following exclusions and restrictions.

## Excluded countries or areas

No cover at all is provided in the USA, Canada, any Caribbean country or island, and the **London area**.

## Restricted countries and regions

For all countries within the European Union, Andorra, Channel Islands, Gibraltar, Greenland, Iceland, Liechtenstein, Monaco, Norway, San Marino, Switzerland, Australia, Bali, China, Hong Kong, Japan, Macau, New Zealand, Singapore and Taiwan the cover we provide is restricted to **emergency treatment you** receive while on a temporary trip.

**Emergency treatment** is essential **treatment** covered by **your plan** and required if **you** suffer an **accident** or a sudden and unforeseen illness **you** have never suffered from before. Cover is only provided in accordance with the benefits of the **plan** stated on **your certificate of insurance** and no cover will be provided in respect of a **pre-existing medical condition or related condition**, or any condition specifically excluded on **your certificate of insurance**. We will not pay for **treatment** if **you** have travelled to a restricted country or region knowing that **you** would require **treatment**. We only pay for **treatment** that in **our** opinion was essential and could not reasonably have been delayed until **your** return to a country within **your area of cover**.

A temporary trip is a trip of not more than 90 days' duration. Any trip of longer than 90 days will not be covered.

The maximum benefit we will pay in respect of all **emergency treatment you** receive in restricted countries or regions during an annual **period of cover** is US\$50,000.

# What you are covered for

The following **table of benefits** sets out the cover provided by each **plan type**. The **plan type** you have is as shown on **your certificate of insurance**. We will pay only for the **treatment** or services stated in the **table of benefits** relating to **your plan**.

Each benefit limit in the **table of benefits** is expressed in US Dollars. The currency of the benefit limits that we will apply to **your plan** is shown on **your certificate of insurance**.

The limits shown in the **table of benefits** are the maximum amounts we will pay after the application of any **excess** and **co-insurance**, and will be subject to the annual benefit limit and any other specified applicable benefit limits.

Certain benefits in the **table of benefits** specify a **waiting period**. You must be covered by the same **plan** for the full duration of the specified **waiting period** before you can **claim** for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**.

Wherever the term 'Full cover' appears in the **table of benefits**, this means full refund of **reasonable and customary** charges, less any **excess** or **co-insurance** applicable to **your plan**, and subject to any limits that are specified anywhere else in the **table of benefits** for the type of **treatment** or care you receive.

Where there is a lifetime benefit limit, this is the maximum amount we will pay in respect of that particular benefit during **your** lifetime.















There are certain benefits in the **table of benefits** for which you must obtain pre-authorisation.

The **table of benefits** should be read in conjunction with the 'What you are not covered for' section of this **agreement**.









**Key** ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover

Cover	Essential Care	Essential Care Plus
<p><b>Annual benefit limit</b></p> <p>The overall maximum limit that each <b>insured person</b> can <b>claim</b> during any one <b>period of cover</b>.</p>	US\$250,000	US\$500,000
<p><b>Hospital costs</b></p> <p>Important notes:</p> <ul style="list-style-type: none"> <li>You must obtain pre-authorisation for all benefits included in this section.</li> </ul>		
<p><b>Hospital accommodation</b></p> <p>The cost of a standard single room with an en-suite bath or shower room, when you are an <b>in-patient</b> or <b>day-patient</b>.</p>	<span style="color: green;">○</span> Full cover	<span style="color: green;">○</span> Full cover
<p><b>Hospital treatment</b></p> <p><b>Treatment</b> you receive while you are an <b>in-patient</b> or <b>day-patient</b>, including surgeons' and anaesthetists' and <b>doctors'</b> fees, nursing care, drugs and surgical dressings, operating theatre charges and intensive care, pathology, X-rays, scans, <b>diagnostic tests</b> and physiotherapy.</p> <p>We will also pay for <b>pre-admission tests</b> that you undergo on an <b>out-patient</b> basis for <b>hospital treatment</b> you are scheduled to receive that is covered by <b>your plan</b>.</p> <p>We will also pay for <b>in-patient</b> surgical removal of impacted, buried or unerupted wisdom teeth. This is subject to a 12-month <b>waiting period</b> and covered only when the surgery is performed by a <b>medical doctor</b> (not a <b>dentist</b>) in a <b>hospital</b> (not a dental surgery) and under general anaesthetic.</p>	<span style="color: green;">○</span> Full cover	<span style="color: green;">○</span> Full cover
<p><b>Parent accommodation</b></p> <p>The cost of one parent staying in <b>hospital</b> with a child under 18 years of age while the child is receiving eligible <b>treatment</b> covered by their <b>plan</b>.</p>	<span style="color: green;">○</span> Full cover	<span style="color: green;">○</span> Full cover

Key  Full cover within annual benefit limit  Partial or limited cover  No cover











Cover	Essential Care	Essential Care Plus
<p><b>Hospital costs (continued)</b> Important notes:</p> <ul style="list-style-type: none"> <li>You must obtain pre-authorisation for all benefits included in this section.</li> </ul>		
<p><b>Road ambulance</b> The cost of a private road ambulance if you need <b>hospital treatment</b> covered by <b>your plan</b> and if it is <b>medically necessary</b> for you to travel to <b>hospital</b> by ambulance.</p>	 Cover up to US\$1,200 per <b>period of cover</b>	 Cover up to US\$1,600 per <b>period of cover</b>
<p><b>In-patient emergency restorative dental treatment</b> <b>Treatment</b> as an <b>in-patient</b> required to restore sound and natural teeth following an <b>accident</b> covered by <b>your plan</b>, provided that <b>treatment</b> is received within 15 days of the <b>accident</b>. All <b>treatment</b> must be carried out by a <b>dentist</b> in a <b>hospital</b> emergency room or dental surgery.</p>	 Cover up to US\$5,000 per <b>period of cover</b>	 Cover up to US\$5,000 per <b>period of cover</b>
<p><b>Cancer treatment</b> Important notes:</p> <ul style="list-style-type: none"> <li>You must obtain pre-authorisation for all benefits included in this section.</li> </ul>		
<p><b>Cancer treatment</b> Cancer <b>treatment</b>, including chemotherapy, radiotherapy, immunotherapy, consultations, tests, scans, and drugs. <b>We</b> will also pay for restorative <b>dental treatment</b> following chemotherapy or radiotherapy. On the Essential Care <b>plan</b>, cover for <b>out-patient</b> cancer <b>treatment</b> is limited to a period of 5 years from the later date of the surgery, or the completion of, chemotherapy or radiotherapy.</p>	 Full cover	 Full cover
<p><b>Cancer genome tests</b> The cost of tests to sequence the genes of cancer cells.</p>	 Cover up to US\$6,000 per <b>period of cover</b>	 Cover up to US\$6,000 per <b>period of cover</b>
<p><b>Organ, bone marrow or tissue transplants</b> Important notes:</p> <ul style="list-style-type: none"> <li>You must obtain pre-authorisation for all benefits included in this section.</li> <li>We only cover transplants carried out in internationally accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO (World Health Organisation) guidelines.</li> <li>We do not cover any costs associated with the acquisition of the organ.</li> </ul>		
<p><b>Transplant and related treatment</b> Costs incurred while hospitalised, including anti-rejection drugs, and all related <b>out-patient treatment</b> required prior to and after the transplant.</p>	 Full cover	 Full cover
<p><b>Donor costs</b> Medical costs associated with the donor as an <b>in-patient</b> or <b>day-patient</b>.</p>	 Cover up to US\$25,000 per transplant	 Cover up to US\$25,000 per transplant
<p><b>Kidney dialysis</b> Important notes:</p> <ul style="list-style-type: none"> <li>You must obtain pre-authorisation for this benefit.</li> </ul>		
<p>Short-term kidney dialysis of up to 4 weeks, if you need this immediately before or after a kidney transplant operation covered by <b>your plan</b>. <b>We</b> will also pay for dialysis for up to 4 weeks if this is needed temporarily for sudden kidney failure resulting from a disease or injury, covered by <b>your plan</b>, which affects another part of <b>your</b> body. <b>We</b> do not cover regular or long-term kidney dialysis.</p>	 Full cover	 Full cover

