


POLICY GUIDE  
2017 – 2018

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# CONTRACTORS INTERNATIONAL HEALTH PLAN

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Insurance made easy.

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## 1. INTRODUCTION

Welcome to April International UK. The Contractors International Health Plan is provided by **us** acting on behalf of the **Insurer**. The contract between **you** and **us** includes **your Application Form**, this Policy Guide and **your Certificate** of Insurance. **You** must read this Policy Guide in conjunction with **your Certificate** to ensure that **you** understand the cover **we** are providing and that it meets **your** requirements.

The **Plan** will only pay for eligible **treatment** for the **benefits** shown on **your Certificate** received within the period of cover shown on **your Certificate**. **Benefits** are limited to **reasonable and customary charges** (as determined by **us**) in the area where **treatment** is provided. **Your Plan** provides cover for the **benefits** shown on **your Certificate**, and not necessarily for all the **benefits** defined in this Guide. The **benefits** are fully explained in the **Benefits** Definitions section of this guide. **We** cannot pay any **benefit** if **your Plan** is not in force or the premiums are not paid up to date at the time **you** have **your treatment**.

**Your Plan** is not intended to provide cover for the **treatment** of medical conditions that are in existence before **your Plan start date**. These are called **Pre-existing Medical Conditions** and are fully explained in the **Plan** Definitions.

Words written in **bold** are important and have a specific meaning relevant to this Policy Guide. These words are clearly explained in the **Plan** and **Benefit** Definitions.

**We** are committed to providing the highest level of customer service and **we** aim to be clear, fair and accurate in **our** communications with **you**. **You** can contact us if **you** need further clarification about **your Plan**, or if **you** would like to inform **us** of any changes in **your** personal circumstances. **You** must tell **us** if **you** change **your country of residence**, correspondence address or any other important personal information. **We** will do all **we** can to help **you** and **your dependants** when **you** need to use **your Plan**.

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## 2. ADMINISTRATION OF YOUR PLAN

### 2.1 ACCESSIBILITY

Upon request **we** can provide Braille, audio or large print versions of the **plan** and associated documentation including the Key Facts. If **you** require an alternative format **you** should contact **us**.

### 2.2 ELIGIBILITY

The Contractors International Health Plan (the **Plan**) is designed for individuals of any nationality who are on temporary contract assignments, working outside of their **Home Country**.

The **Plans** are not available to USA or Caribbean nationals who are resident in their **Home Country**.

The **Plans** are not available to persons or in countries where it would breach any sanction, prohibition or restriction imposed by law or regulation.

The maximum age **you** can apply for a **Plan** is 70.

**You** may apply for cover on behalf of **your** spouse/partner and/or on behalf of **your** (un)married children (including step-children, foster children and legally adopted children) providing that they are aged less than 18 years old (or 24 years old if in full-time education). **We** will require proof of education for **dependent** children aged between 18 and 24 years old.

Newborn children are eligible for cover from birth. Please refer to the **How to Make Changes to Your Plan** section of this Guide.

**You** must complete and sign a **Moratorium Underwriting Application Form** providing details for all persons to be covered by the **Plan**. If **you** are aged over 65 years at the time of applying for a **Plan**, **you** must complete the **Full Medical Underwriting Application Form**.

**Your Certificate** will show any **specific exclusions** that are specific to **you** or **your dependants** and are in addition to the standard **Plan** exclusions shown in this Policy Guide.

### 2.3 UNDERWRITING

If **you** and/or **your dependants** are aged less than 65 years on the **start date** of **your Plan** **Moratorium Underwriting** will apply.

If **you** and/or **your dependants** are aged 65 or over on the **start date** of **your Plan** **you** will only be eligible for a **Plan** on a **Full Medical Underwriting** basis.

**Moratorium Underwriting** means that **you** will not be covered for any **pre-existing medical conditions**. After two years of continuous cover, **pre-existing medical conditions** may become eligible for cover (unless the condition or **benefit** is specifically excluded under the **Plan**) if, at the first time of receiving **treatment**, **you/your dependant** has not

- > suffered any symptoms
- > consulted any medical practitioner for check-ups/monitoring of a condition, follow up examinations, medical **treatment** or advice.
- > been prescribed or taken medicine, including over the counter drugs, special diets, injections or physiotherapy

for the **pre-existing medical condition**, or any related condition for a continuous period of two years.

**Full Medical Underwriting** means **we** will review the information provided on the **Full Medical Underwriting Application Form** to ascertain whether **your Full Medical Underwriting Application** will be accepted with or without **specific exclusions**. **You** must therefore ensure that **your Full Medical Underwriting Application Form** is fully and accurately completed. If **specific exclusions** will apply to **your Plan**, **we** will advise **you** in writing or by email and **you** will need to let **us** have written confirmation that **you** accept these **specific exclusions** before the **Plan** can start. **We** may refuse to accept **your** application at **our** sole discretion. Any **Pre-existing medical conditions** not declared on **your Full Medical Underwriting Application Form** will not be covered by the **Plan**.

### 2.4 THE INSURER

The **Insurer** of **your Plan** is Catlin Insurance Company (UK) Ltd., or Catlin Underwriting Agencies Limited, as displayed on **your Certificate**.