Key  Full cover within annual benefit limit  Partial or limited cover  No cover

Cover	Essential Care	Essential Care Plus
<p><b>Reconstructive surgery</b> Important notes:</p> <ul style="list-style-type: none"> <li><b>You</b> must obtain pre-authorisation for this benefit.</li> </ul> <p>A maximum of two surgeries to restore <b>your</b> appearance after an <b>accident</b> or after surgery for cancer, provided the original <b>treatment</b> for the <b>accident</b> or cancer was paid for by <b>us</b>, and provided the reconstructive surgery takes place within two years of the <b>accident</b> or the original cancer surgery.</p>	<p> Cover for <b>in-patient, day-patient and post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b></p>	<p> Full cover</p>
<p><b>Congenital conditions or hereditary conditions</b> Important notes:</p> <ul style="list-style-type: none"> <li><b>You</b> must obtain pre-authorisation for this benefit.</li> <li>Cover for all benefits in this section is up to the annual sub-limit for <b>out-patient treatment</b>.</li> </ul> <p><b>Treatment</b> for a <b>congenital condition</b> or hereditary condition (whether diagnosed as a <b>chronic condition</b> or not) and <b>treatment</b> for any <b>related condition</b>.</p> <p>This benefit does not extend to psychiatric <b>treatment</b> or psychotherapy, complimentary medicine, traditional Chinese medicine, acupuncture or homeopathic <b>treatment</b>.</p> <p>There is no cover for <b>congenital conditions</b> or hereditary conditions if, prior to commencement of <b>your</b> cover, <b>you</b> have had any abnormal signs, symptoms or test results related to the <b>congenital condition</b> or hereditary condition (whether or not a specific diagnosis has been made). However, there may be some cover for newborn babies under the newborn babies benefit.</p> <p><b>Your</b> lifetime limit for this benefit will be reduced by any payments <b>we</b> have made under the newborn babies benefit with respect to birth defects, <b>congenital conditions</b> or hereditary conditions.</p> <p>The lifetime limit shown applies irrespective of the number of <b>congenital conditions</b> and hereditary conditions.</p> <p>Cover is up to the annual sub-limit for <b>out-patient treatment</b>.</p>	<p> Cover for <b>in-patient, day-patient and post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b> only, up to a lifetime limit of US\$20,000</p>	<p> Cover for <b>in-patient, day-patient and post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b> only, up to a lifetime limit of US\$40,000</p>
<p><b>HIV/AIDS treatment</b> Important notes:</p> <ul style="list-style-type: none"> <li><b>You</b> must obtain pre-authorisation for this benefit.</li> </ul> <p><b>(24-month waiting period)</b></p> <p><b>Treatment</b> arising from or related to Human Immunodeficiency Virus (HIV) and/ or HIV-related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC) for a maximum period of 5 years.</p> <p><b>We</b> do not provide cover if the virus was contracted before <b>your date of entry</b>.</p>	<p> Cover up to US\$1,000 per <b>period of cover</b></p>	<p> Cover up to US\$2,500 per <b>period of cover</b></p>
<p><b>Prosthetic implants</b></p> <p>Surgically-implanted, artificial body parts necessary to replace a joint or ligament, a heart valve, the aorta or an arterial blood vessel, a sphincter muscle, the lens or cornea of the eye, or to control urinary incontinence, or to act as a heart pacemaker, or to remove excess fluid from the brain.</p> <p>As part of this benefit, <b>we</b> will also pay for a knee brace if it is an essential part of a surgical operation for the repair to a knee ligament, and for a spinal support if it is an essential part of a surgical operation to the spine.</p>	<p> Full cover</p>	<p> Full cover</p>















Key  Full cover within annual benefit limit  Partial or limited cover  No cover

Cover	Essential Care	Essential Care Plus
<b>Everyday medical costs</b>		
<b>Annual sub-limit for out-patient treatment</b> The overall maximum limit to the amount that each <b>insured person</b> can <b>claim</b> for all <b>out-patient treatment</b> covered by <b>your plan</b> during any one <b>period of cover</b> .	US\$2,500	US\$10,000
<b>Primary medical care</b> Visits to a GP or <b>doctor, specialist</b> consultations, prescribed drugs and dressings, pathology, scans, radiology and <b>diagnostic tests</b> received as an <b>out-patient</b> .	 Cover for <b>post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b>	 Full cover
<b>Emergency ward treatment</b> <b>Emergency treatment</b> that <b>you</b> have received at a <b>hospital</b> .	 No cover	 Full cover
<b>Out-patient surgical procedures</b> Surgical procedures that do not require <b>in-patient</b> or <b>day-patient treatment</b> .	 Full cover	 Full cover
<b>Advanced diagnostic tests</b> MRI and CAT (CT) scans performed on the advice of a <b>medical doctor</b> and PET scans performed on the advice of a <b>specialist</b> . <b>Your medical referral letter</b> will be required. <b>We</b> will pay for one consultation only to obtain the results of the <b>diagnostic test</b> .	 Cover for <b>post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b>	 Full cover
<b>Physiotherapy</b> <b>Medically necessary</b> physiotherapy when <b>you</b> have been referred on the advice of your <b>medical doctor</b> to a physiotherapist who is registered to practice physiotherapy in the country where the <b>treatment</b> is administered. <b>You</b> must send <b>us your medical referral letter</b> in support of <b>your claim</b> . After <b>your</b> first 6 <b>sessions</b> of physiotherapy, if <b>you</b> need more <b>sessions</b> <b>you</b> must contact <b>us</b> and <b>we</b> will write to <b>your doctor</b> for a medical report in order to assess your <b>claim</b> further. <b>We</b> will not pay for any physiotherapy that we have not pre-authorised. If <b>your</b> condition is (or becomes) a <b>chronic condition</b> and ongoing <b>treatment</b> is aimed at maintaining rather than curing it, no further payments will be made.	 Cover up to US\$250 for <b>post-hospital treatment</b> received within the 90 day period following the date <b>you</b> are discharged from <b>hospital</b> only, up to US\$1,000 per <b>period of cover</b>	 Cover up to US\$1,000 per <b>period of cover</b>

**Key** ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover

Cover	Essential Care	Essential Care Plus
<p><b>Chronic conditions</b> Important notes:</p> <ul style="list-style-type: none"> <li>Cover for all benefits in this section is up to the annual sub-limit for <b>out-patient treatment</b>.</li> </ul>		
<p><b>Acute flare-ups</b> Short-term <b>treatment</b> to treat acute flare-ups of a <b>chronic condition</b> covered by <b>your plan</b>. Cover is up to the annual sub-limit for <b>out-patient treatment</b>.</p>	<p>○ Cover for <b>in-patient, day-patient and post-hospital treatment</b> received within the 90-day period following the date <b>you</b> are discharged from <b>hospital</b> only</p>	<p>○ Cover for <b>in-patient, day-patient and post-hospital treatment</b> received within the 90-day period following the date <b>you</b> are discharged from <b>hospital</b> only</p>
<p><b>Monitoring and maintenance</b> Regular consultations, tests, and prescribed medication required to monitor and maintain the stability of a <b>chronic condition</b>. Cover is regardless of the number of <b>chronic conditions</b>. Cover is up to the annual sub-limit for <b>out-patient treatment</b>.</p>	<p>○ No cover</p>	<p>○ Cover up to \$1,000 per <b>period of cover</b></p>
<p><b>Lifetime care</b> Important notes:</p> <ul style="list-style-type: none"> <li><b>You</b> must obtain pre-authorization for all benefits included in this section.</li> </ul>		
<p><b>Lifetime limit for all lifetime care</b> The overall maximum limit to the amount <b>you</b> can <b>claim</b> during <b>your</b> lifetime for all benefits within the lifetime care benefit section.</p>	<p>US\$25,000</p>	<p>US\$50,000</p>
<p><b>Hospice and palliative care</b> On diagnosis of a <b>terminal medical condition</b> covered by <b>your plan</b>, all costs for <b>treatment</b> received on the advice of a <b>medical practitioner</b> or <b>specialist</b> for the purpose of offering relief of symptoms. This includes all <b>hospital</b> or hospice accommodation, and nursing care by a <b>qualified nurse</b>.</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>
<p><b>Artificial life maintenance</b> <b>Treatment you</b> require after <b>you</b> have already been on <b>artificial life maintenance</b> for 8 weeks.</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>
<p><b>Persistent vegetative state and neurological damage</b> <b>Treatment you</b> require after <b>you</b> have been in <b>hospital</b> for 8 weeks for permanent neurological damage or if <b>you</b> are in a persistent <b>vegetative state</b>.</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>

Key  Full cover within annual benefit limit  Partial or limited cover  No cover

Cover	Essential Care	Essential Care Plus
<p><b>Complications of pregnancy</b> Important notes:</p> <ul style="list-style-type: none"> <li>Dependant children included in <b>your plan</b> are not eligible for this benefit.</li> </ul>		
<p><b>(10-month waiting period)</b> <b>In-patient or day-patient treatment</b> necessary as a direct result of a <b>complication of pregnancy</b>. <b>We</b> do not provide cover under this benefit for childbirth (which includes any caesarean section). <b>We</b> do not provide cover under this benefit if <b>you</b> act as a surrogate or have anyone else acting as a surrogate for <b>you</b>. <b>We</b> do not provide cover under this benefit for a pregnancy established through <b>assisted reproduction</b> (e.g. IVF) until after the standard 12-week scan, irrespective of how long <b>you</b> have been covered by the <b>plan</b>. <b>We</b> do not cover termination of pregnancy or any <b>treatment</b> or investigations that arise as a result of complications relating to termination of pregnancy.</p>	 No cover	 Cover up to US\$5,000 per <b>period of cover</b>
<p><b>Expat benefits</b> Important notes:</p> <ul style="list-style-type: none"> <li><b>You</b> must obtain pre-authorisation for all benefits included in this section.</li> </ul>		
<p><b>24-hour medical assistance helpline</b> If <b>you</b> have a medical emergency which requires immediate medical assistance, <b>you</b> must contact <b>our</b> 24-hour helpline (provided by CEGA) at +44 (0) 1243 621155 or <a href="mailto:william.russell@cegagroup.com">william.russell@cegagroup.com</a>.</p>	 Full cover	 Full cover
<p><b>Medevac</b> If <b>you</b> have a life-threatening or limb-threatening condition covered by <b>your plan</b> which requires immediate <b>in-patient treatment</b> that cannot be adequately provided locally, the <b>Assistance Service</b> will arrange for <b>you</b> to be moved by air and/or by surface transportation, to the nearest <b>hospital</b> within <b>your area of cover</b> where appropriate medical <b>treatment</b> is available. <b>We</b> do not cover any other costs under this benefit such as hotel accommodation charges. <b>We</b> do not cover emergency evacuation to, from or within the USA. The <b>Assistance Service</b> retains the absolute right to decide whether <b>your</b> medical condition is eligible for evacuation, where <b>you</b> are evacuated to and the means and method of the evacuation.</p>	 Full cover	 Full cover
<p><b>Return airfare</b> Following an emergency evacuation covered by <b>your plan</b>, <b>we</b> will pay for <b>your</b> economy return airfare to <b>your country of residence</b>.</p>	 Full cover	 Full cover
<p><b>Travelling expenses of a companion</b> The transportation costs of another person to accompany <b>you</b> on <b>your</b> emergency evacuation, and their economy class ticket back. If it is not possible for them to accompany <b>you</b> on <b>your</b> medical evacuation because of the method of evacuation, <b>we</b> will pay either for their economy class round-trip airfare on a scheduled flight, or their suitable round-trip surface transportation, whichever is the most appropriate.</p>	 Full cover	 Full cover
<p><b>Repatriation of mortal remains</b> If <b>you</b> die as the result of a condition that is covered by <b>your plan</b> while <b>you</b> are outside <b>your country of nationality</b>, <b>we</b> will pay for <b>your</b> body or ashes to be transported to <b>your country of nationality</b> or <b>country of residence</b>. This benefit is not available if a <b>claim</b> is made for the burial or cremation benefit at the place where <b>you</b> died.</p>	 Cover up to US\$5,000	 Cover up to US\$5,000

**Key** ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover

Cover	Essential Care	Essential Care Plus
<p><b>Expat benefits (continued)</b>                      Important notes:                      • <b>You</b> must obtain pre-authorisation for all benefits included in this section.</p>		
<p><b>Burial or cremation</b>                      If <b>you</b> die as the result of a condition that is covered by <b>your plan</b> while <b>you</b> are outside <b>your country of nationality</b>, <b>we</b> will pay for <b>you</b> to be buried or cremated at the place where <b>you</b> died.                      This benefit is not available if a <b>claim</b> is made under the repatriation of mortal remains benefit.  <b>We do not provide cover under this benefit if you die in your country of nationality.</b>  <b>We do not provide cover under this benefit for the costs of a religious practitioner.</b></p>	<p>○ Cover up to US\$1,600</p>	<p>○ Cover up to US\$1,600</p>

# What you are covered for

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The following are not covered by **your plan**, as well as any specific exclusions stated on **your certificate of insurance**, and other exclusions stated within the **table of benefits**. Other benefits, as stated within the **table of benefits**, may also be restricted or excluded depending on **your plan type**.

All conditions, tests, **treatments** or increased **treatment** costs **you** incur because of complications that occur directly or indirectly as a consequence of **treatment** of any excluded condition will also not be covered.

**We** will also not pay for the fees and charges listed below. **You** will be responsible for them.

- fees for the completion, or providing of, claim forms or any other medical reports or forms such as **medical referral letters**, even if **we** have requested them
- bank charges incurred as a result of **us** transferring money
- losses **you** may incur due to fluctuations in exchange rates
- charges incurred as the result of payment errors that arise as the result of **you** having provided **us** with incorrect information
- administration, registration, or cancellation fees charged by **hospitals, doctors**, or other providers of medical services
- any charges made by **your** bank or credit card company

## Addictive conditions or disorders, and alcohol, drug, and solvent abuse

**You** are not covered for **treatment** related to:

- addictions (such as alcohol or drug addiction) or substance abuse (such as alcohol, drug or solvent abuse)
- any illness or injury needed directly or indirectly as a result of any such abuse or addiction
- any illness or injury needed directly or indirectly as a result of being under the influence of any substance (such as alcohol, drugs or solvents)

## Allergy testing and/or desensitisation

**You** are not covered for **treatment** related to:

- allergy testing by hair analysis
- allergy desensitisation or food neutralising injections

**We** will only pay for patch testing if **you** have been referred by a **medical doctor** and this is limited to one patch testing investigation over the lifetime of **your plan**. **Your medical referral letter** will be required.

## Alternative treatment and therapies

**You** are not covered for alternative **treatments** and therapies, including, but not limited to, aqua physiotherapy, bone-setting, colonic irrigation, hydrotherapy, Intervertebral Differential Dynamics (IDD), kinesiology, naturotherapy, Ayurveda and massage therapy.

## Artificial life maintenance

**You** are not covered for **artificial life maintenance**, other than any benefit **you** are eligible for under the lifetime care benefit.

## Birth control, sexual problems and gender reassignment

**You** are not covered for **treatment** directly or indirectly arising from or connected with:

- contraception or sterilisation
- sexual problems (including impotence and decreased libido)
- gender reassignment

## Chemical exposure and contamination

**You** are not covered for **treatment** costs directly or indirectly related to **treatment** for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material whatsoever, including the combustion of nuclear fuel.

## Circumcision

**You** are not covered for **treatment** related to circumcision, unless it is required for **treatment** of an **acute medical condition** covered by **your plan**.

## Complementary medicine

**You** are not covered for consultations or **treatment** performed by a chiropractor, osteopath, homeopath acupuncturist, a therapist using acupressure or traditional Chinese **medical practitioners**.

## Convalescence, rehabilitation, nursing homes, and health spas or hydros

**You** are not covered for:

- **hospital** accommodation if the reason **you** are hospitalised is for the purpose of convalescence, **rehabilitation** or supervision
- relaxation or rest **treatments**, or **treatments** in nature cure clinics, health spas and health hydros
- private beds registered as nursing homes attached to such establishments or a **hospital** where the **hospital** has effectively become **your** home or permanent abode

## Cosmetic surgery and treatment

**You** are not covered for investigations or **treatment** related to:

- cosmetic or aesthetic **treatment** to enhance **your** appearance, even when medically prescribed
- the removal of fat or surplus tissue
- breast enlargement or reduction
- sclerotherapy for spider veins, **treatment** of superficial varicose veins

- Botox, dermal fillers, or **treatment** of vitiligo or any skin pigmentation disorder

### Criminal activity

**You** are not covered for **treatment** arising from or related to injuries sustained while **you** are engaged in a criminal, illegal or unlawful act.

### Dental treatment

**You** are not covered for dental, gum, oral or orthodontic consultations or **treatment** of any kind, unless covered under the **in-patient** emergency restorative **dental treatment** benefit.

### Development, learning difficulties, speech disorders, and behavioural problems

**You** are not covered for consultations, tests required to diagnose, or **treatment** of or related to:

- developmental delays
- learning and education difficulties, including, but not limited to, dyslexia and speech disorders
- behavioural problems, including, but not limited to, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) and Tourette's syndrome
- physical development of any kind
- teething

### Dietitian

**You** are not covered for **treatment** or advice by a dietitian or nutritionist.

### Experimental drugs and treatments

**You** are not covered for **treatment** or medicine which in **our** reasonable opinion is experimental or unproven based on generally acceptable current clinical evidence and generally accepted medical practice.

### Eyesight

**You** are not covered for:

- **treatment** to correct **your** eyesight, such as laser **treatment**, refractive keratotomy and photorefractive keratotomy
- spectacles, and other visual aids, **treatment** of strabismus (squint) or amblyopia (lazy eye)
- sight tests

### Failure to follow medical advice

**You** are not covered for:

- **treatment** arising from or related to **your** unreasonable failure to seek or follow medical advice and/or prescribed **treatment**, or **your** unreasonable delay in seeking or following such medical advice and/or prescribed **treatment**
- complications arising from ignoring such advice

### Foetal surgery

Surgery undertaken on a child while it is in its mother's womb.

### Foot care

**You** are not covered for podiatry, chiropody, orthotics and gait scans.

### Genetic testing or genetic engineering

**You** are not covered for genetic testing or genetic engineering, other than **treatment you** are eligible for under the cancer genome tests benefit within the cancer **treatment** benefit section of the **table of benefits**.

### Hearing

**You** are not covered for:

- **treatment** for or arising from deafness caused by maturing or ageing
- **treatment** for or arising from deafness caused by a **congenital condition** if either the abnormality was diagnosed, or **you** were showing signs or symptoms of the abnormality, before **your date of entry**
- hearing aids
- hearing tests

### Infertility, IVF and assisted reproduction

**You** are not covered for:

- testing or diagnosis related to infertility
- infertility **treatment, assisted reproduction** (e.g. IVF **treatment**), including establishing pregnancy

### Learning and educational difficulties

**You** are not covered for learning and educational difficulties, including, but not limited to, dyslexia and speech disorders.

### Menopause and puberty

**You** are not covered for:

- **treatment** to relieve the symptoms commonly associated with physiological or natural changes as a result of ageing e.g. menopause or puberty
- bone densitometry
- reproductive hormone testing, reproductive hormone therapy or hormone replacement therapy (HRT)

### Nasal septum deviation

**You** are not covered for **treatment** related to nasal septum deviation and nasal concha resection.

### Palliative care

**You** are not covered for palliative care other than cover available to **you** for the palliative care of a **terminal medical condition** under the lifetime care benefits section of the **table of benefits**.

### Persistent vegetative state and neurological damage

**You** are not covered for **treatment** received after:

- **you** have been in a **vegetative state** for a period of eight weeks
- **you** have sustained permanent neurological damage and

remained in **hospital** for a period of eight weeks

Except for any **treatment you** are eligible for under the lifetime care benefit.

### Pre-existing medical conditions or related conditions

**You** are not covered for **treatment** related to:

- any **pre-existing medical conditions** and **related conditions** which **you** have had during the five years before **your date of entry**, unless **we** have agreed otherwise
- any **pre-existing medical conditions** of the following types and any **related conditions**, if **you** have ever had them at any time before **your date of entry**, unless **we** have agreed otherwise:
  - brain or nervous system conditions
  - cancer, tumours or growths
  - heart or circulatory conditions
  - psychiatric or psychological conditions, drug and alcohol issues or sleep disorders
  - joint replacements

### Pregnancy and childbirth

**You** are not covered for any investigations or **treatment** related to pregnancy and childbirth, unless covered under the **complications of pregnancy** benefit.

### Preventive surgery

**You** are not covered for surgery when no physical signs or symptoms are shown, or diagnosis has been made.

### Professional sports and motorised racing as an amateur or a professional

**You** are not covered for **treatment** for an illness or injury related to:

- participation, to include training for or practising for, in any kind of professional sport or professional racing (by professional **we** mean sport where **you** are being paid to participate)
- participation, to include training for or practising for, in any kind of racing (whether amateur or professional) which involves the use of a motorised vehicle

### Psychiatric conditions

**You** are not covered for any investigations or **treatment** of any psychiatric condition, or investigations or **treatment** of any condition caused by or relating to any psychiatric condition. This includes, but is not limited to, eating disorders, psycho-geriatric conditions, phobias, hypnotherapy, marriage counselling and postnatal depression.

### Scalp conditions

**You** are not covered for:

- **treatment** specifically related to scalp conditions, including, but not limited to, alopecia
- wigs

### Search and/or rescue

**You** are not covered for:

- search and/or rescue operations, including, but not limited to, mountain rescue or rescue from ski slopes or pistes
- evacuations from offshore installations such as oil rigs, or from any type of sea going vessel such as a ship, ferry or yacht

### Second opinions or duplicate tests

**You** are not covered for second or subsequent opinions from a **medical doctor**, **medical practitioner** or **specialist** or for duplicate tests for the same condition.

### Self-inflicted injuries

**You** are not covered for **treatment** of self-inflicted injuries or **treatment** of any injury or illness directly or indirectly caused by self-inflicted injuries.

### Sexually transmitted diseases

**You** are not covered for **treatment** related to sexually transmitted diseases including genital/anal warts.

### Sleep disorders

**You** are not covered for **diagnostic tests** for or **treatment** of any sleep related disorder, including, but not limited to, insomnia, snoring and sleep apnoea.

### Stem-cell harvesting

**You** are not covered for stem cell harvesting other than prior to a stem cell transplant, or any **treatment** undertaken in anticipation of, prior to, or following such harvesting.

### Sundry medical supplies

**You** are not covered for non-prescribed items such as hot and cold packs and support bandages, unless these are required as a result of **treatment** received during a medical emergency.

### Surgical or medical appliances and prostheses

**You** are not covered for:

- supplying, fitting or hiring physical aids and devices (for example crutches, splints, walking sticks and wheelchairs)
- unprescribed aids such as gym equipment, even if **you** have been advised to use such an aid
- preparation for, or the fitting of artificial limbs
- hot and cold packs and support bandages

### Travel costs

**You** are not covered for travel costs including airfares and hotel accommodation, unless specifically covered under the expat benefits section of the **table of benefits**.

### Treatment by a related party

**You** are not covered for **treatment** provided by and/or under the control of and/or on referral from:

- any family member, including, but not limited to, a spouse, partner, parent, brother, sister, child, grand-parent, grand-child, uncle or aunt
- any **medical services provider**, **medical practitioner** or **specialist** where the **insured person** has a financial interest and/



or a professional interest, including, but not limited to, employees, employers, consultants and owners

### Vitamins, dietary supplements, natural substances, and creams

**You** are not covered for commercially available substances that can be purchased without prescription, including, but not limited to, vitamins, minerals, organic substances, moisturisers, oils, creams, or other pharmaceutical products, other than any **treatment** available to **you** under the routine maternity care and childbirth benefit within the maternity costs benefits section of the **table of benefits**.

### War and terrorism

**You** are not covered for **treatment** arising directly or indirectly from war, foreign enemy hostility, terrorism, rebellion, civil war, revolution, military coup, riot, strike, martial law, state of seige or attempted overthrow of a government, unless **you** are an **innocent bystander** in a country or region that the British Foreign & Commonwealth Office has not advised its citizens to leave.

### Weight-related conditions and eating disorders

**You** are not covered for investigations or **treatment** related to:

- obesity, or which is necessary because of obesity
- weight monitoring or control, such as slimming classes, aids and drugs
- bariatric surgery, or complications resulting from bariatric surgery
- eating disorders of any kind, such as anorexia nervosa or bulimia

### Wilful exposure to needless danger

**You** are not covered for **treatment** of any conditions arising directly or indirectly from **your** gross negligence and/or **your** wilful exposure to needless danger except in an attempt to save a human life.



# If you need to make a claim

As stated in the **table of benefits**, there are certain benefits and **treatments** for which **you** must obtain pre-authorisation.

If **you** need to **claim** for a benefit or **treatment** for which **you** must obtain pre-authorisation, **you** must contact **us** in advance of starting **your treatment** and give **us** all the information **we** require to assess if **your** proposed **treatment** will be eligible for cover under **your plan**. If **your** proposed **treatment** is eligible for cover, **we** will pre-authorise all eligible expenses. **We** will not pay for any **treatment** costs or expenses that have not been pre-authorised by **us** in advance.

## Eligible medical services providers

**You** have the freedom to choose when and where **you** receive **your** medical **treatment** within **your area of cover**.

## If you are admitted to hospital

All **in-patient** and **day-patient hospital treatment** must be pre-authorised by **us** or by the **Assistance Service** more than 48 hours in advance.

Please contact **us** as soon as **you** know **you** need to have **in-patient** or **day-patient treatment** so **we** can contact the **hospital** to obtain the necessary medical information.

**We** will ask **you** to complete a pre-authorisation form and a consent form for the **hospital** to release details to **us**. Once **we** have received all information required from the **hospital** and **yourself** (to include any additional information **we** may request) **we** will advise **you** if the proposed **treatment** will be covered by **your plan**.

If **you** are admitted to **hospital** in an emergency and it is not reasonably possible for **you** to contact **us** in advance of **your** admission, **we** will consider **your claim**, provided **you** contact **us** within 24 hours of **your** admission. If **you** do not contact **us** within 24 hours, **we** may decline **your claim**, or subject **your claim** to 20% **co-insurance**.

## If you have out-patient treatment

Although most **out-patient treatment** does not need to be pre-authorised in advance by **us**, **we** recommend that **you** do contact **us** or the **Assistance Service**, even in the event of an emergency, before undergoing any **treatment** to ensure that the **treatment** is covered by **your plan**.

## How to claim back your eligible treatment costs

If **you** are claiming for a medical condition, **you** will need to download a claim form from **our** website.

Please complete Section A of the claim form. If the total amount of **your claim** is likely to exceed US\$500 (or the foreign currency equivalent), please take the claim form with **you** when **you** visit **your doctor** and ask him or her to complete and sign Section B of the claim form.

Scan the completed claim form and the fully itemised invoices and receipts for the **treatment** **you** have received, and send to [claims@william-russell.com](mailto:claims@william-russell.com).

Even if **your claim** is less than US\$500 **we** may in some cases require **your doctor** to complete and sign section B of **your** claim form before **we** can settle **your claim**.

**We** can only reimburse **your claim** when **we** have fully itemised invoices and receipts which give a breakdown of the **treatment** and medical services **you** have received, and any drugs **you** have been prescribed.

Please retain **your** original invoices, receipts and claim forms for 12 months. **We** may require these for auditing purposes.

## Claims for which a medical referral letter is required

If **you** are claiming for **out-patient** physiotherapy, an MRI, CAT (CT) or PET scan **you** must also send **us** **your medical referral letter**. If **you** are claiming for a PET SCAN, **you** must also send **us** **your specialist's medical referral letter**.

## Supplying the information required to process your claim

**We** can accept the information required to process **your claim** via email. Simply, scan in PDF format **your** itemised invoices, receipts, **medical referral letter** (when required) and **your** fully completed claim form and email them all to [claims@william-russell.com](mailto:claims@william-russell.com). Please always retain the original copies of everything for a period of 12 months as **we** reserve the right to receive these documents before **we** assess **your claim**. **We** may also require them at any time for auditing purposes. Or, **you** can send the information required to process **your claim** by post.

**You** must submit **your claim** within 6 months of **your treatment** date, unless it was not reasonably possible for **you** to submit the **claim** within this time. **We** will not pay any invoices received by **us** more than 12 months after the **treatment** date.

**We** will not pay fees charged by a **medical practitioner**, or anyone else, for completing a claim form.

## Paying your claim

Where possible **we** will settle invoices for **in-patient** or **day-patient treatment** direct with the **hospital** or **medical services provider**. **We** will deduct any **excess** or **co-insurance** amount, as well as any other ineligible items, and **you** will be responsible for paying the shortfall direct to the **hospital** or **medical services provider**.

If **we** are paying **you** direct, **our** preferred method of payment is bank transfer. If **you** provide us with incorrect payment details and **we** cannot recover the payment, **we** will not make the payment again to **you**.

**We** will only make payment to **you** or to the **medical services provider** that provided **your treatment**. Payment will not be made for **treatment** that has not been received yet.

If **we** or the **Assistance Service** pre-authorise costs which subsequently turn out to have been related to a condition which is not covered by **your plan**, **you** will be responsible for all the costs incurred, and if **we** have made any settlement on **your** behalf, **you** will be responsible for repaying to **us** the amount **we** have paid.

## Exchange rates

We will settle **your claim** in US dollars unless **you** instruct **us** otherwise. If **we** have to make a currency conversion, **we** will use the historic exchange rate (provided by [oanda.com](https://www.oanda.com)) applicable on the date of each separate invoice **you** submit.

Exchange rates are imported into **our** computer system overnight, each night, using the live exchange rate at the time of the import. This may vary slightly from the historic exchange rates shown on [oanda.com](https://www.oanda.com) for the relevant day, which are based on the average exchange rate for the day.

If **we** have placed a Guarantee of Payment **we** will use the exchange rate applicable on the date **we** placed the guarantee.

## Excesses, co-insurance and benefit limits

The **excess** shown on **your certificate of insurance** is the amount **you** will have to pay towards the cost of **your treatment**.

If **your plan** has an **excess** and the benefit **you** are claiming for has **co-insurance** and/or limits, **we** will apply the **co-insurance** first, then the **excess**, then the limit.

If **you** have chosen a **plan** which has an **excess** per **claim**, this is the amount **you** will have to pay each time **you** make a new **claim** for **treatment** covered by **your plan**. New **claims** are those that are for a condition which is not related to an existing **claim**.

If **your claim** is for the **treatment** of a **chronic condition**, AIDS/HIV, or for **out-patient** follow-up consultations and/or tests for cancer and the **treatment** continues into a new **period of cover**, **we** will treat it as a new **claim**. In these circumstances **we** will re-apply the **excess** at **your plan renewal date** and each subsequent **plan** renewal until the **claim** is finished.

If **your excess** is per annum it will be applied once per **period of cover**. For example, if **your excess** is US\$250 per annum, **we** will not pay for the first US\$250 of eligible expenses **you** incur during **your period of cover**. **We** will apply one **excess** per **period of cover** irrespective of the number of **claims** **you** make. **You** must submit all eligible **claims** to **us** - even **claims** within **your** annual **excess**, as **we** will only be able to reimburse **you** when the value of the eligible expenses **you** incur exceeds the amount of **your** annual **excess**. When **you** renew the **plan**, the annual **excess** will apply again in respect of **your** new **period of cover**.

## Our right to request additional information

**We** may request additional medical information to enable **us** to assess **your claim**, such as medical reports or tests. These must be provided at **your** own expense. **We** may also request an independent medical examination. If **you** do not agree to supply **us** with additional medical information that **we** reasonably request, **we** will not be able to assess **your** claim.

If **you** require ongoing **treatment** **we** may ask for further medical information, and if **we** do, the cost of providing this information must be borne by **you**. **We** are unable to return original documents such as invoices or medical letters, but **we** will send **you** copies upon request.

## Our right to request a treatment review

**We** will not pay for **treatment** which in **our** opinion is inappropriate based on established medical and clinical practice and **we** are entitled to conduct a review of **your treatment** when it is reasonable for **us** to do so.

## Illness or injury caused by a third party

If **you** are claiming for an illness or injury that was caused by some other person or organisation (a third party) **you** must let **us** know in writing straight away, or tell **us** on **your** claim form. **We** will then pay benefit in accordance with the terms of this **agreement** provided that **you** take all necessary steps **we** ask **you** to take to assist **us** in recovering **our** costs from the person or organisation at fault (such as through their insurance company) the cost of the **treatment** paid for by **us**, plus interest, at **your** own expense.

If **you** pursue a personal **claim** for damages against the third party, **you** must provide **us** with the full name and address of the solicitor handling the action. **We** will then contact the solicitor to register **our** interest and seek to recover **our** own costs, plus interest, in addition to any damages that **you** may recover or be awarded. **We** reserve the right to appoint **our** own solicitor to act on **your** behalf in this matter and to take over the conduct of the action.

If **you**, or any **insured person**, are able to recover from the third party (whether or not through legal action) compensation that includes any **treatment** costs **we** have paid, **you** must repay that amount to **us**. Any interest that **you** or any **insured person** may also have been awarded that relates to the recovered **treatment** costs **we** have paid for must also be repaid to **us**. If **you** only receive a proportion of **your claim** for damages then **you** must repay to **us** the same proportion of **our** costs.

## If you are covered by another insurance plan

If **you** have any other insurance that covers the same costs as **we** do, **we** will only pay **our** proportionate share of the **claim**. In this event, **you** must provide **us** with full details of the other insurance, including the name and address of the other insurer, their policy and **claim** number and any other relevant information, when **you** first submit **your claim**. **We** will then contact the other insurance company to ensure that **we** only pay **our** proportion of the **claim**. This may involve **us** sending **your** personal information regarding **your claim** to the other insurer.

**We** will also allow sums paid by another insurer to be offset against the **excess** payable under **your plan** with **us**, subject to receiving confirmation from the other insurer of any amounts already paid by them, and subject to the **treatment** costs being eligible for cover under **your plan** with **us**.

# Other information about your plan

## Plan premiums

The **plan premiums** are age-related and will increase as **you** get older. The **plan premiums** are not guaranteed for the duration of **your plan** and are subject to annual review. The **plan premiums** are also dependent upon **your country of residence**. **You** must tell **us** if **your country of residence** changes.

All **premiums** are payable in advance of the **premium due date** as shown on **your invoice**. **Premiums** must be paid in US dollars.

**You** may pay **your premiums** by the following method:

- Annually by cheque, bank transfer, or an acceptable credit or debit card.
- Half-yearly, quarterly, or monthly by an acceptable credit or debit card.

If insurance **premium tax** or any similar charge is levied by the government in **your country of residence**, **you** must also pay to **us** the amount of such tax.

**Premiums** must be paid directly to **us**. If **you** pay **your premiums** to anyone else such as an intermediary or insurance broker, then that person is acting on **your** behalf as **your** agent. **We** are not responsible for any **premiums** paid to any third party.

When **you** provide **us** with **your** debit/credit card details **you** are authorising **us** to debit **your** account with the appropriate **premiums** due for the current **plan** year and for all subsequent renewal **premiums** due as invoiced by **us**, until such time as **you** advise **us** in writing that **you** wish to alter **your** payment method or cancel **your plan**. It is **your** responsibility to keep **us** informed about **your** current credit/debit card details. Provided the details **we** hold for **you** are still valid, **we** will automatically debit **your** account with **your** renewal **premium** on or before **your** renewal **date**.

## Unpaid or late premiums

**We** will automatically cancel **your** cover if **you** fail to pay **your premium** on or before the **premium due date**, or if **we** are unable to collect **your premium** from **your** credit/debit card for any reason.

**We** may allow **your** cover to continue without **you** having to complete a new **application form** and health declaration if **you** pay the outstanding **premium** within 30 days of the **premium due date**. During this 30 day period **we** will not accept any **claims** for **treatment** incurred on or after the **premium due date** until **you** have paid the **premium** due. This also applies to **treatment** that **we** have already pre-authorised.

If **you** do not pay **your premium** within 30 days of the **premium due date**, **we** will cancel **your plan** from midnight on the day before **your premium due date**. Once **we** have cancelled **your plan**, **you** will have to complete a new **application form** which will be subject to **medical underwriting**.

## Enhancing your cover

**You** may apply to enhance **your** cover at any time by completing a new **application form**, and the enhanced cover will be subject to

**medical underwriting**.

If **we** accept **your application** for enhanced cover, **we** will issue an invoice for the increased **premium**. **Your** enhanced cover will commence from the date **we** receive **your premium**, provided it is received within 30 days of the date of **your application**.

If **you** enhance **your plan type**, **claims** in respect of benefits that are subject to a **waiting period** will be assessed in accordance with **your** former **plan type** until the expiry of **your** new **plan's waiting period** for that benefit.

If **you** enhance **your plan type** from Essential Care to Essential Care Plus **you** will not be eligible to **claim** for any expenses related to **complications of pregnancy** that arise within the first 10 months of **your** Essential Care Plus **plan**.

If **you** apply to reduce **your excess**, **we** will continue to apply **your** previous **excess** to any **claim** for any condition that first manifests itself after **your** original **date of entry** to **your** previous **plan**, but before the date **your excess** is reduced. If **you** wish to transfer **your plan type** from Essential Care Plus to Essential Care and **you** apply to decrease **your excess**, **your** previous **excess** will continue to apply for a **waiting period** of 10 months in respect of **claims** for the 'Complications of pregnancy' benefit.

If **we** accept **your application** for enhanced cover and **you** have previously reduced **your** cover, all conditions whether diagnosed or not prior to the enhancement will be restricted to the cover prior to the enhancement.

## Reducing your cover

If **you** wish to reduce the cover under **your plan** in any way, **you** must tell **us** in writing and **we** will make the change from **your** next **renewal date** only.

**We** may refuse any request to change **your excess** to a per annum basis.

## Changing your plan currency

The **plan** currency is US dollars – this cannot be changed.

## Adding dependants to your plan

**You** may apply for cover on behalf of **your** spouse or partner, provided they are under 70 years of age on their **date of entry**.

**You** may also apply for cover for **your eligible dependant** children, provided they are under 18 years old, or under 25 years old if they are in continuous full-time education. **We** reserve the right to request proof of a child being in full-time education.

**We** will not commence cover for a new **eligible dependant** until **we** have accepted their **application** and **we** have received payment of their **premium**.

## Adding newborn babies to your plan

**You** may add **your** newborn child to **your plan**, without any **medical underwriting**, provided **you** notify **us** of their full name and date of birth, and make payment of their **premium**, within 30 days of their date of birth. If **you** have been insured with **us** for a



continuous period of ten months or more at the date of birth, the **date of entry** can be backdated to their date of birth. The child's cover will be restricted to the cover provided by **your** (the **plan holder's**) **plan type**.

If **you** wish **your** child to have cover that is enhanced in any way in comparison to **your** (the **plan holder's**) cover **we** will require an **application form**, and **your** child's **application** will be subject to **medical underwriting**.

If **you** do not inform **us** about the birth of **your** child within 30 days of their birth, and/or **you** do not pay the additional **premium** within 30 days of their date of birth, **you** will have to make a new **application** for **your** child to be added to **your plan**, and this **application** will be subject to **medical underwriting**.

Newborn children who have been born as a result of **assisted reproduction treatment** and born within 36 weeks of conception are always subject to **medical underwriting**.

### In the event of the death of an insured person

If **you** (the **plan holder**) die, provided no **claim** has been made on **your plan**, **we** will refund any unused **premium** from **your** date of death.

If **you** (the **plan holder**) have **eligible dependants** insured under **your plan**, as the contract is between **us** and **you** as the **plan holder**, **we** will have to transfer **your eligible dependants** on to their own **plan**.

To enable **us** to do this **we** will require a new **application form** which must be completed and returned to **us** within 30 days of **your** date of death. Provided **we** receive the new **application form**, and provided **premiums** continue to be paid up to date, **we** will continue their cover as before.

If **your eligible dependants** want to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

If **your eligible dependants** are under the age of 18, their legal guardian will have to sign the **application form** as the **plan holder** on their behalf.

If an insured **eligible dependant** dies, please inform **us** as soon as possible. If they have made no **claim** on their **plan**, any unused **premium** from their date of death will be refunded. However if the deceased **insured person** had made a **claim**, no **premium** refund will be made.

### Divorce and separation

If **you** (the **plan holder**) have **your** spouse or partner included under **your plan** and **you** become separated or divorced, **we** will have to transfer **your** insured spouse or partner on to their own **plan**. To enable **us** to do this **we** will require **your** spouse or partner to complete a new **application form** which must be completed and returned to **us** within 30 days of **your** date of divorce or separation.

Provided **we** receive the new **application form**, and provided **premiums** continue to be paid up to date, **we** will continue to cover **your** insured ex-spouse or partner as before. If **your** ex-spouse or partner want to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

### When a child dependant is no longer eligible to be covered under your plan

If one of **your** children has married, or has reached the age of 18 (or the age of 25 if they are in full time education) they will no longer be eligible to be included in **your plan** from the **renewal date** following their marriage/birthday.

However, **your** child may apply to continue their cover on their own **plan**, at the applicable adult **premium** rate, provided they send **us** their completed **application form** and **we** receive the appropriate **premium** within 30 days of **your renewal date**.

If they want to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and any enhancement in their cover will be subject to **medical underwriting**.

If **we** do not receive **your** child's **application form** and **premium** within 30 days of **your renewal date**, their cover will automatically cease from midnight on the day before **your renewal date**. If they subsequently wish to apply for cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

### Changing your address, country of residence or nationality

**You** must inform **us** if **you** change **your** address and provide **us** with the new details.

If **you** change **your country of residence** or **you** change **your country of nationality**, **you** must tell **us** straight away.

If **you** move to a country outside **your area of cover**, **you** must apply to change **your area of cover**. **Your** application will be subject to **medical underwriting**.

If **you** have the standard **area of cover** and **you** return to **your country of nationality**, **you** may continue to renew **your plan** provided that the local laws in **your country of nationality** permit **us** to offer **you** cover, and provided that **we** agree to offer cover in that country. **We** reserve the right to refuse to offer cover in certain countries.

### If you take up residence in an excluded or restricted country or region

Under the terms of this **agreement** cover is not available to **you** if **you** take up residence in an excluded or restricted country and/or region, irrespective of **your** nationality.

These countries and/or regions are as follows: USA, Canada, any Caribbean country or island, all countries within the European Union, Andorra, Channel Islands, Gibraltar, Greenland, Iceland, Liechtenstein, Monaco, Norway, San Marino, Switzerland, Australia, Bali, China, Hong Kong, Japan, Macau, New Zealand, Singapore and Taiwan.

If **you** take up residence in an excluded or restricted country and/or region **you** must tell **us**. **Your** cover will automatically terminate from the date on which **you** take up residence in the excluded or restricted country and/or region.

Provided there have been no **claims** made, **we** will refund any **unused premium**, if a **claim** has been made by any **insured person**, no **premium** refund will be paid.

### Renewing your plan

**You** may continue to renew **your plan**, each year, regardless of **your** age or state of health, or the number or value of **claims you**

have made. **We** will not cancel **your plan** unless **we** are entitled to do so under **our** cancellation policy.

Prior to **your plan renewal date** **we** will send **you** an invoice by email stating **your premiums** for **your new period of cover**.

**Your premium** for each new **period of cover** will be determined by the following:

- **your** age at the start of **your new period of cover**
- the ages of **your eligible dependants** at the start of their new **period of cover**
- the number of eligible children **you** insure
- **your plan type**
- **your area of cover** and
- **your excess** amount
- **your country of residence**

Other factors may affect **your** renewal **premiums**, such as general changes **we** make to **our plan premiums** annually, and changes to the discounts **we** apply to increase the standard **excess**, to the loadings **we** make to decrease the standard **excess**, to the child **premium** discounts, and to the surcharge for instalment **premiums**.

**We** may also change the methods of payment **we** offer.

**Your premiums** may also be affected by the introduction of, or increase to insurance **premium** tax or other tax, levy or charge applicable in **your** county of residence.

**We** may also change the benefits offered by **your plan type** and if **we** do, **we** will write to **you** before **your renewal date** to confirm these benefit changes. Any changes **we** make to **your** benefits will come into effect from the **renewal date** of **your plan**.

From time to time **we** may decide to discontinue the **plan** **you** are a member of. If this happens **we** will transfer **your** membership to another similar **plan**.

## Paying your renewal premium

**You** must pay **your** renewal **premium** on or before the due date.

If **you** pay **your** **premium** by credit or debit card, unless **you** tell **us** not to, and provided **your** credit and debit card details are current, **we** will withdraw **your** renewal **premium** on or around its due date.

If **you** do not pay **your** renewal **premium** within 30 days of the **premium due date**, **we** will cancel **your plan** from midnight on the day before **your premium due date**.

**We** may allow **your** cover to continue without **you** having to complete a new **application form** and health declaration if **you** pay the outstanding **premium** within 30 days of the **premium due date**. During this 30 day period **we** will not accept any **claims** for **treatment** incurred on or after the **premium due date** until **you** have paid the **premium** due. This also applies to **treatment** that **we** have already pre-authorised.

If **you** do not wish to renew **your plan** **you** must inform **us** in writing as soon as **you** receive **your** renewal **premium** invoice and prior to **your renewal date**.

## Cancelling your plan

If **you** wish to cancel **your plan**, or if **you** want to cancel cover for one of **your dependants**, **you** must instruct **us** in writing by letter, email, or fax. **We** will cancel cover from the date we receive **your**

written instructions, or from a date in the future that **you** have specified. **We** will not cancel cover from a date prior to **us** receiving **your** written instruction to cancel.

**We** will only make a refund in respect of **unused premium** if no **claim** has been made. If a **claim** has been made by any **insured person**, no **unused premium** will be refunded in respect of that **insured person**.

## When we can cancel your plan

**We** have the right to cancel **your plan** immediately if:

- **you** do not pay **your** **premium** and other charges such as insurance **premium** tax within 30 days of any **premium due date**
- **you** are no longer eligible to be included in the **plan** or **you** move to a country where **we** are unable to offer health cover
- **you** have not provided **us** with medical information **we** have requested to enable **us** to assess a **claim** or any potential **claim** that may arise in the future
- **you** have not repaid to **us** fully any ineligible **claim** payments **we** have invoiced **you** with
- **you**, any **insured person** or any person acting on **your** behalf has made any threatening or abusive comment, or used any unacceptable language towards **us** or any member of **our** staff, or any service provider acting on **our** behalf, whether verbally (including any telephone conversation) or in writing (including any electronic communication)
- **we** reasonably suspect that any **insured person** has misled **us** or attempted to mislead **us**, whether intentionally or carelessly, either at the time of joining or when making a **claim**, by:
  - making a **claim** under this policy knowing it to be dishonest, intentionally exaggerated or fraudulent in any way
  - providing **us** with incomplete or false information; or
  - working with another party to provide false information to **us**; or
  - changing original documents

If **we** cancel **your plan** for any of the above reasons **we** will not refund any **premium** **you** have paid to **us**. **We** may also report the matter to the relevant authorities, if appropriate.

## Child premium discounts

When **you** have **eligible dependant** children included in **your** (the **plan holder's**) **plan**, the child **premium** discounts will be applied as follows:

- the first child will be charged 100% of the child **premium** rate
- the second child will be charged 80% of the child **premium** rate
- the third child and all subsequent children will be charged 60% of the child **premium** rate

If a child leaves **your**, the **plan holder's**, **plan**, **we** will re-calculate the **premiums** for the remaining children with effect from the date on which the child leaves. This means that the child **premiums** **you** pay will always be based on the actual number of children **you** insure.

Child premium discounts are not available when **you**, the **plan holder**, are not an **insured person**. In such cases, the child **premium** rate will be increased by 20%.

### When we may apply special terms to your plan

We have the right to apply **special terms** to **your plan** if **you** give **us** inaccurate or incomplete information. Such **special terms** will be applied from **your date of entry**.

### Our liability under this plan

**Our** liability under this **plan** is limited to paying for **treatment** or services in respect of eligible **claims** under this **plan**. The choice of provider of the **treatment** or services for which **you** are claiming under this **plan** is **your** responsibility. **We** make no representations or recommendations regarding the availability and standard of any **treatment** or services offered or provided by any **hospital** or **medical services provider**. **We** will not be held liable to **you** or any **insured person** for any loss, harm or damage of any description resulting from lack of availability or from a defect in the quality of any **treatment** or service offered or provided by any **hospital** or **medical services provider**. This **plan** represents the whole and only **agreement** between **you** and the **insurer** relating to the provision of private medical insurance.

### Your responsibilities as the plan holder

It is **your** responsibility to:

- ensure that all **premiums** are paid when they are due
- inform **us** if **your** personal details, or the personal details of any **insured person**, change
- keep **us** advised of **your** current email address
- inform **us** if **you** change **your** address, country of residency or **country of nationality**

# How to make a complaint

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At William Russell, each one of **our** customers is important to **us**. We believe that **you** have the right to professional customer service of the highest quality at all times. If you think **we** have fallen short of this standard, please follow the procedures outlined below.

If **you** are not happy with the service **you** have received, **you** may write to **us** at any time at the following address:

**William Russell Ltd.**  
William Russell House  
The Square, Lightwater  
Surrey, GU18 5SS, UK

**Tel** +44 1276 486455

**Fax** +44 1276 486466

**Email:** [enquiries@william-russell.com](mailto:enquiries@william-russell.com)

We will acknowledge receipt of **your** complaint within 2 working days. We will investigate **your** complaint and send a response to **you** within 4 weeks of the receipt of your complaint. If **we** are unable to provide **you** with a final response within this time period, **we** will write to **you** advising **you** of when **we** will be able to respond. We will endeavour to send a final response to **you** within 8 weeks of the receipt of **your** complaint. If **we** are unable to provide **you** with a final response within this time period, **we** will write to **you** again explaining why and advising **you** of when **you** may expect a final response.

William Russell Ltd. acts on behalf of the **insurer** of **your plan** in respect of policy administration and **claims** handling. If **your** complaint relates to a decision **we** have made on behalf of **our insurer** (e.g. a decision regarding a **claim** you have made), **you** can write to the **insurer** at any stage in the process.

## **AWP Health & Life S.A.**

Customer Relationships  
Eurosquare 2  
7 rue Dora Maar  
93400 Saint Ouen  
France

**Email** [client.care@allianzworldwidecare.com](mailto:client.care@allianzworldwidecare.com)

AWP Health & Life S.A. is a signatory to the French Insurance Mediation charter. In the event of a persistent and definitive disagreement, the **plan holder** has the option, after the exhaustion of all domestic remedies referred to above, to call for the French Insurance Mediator without prejudice to possibilities of legal action.

## **La Médiation de l'assurance**

TSA 50 110  
75441 Paris Cedex 09  
France

**Web** [mediation-assurance.org](http://mediation-assurance.org)

If **your** complaint relates to a service provided by William Russell Ltd. and **you** have not received a response from **us** within 8 weeks of **our** receipt of **your** initial complaint, or **you** are dissatisfied with the final response **you** have received from **us**, **you** may write to the UK Financial Ombudsman Service.

## **The Financial Ombudsman Service (FOS)**

Exchange Tower  
London E14 9SR

**Tel** +44 800 023 4 567

**Fax** +44 020 7964 1001

**Email** [complaint.info@financial-ombudsman.org.uk](mailto:complaint.info@financial-ombudsman.org.uk)

**Web** [financial-ombudsman.org.uk](http://financial-ombudsman.org.uk)

## **Arbitration and applicable law**

All disputes arising out of or in connection with the present contract shall be finally settled under the Rules of Arbitration of the International Chamber of Commerce of Paris by one or more arbitrators appointed in accordance with the said rules, and shall take place in Paris. The arbitration shall be conducted in English and English law shall apply. A sole arbitrator shall be appointed by the International Chamber of Commerce of Paris unless the parties to the dispute agree otherwise.

# How we process your information

We think it is important for all **our** customers to be made aware of what information **we**, as a data controller, hold about them and to have the reassurance of knowing that **we** will process their personal information fairly and securely. The following statements refer to the personal information of **yourself** and all other **insured persons on your plan**.

## The information we collect

We collect information **you** give **us** as part of **your application**, and in correspondence with **us** by phone, email, post or other means of communication. This information may include sensitive personal information, such as details of **your** physical and mental health.

In addition, **we** may receive information about **you** from third parties, such as those who provide services on **our** behalf. Failing to provide the personal information **we** require in order to underwrite and administer **your** plan, or to process **your claims**, could result in **your claims** being rejected or not being fully paid, or **your plan** being cancelled.

## How we use your personal information

We will only collect information that is necessary to provide **you** with the services **we** offer. These include:

- Underwriting and administration of **your plan**
- Processing **claims**
- **Our** business processes, such as auditing, business planning, and accounting
- Compliance with legal and regulatory obligations
- Research or statistical analysis to help **us** improve **our** services
- Communicating with **you**

By taking out a **plan** with **us**, you agree to **us** processing **your** personal information and sensitive personal information for the above purposes.

## Who we may share information with

We may disclose **your** personal information to selected third parties for the listed purposes above, including:

- Our providers of payment services
- Organisation (such as regulatory authorities) where **we** have a duty to disclose or share **your** personal information to comply with legal obligations
- Providers of research, marketing, and analysis services
- The **insurers** or reinsurers of your plan
- **Our** emergency Assistance Service providers
- **Your** insurance adviser (if **you** have appointed one)

**Your** information may be disclosed to other parties (such as other insurance companies) with a view to preventing fraudulent or improper **claims**.

## Processing claims

In the event of a **claim**, **we** may have to give some information

to those involved in **your treatment** or care, or to **your** representative (if **you** have chosen one). This will be done confidentially. Unless specifically instructed, correspondence about all **claims** (including those made by dependants) will be addressed to the **plan holder**. An insured dependant over the age of 16 has the right to confidentiality in relation to their **claims** and information. For them to exercise this right, they should contact customer services. If **you** have another insurance plan that covers the same costs that **you** are claiming from **us**, then **we** may also disclose **your** relevant personal information to that other **insurer** so **we** can ensure that **we** only pay **our** proportion of the costs.

## How we keep, store, and dispose of your personal information

We hold **you** information in various forms, including electronic databases, computerised files, and paper files. Information may be held for a period after **your plan** ends with a view to preventing or detecting fraud, or as **we** are required to under UK law. When **we** dispose of **your** information, **we** will do so securely. **We** may continue to keep non-personally identifiable information for the purposes of research and statistical analysis to improve the services **we** offer.

## Where we store your personal information

The information **we** collect from **you** may be transferred to and stored at a destination outside the European Economic Area (EEA). It may also be processed by staff operating outside of the EEA who work for **us** or for one of **our** suppliers. By submitting **your** personal information, **you** agree to this transfer, storing, and processing. **We** will take all steps necessary to ensure that **your** information is treated securely and in accordance with this data protection notice.

## Marketing

**You** have the right to ask **us** not to process **your** information for marketing purposes. **We** will always inform **you** (before collecting **your** information) if **we** intend to use **your** information for such purposes. **You** can withdraw **your** consent for **us** to use **your** information in this way at anytime by sending **us** an email at [marketing@william-russell.com](mailto:marketing@william-russell.com).

## Obtaining a copy of the information we hold about you

**You** have a right to request a copy of the information **we** hold about **you**. **You** also have a right to restrict or object to how **we** use **your** information, or to request that any inaccurate information be corrected. To exercise any of these rights, please contact:

### Data Protection Officer

William Russell Ltd.  
William Russell House  
The Square, Lightwater  
Surrey, GU18 5SS, UK

Tel +44 1276 486455

Fax +44 1276 486466

Email: [enquiries@william-russell.com](mailto:enquiries@william-russell.com)



Where information has been supplied by a **medical practitioner**, **you** should be aware that **we** need their consent before **we** can supply this to **you**, or alternatively **you** can request such information direct from the **medical practitioner**.

If **you** believe **we** are not processing **your** personal data in accordance with the law, **you** can complain to the UK Information Commissioner's Office (ICO).

# Definitions

This section explains what **we** mean by certain words and phrases bolded in this **agreement**.

## Accident

A sudden, unexpected, unusual, specific, violent, external event which occurs at a single identifiable time and place independently of all other causes, which results directly, immediately and solely in physical bodily injury which results in a loss. In no event shall the contracting of any disease and/or illness (including, but not limited to, heart attack, stroke or cancer), nor the injection or ingestion of any substance, be considered an **accident**. An event which directly or indirectly exacerbates a previously existing physical bodily injury shall not be considered an **accident**.

## Acute medical condition

A disease, injury or illness that is likely to respond quickly to **treatment** which aims to return **you** to the state of health **you** were in immediately before suffering the disease, illness or injury, or which leads to **your** full recovery.

## Agreement

The contents of this document, read in conjunction with **your** completed and signed **application form** and **your certificate of insurance**. Together, these items make up **your plan** contract with **us**.

## Application or application form

The **application form** **you** have completed and signed on behalf of **yourself** and on behalf of any **eligible dependants** for whom cover is requested. Please note that on some occasions an alternative form such as a health declaration or an upgrade form may be required to be completed instead of a full **application form**. **We** will advise **you** when this is the case. The alternative form will then be classed as the **application/application form** for the purpose of this **agreement**. Information on previously completed **application forms**, if applicable, may also be used by **us** for underwriting and **claims** assessment reasons.

## Area of cover

The territorial limits of **your plan**.

## Assistance Service

The emergency assistance company contracted by **us** to provide assistance services to **plan** members at the time of **your claim**. The contact details for the **Assistance Service** can be found at the beginning of this **agreement**.

## Assisted reproduction

The use of medical techniques, including, but not limited to, in-vitro fertilisation (IVF) with or without intra-cyotoblastic sperm injection (ICSI), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), egg donation and intra-uterine insemination (IUI) with ovulation induction, received during the 3 month period prior to conception.

## Caribbean country and island

All countries in the Caribbean region including the West Indies and all islands surrounded by or bordering the Caribbean Sea.

## Certificate of insurance

The confirmation of **your** insurance cover issued by **us**. It confirms the **plan type** **you** have bought, **your area of cover**, **period of cover**, **date of entry**, **renewal date**, **excess** amount, **special terms**, **your country of residence**, **your country of nationality**, and the schedule of **insured persons**. The schedule of **insured persons** lists the persons insured by **us** under **your agreement** with **us**. If there are any changes to the details on **your certificate of insurance** **we** will issue **you** with a new one confirming the changes.

## Chronic condition

A disease, illness or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- **you** need to be rehabilitated or specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

## Claim

A course of **treatment** for a specific illness, injury, medical condition, dental condition or pregnancy, or the use of an expat benefit.

## Co-insurance

A contribution that **you** must make towards the eligible costs of **your claim**.

## Complications of pregnancy

**Treatment** received for a medical condition which arises because of the antenatal or postnatal stages of pregnancy.

## Congenital condition

Whether hereditary or not, any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not, or any deformity arising during the antenatal stages of pregnancy, or caused during childbirth.

## Country of residence

The country in which **you** are habitually resident as specified on **your application form** or subsequently advised to **us** in writing.

## Country of nationality

Your country of origin, for which you hold a passport. If you hold more than one passport your country of nationality will be the country you have declared on your application form.

## Date of entry

The date on which cover for you, and each of your dependants, first commenced. Your date of entry is as stated on your certificate of insurance.

## Day-patient

A patient admitted to a hospital or day-patient unit for a medical procedure which for medical reasons could not have been performed on an out-patient basis and which requires them to occupy a hospital bed for a period of medically supervised recovery, but it is not medically necessary for them to occupy a bed overnight.

## Dental treatment

Dental procedures undertaken by your dental practitioner which are clinically necessary for the maintenance and/or restoration of oral health, and are provided in accordance with accepted standards of dental practice.

## Dentist or dental practitioner

A qualified person legally carrying out this profession in the country in which he or she is located.

## Diagnostic tests

Investigations, such as x-rays or blood tests to diagnose the cause of your symptoms.

## Doctor

See medical doctor.

## Eligible dependants

Your spouse or partner, provided they are under age 70 at their date of entry, and your unmarried children (i.e. your son, daughter, step-son, step-daughter, adopted children and children subject to legal guardianship) provided the unmarried children are aged less than 18 years old, or less than 25 years old if in continuous full-time education. If a child is adopted or the subject of legal guardianship we may require proof. We may also require proof of a dependent child being in full time education.

## Emergency caesarean section

A caesarean section, which has been scheduled to take place less than 24 hours in advance.

## Emergency treatment

Essential treatment, covered by your plan, that is immediately required if you suffer an accident or a sudden and unforeseen illness you have never suffered from before, which is not a pre-existing medical condition, or a related condition, or a condition for which you have a personal medical exclusion.

## Excess

The amount stated as the excess in your certificate of insurance,

being the amount you must contribute to each claim. If your excess is per annum, the excess stated on your certificate of insurance is the amount you must contribute towards the cost of eligible treatment covered by your plan and received within the same period of cover.

## Hospital

An establishment which is legally licensed as a medical or surgical hospital under the laws of the country in which it is situated.

## Innocent bystander

Someone who is not involved with, participating in or reporting on war, 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 acts of terrorism, or actively participating in operations countering any such activities.

## In-patient

A patient who is admitted to hospital and who occupies a bed overnight or longer for medical reasons.

## Insured person

You and any eligible dependants specified in your certificate of insurance as being included in the plan.

## Insurer

The insurance company that provides the insurance cover for your plan. The insurer is Allianz (AWP Health & Life S.A.).

## Life-threatening condition

A critical medical condition covered by your plan, which in the opinion of the Assistance Service constitutes a life-threatening situation which requires immediate in-patient treatment.

## London area

Any address in the United Kingdom within the E, EC, N, NW, SE, SW, W or WC postcode areas.

## Medical doctor

A person who is legally qualified in medical practice following attendance at a recognised medical school (as listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation) to provide medical treatment and who is licensed to practise medicine in the country where the treatment is received.

## Medically necessary

Treatment that is medically necessary and appropriate. The treatment must be:

- essential to diagnose or treat a patient's condition, illness or injury;
- consistent with the patient's symptoms, diagnosis or treatment of the underlying condition;
- in accordance with generally accepted medical practice and professional standards of medical care at the time;

- required for reasons other than the comfort or convenience of the patient or his or her physician
- proven and been demonstrated to have medical value, with international medical and scientific evidence of the effectiveness and safety of the **treatment**;
- considered to be the most appropriate type and level of **treatment** taking patient safety and cost effectiveness into consideration;
- provided at an appropriate facility, in an appropriate setting, and at an appropriate level of care for the **treatment** of the patient's medical condition;
- provided only for an appropriate duration of time.

### Medical practitioner

A person who has full registration under the Medical Acts of the country where they practice and who specialises in nursing, homeopathy, acupuncture, orthopaedic medicine, osteopathy, chiropractic, chiropody, podiatry or physiotherapy **treatment**, and to whom **you** have been referred by a **medical doctor**.

### Medical referral letter

A letter from **your medical doctor** or **specialist** which refers **you** to another **medical practitioner** for **treatment** covered by **your plan**. We will only pay for **treatment** when the start date of **your treatment** is within 3 months of the date of **your medical referral letter**.

### Medical services provider(s)

A **hospital**, **out-patient clinic**, **medical practitioner**, **dental practitioner**, optician or pharmacy.

### Medical underwriting

The process of **you** providing and **us** assessing the health and medical information **we** ask for to decide the terms under which **we** will accept **your application** for cover, or for enhanced cover. Based on the information **you** give **us**, **we** may decide to place **special terms** on **your** cover, such as **personal medical exclusions**, or **we** may decide not to offer **you** cover.

### Out-patient

A patient who attends a **hospital** consulting room, emergency room or **out-patient clinic**, when it is not **medically necessary** for them to be admitted as a **day-patient** or an **in-patient**.

### Out-patient surgical procedure

An **out-patient** procedure where one or more of the following is **medically necessary**:

- general or local anaesthesia or intravenous sedation
- manipulation or relocation of a fractured bone or dislocated joint by a **medical doctor**
- invasive surgical procedures
- invasive diagnostic procedures involving intra-arterial cannulation
- the use of endoscopic equipment

### Period of cover

A period of 12 months from **your date of entry** or from any subsequent **renewal date**. **Your period of cover** is as shown on **your certificate of insurance**.

### Persistent vegetative state and neurological damage

We will not pay for any **treatment** received after **you** have been in a **vegetative state** for a period of eight weeks or received after **you** have sustained permanent neurological damage and remained in **hospital** for a period of eight weeks, apart from any treatment **you** are eligible for under the lifetime care benefit.

### Personal medical exclusions

A restriction on **your** cover that is stated on **your certificate of insurance** and specifically excludes **treatment** of a certain medical condition or conditions and any **related conditions**.

### Plan or plan type

The Essential Care **plan** or Essential Care Plus **plan** on which **you** and **your eligible dependants** are covered.

### Plan holder

The person stated as the **plan holder** on the **certificate of insurance**.

### Planned caesarean section

A caesarean section which has been scheduled to take place more than 24 hours in advance, whether this be for medical or elective reasons.

### Post-hospital treatment

**Medically necessary** follow-up consultations, physiotherapy, **diagnostic tests** and/or **treatment** required on an **out-patient** basis following **in-patient** or **day-patient treatment** covered by **your plan** and received within the 90 day period following the date **you** are discharged from **hospital**.

### Pre-existing medical conditions

Any disease, illness or injury, whether the condition has been diagnosed or not before **your date of entry**, for which:

- **you** have received medication, advice or **treatment**; or
- **you** have experienced symptoms

### Premium

The amount(s) **you** are required to pay to **us** either annually, half-yearly, quarterly or monthly for **your insurance plan**.

### Premium due date

The date on which **your premium** is due to be paid.

### Preventive health checks

Health tests, screening and/ or clinical procedures specifically designed for disease prevention and early detection.

### Qualified nurse

A nurse whose name is currently on any official register of nurses maintained by a statutory nursing registration body within the

country where **treatment** is provided.

### Reasonable and customary

The charge that would typically be made for **your treatment** by **medical services providers** in the country where **you** receive **your treatment**, and for the **medically necessary** length of stay required. If the cost of **your treatment** is not **reasonable and customary**, we will only pay up to the amount which is typically charged in that country. If the length of stay is not **reasonable and customary**, we will only pay for the **medically necessary** length of stay required. In the event of a dispute, we will identify the amount typically charged for **your treatment** by obtaining comparable quotations from three other **medical services providers** in the country where **you** receive **your treatment**, and taking a mean average of these three quotations.

### Rehabilitation

**Treatment** in the form of a combination of therapies such as physical, occupational and speech therapy aimed at restoring full function after an acute event such as a stroke.

### Related condition

Any disease, illness or injury that is caused by a **pre-existing medical condition** or results from the same underlying cause as a **pre-existing medical condition**.

### Renewal date

The anniversary date of **your plan** as shown on **your certificate of insurance**, normally the anniversary of **your original date of entry** to the **plan**.

### Session

A single continuous consultation during which time **you** may receive advice, **treatment** and/or prescribed medication.

### Specialist

A **medical practitioner** who is fully registered by the regulatory body of the country in which he or she practices following attendance at a recognised medical school (as listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation). They must be on a **specialist** register appropriate for the condition for which **treatment** is sought. Where regulation demands, the **medical practitioner** must also have a licence to practice. We reserve the right to withhold or remove recognition of any **specialist** for reasons such as suspension of registration, fraud or unreasonable charges.

### Special terms

Any **personal medical exclusions**, restrictions or **premium** adjustments we may apply to **your plan**. Any **special terms** relating to **your plan** will appear on **your certificate of insurance**.

### Table of benefits

The table beginning on page 6 which sets out the benefits covered by each **plan type**.

### Terminal medical condition

A condition that has become incurable and all the **treatments** given are to prolong life.

### Treatment

Surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

### Unused premium

The amount of **premium** that is attributable to the period from the date after the date of cancellation, up to the date before the next **premium due date**.

In the event of a refund of unused **premium** being eligible, the unused **premium** amount refunded, (using an annually paid **plan** as an example), will be the annual **premium** paid divided by 12 and multiplied by the number of whole calendar months remaining in the **period of cover**. If the **plan** is cancelled part way through a month, an additional amount, equal to one twelfth of the annual **premium** paid, multiplied by the proportion of days without cover in the calendar month of cancellation will also be paid.

For example, if the annual **premium** for an **insured person** is US\$3,000, the **period of cover** is 1st January to 31st December 2018, and the **insured person** leaves the **plan** on 27th September 2018, the unused **premium** will be US\$775, as:

- ((US\$3,000 / 12) x 3) = US\$750 for the 3 whole months without cover (October, November and December); added to -
- ((US\$3,000 / 12) x 0.1) = US\$25 for the 3 days in September without cover (the 0.1 calculated in this example by dividing 3 (the days in September without cover, i.e. the 28th, 29th and 30th) by the total number of days in September (30)).

Appropriate calculation methods using the same principle as the above example will be used if the **premium** frequency is not annual.

### Us, we, our

William Russell Limited on behalf of the **insurer**.

### Vegetative state

A state where there is no sign of awareness or any cognitive function, even if the person can open their eyes and/or breathe unaided. If the person is in a **vegetative state** for a continuous period of eight weeks, they will be considered to be in a persistent **vegetative state**.

### Waiting period

Certain benefits in the **table of benefits** specify a **waiting period**. **You** must be covered by the same **plan** for the full duration of the specified **waiting period** before **you** can **claim** for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**.

### You, your, yourself

Any and all persons named in the schedule of **insured persons** on **your certificate of insurance**.

## We're here to help

Call us on +44 1276 486455  
or visit [william-russell.com](http://william-russell.com)

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