### 2.5 YOUR PLAN

**You** will be covered for the **Plan** that **you** have selected on **your Application Form**. **Your dependants** must be covered under the same **Plan** as **you**. Only **benefits** outlined under the **Plan** **you** have selected will be available to **you** and/or **your dependants** and will be shown on **your Certificate**.

**You** will be covered for the **Area of Cover** that **you** have selected on **your Application Form** which will be shown on **your Certificate**. **Dependants** can select a different **Area of Cover**.

**You** can select the currency of **your Plan**. The **Plan** is available in Pounds Sterling, US Dollars and Euros. The currency selected by **you** will apply to the premium due and **benefit** limits displayed on **your Certificate**.

### 2.6 PERIOD OF COVER

The **Plan** is an annual contract but **you** can select a shorter period of cover for 3, 6 or 9 months. **You** can extend **your Plan** providing that a new contract has been agreed within 60 days of the initial contract end date.

## 2.7 CO-INSURANCES

A **co-insurance** applies to some **Plan benefits** and these are shown on **your Certificate**.

A **co-insurance** will be a partial contribution by **you** for all eligible **treatment** costs incurred for any **benefits** where a **co-insurance** is shown on **your Certificate** and will apply for each **Certificate period**

## 2.8 COMMENCEMENT OF COVER

**You** and/or **your dependants'** cover can start once **we** have accepted **your Application Form** and **your** first premium payment has been received by **us**.

**Your Start Date** will be shown on **your Certificate(s)**. Your **Start Date** must be within 30 days from the date that **you** signed **your Application Form**.

**You** will receive a **Certificate** for each person named on the **Application Form**.

## 2.9 PREMIUM PAYMENT

The base currency of the **Plan** is Pounds Sterling. Premiums can be paid in Pounds Sterling, US Dollars or Euros. Premiums must be paid in the currency selected on **your Application Form**.

Premiums can be paid in full or quarterly.

Full premiums can be paid by bank transfer or by credit/debit card (Visa/MasterCard/American Express). If **you** pay **your** premium by

bank transfer, the premium must be submitted to the currency bank account detailed on the **Application Form** that matches the selected currency of **your Plan**. All charges for making a bank transfer must be paid by **you**. **We** will only pay for any charges that occur for receiving the funds into **our** bank account.

Quarterly premiums can be paid by credit/debit card only (Visa/Mastercard/American Express). All future instalment premiums will automatically be debited, on the **instalment date**, from the credit/debit card details provided until such time as the full premium has been paid. If the card details that **you** have provided are due to expire before the remaining quarterly premiums have been collected, **you** must provide **us** with updated or alternative card details.

**Your Plan** will start from the day **we** receive the full premium or first quarterly premium payment, including any taxes applicable, or the date specified on **your Application Form**, provided that the premium is received by **us** before the specified date.

If **your Country of Residence** falls within an area where **we** are required to collect Insurance Premium Tax (IPT) or local government tax, this will be charged in addition to the premium due under **your Plan**.

**We** will inform **you** prior to the payment due date of **your Plan** if **you** are required to pay Insurance Premium Tax.

If a premium payment transaction is declined by **your** card provider, **we** will advise **you** in writing, by email or by telephone. **You** must promptly contact **your** card provider to resolve the issue or provide another method of payment.

## 2.10 HOW TO MAKE CHANGES TO YOUR PLAN

	WHAT ACTION YOU WILL NEED TO TAKE	WHAT ACTION WE WILL TAKE
<b>Change to Contact Details</b>	If any of <b>your</b> contact details change, <b>you</b> must provide <b>us</b> with <b>your</b> new contact details as soon as practicably possible.	<b>We</b> will confirm receipt of the changes and update <b>our</b> records
<b>Change of Cover Level</b> <i>Only allowed at an Extension Date</i>	If <b>you</b> wish to make a change to <b>your cover level/</b> currency of <b>your Plan</b> , <b>you</b> must notify <b>us</b> in writing or by email prior to the Extension Date.	<b>You</b> and <b>your dependants</b> must have the same <b>cover level/currency</b> . If <b>you</b> change <b>your cover level</b> to one that includes more comprehensive benefits, any <b>waiting periods</b> will start from the date of the change in <b>cover level</b> . The <b>benefits</b> on <b>your Certificate</b> will be displayed in the currency in which <b>you</b> pay <b>your</b> premium
<b>Change to Currency of Plan</b> <i>Only allowed at an Extension Date</i>		
<b>Change to Area of Cover</b> <i>Only allowed once per Certificate Period</i>	<b>You</b> must advise <b>us</b> in writing or by email if <b>you</b> would like to change <b>your Area of Cover</b> and from which date this should be effective. Only one change to <b>your Area of Cover</b> can be made in any one <b>Certificate period</b> . <b>You</b> can also make a change on <b>your</b> Extension Date. <b>We</b> cannot change your <b>Area of Cover</b> if <b>you</b> intend to reside in the USA for a period of more than three consecutive months or if <b>you</b> intend to travel to the USA for the purpose of receiving medical <b>treatment</b> .	<b>We</b> will confirm <b>our</b> acceptance of the change and advise if there is any additional premium to be paid or refunded if a change in <b>Area of Cover</b> is required. <b>We</b> will send <b>you</b> an invoice and payment must be made within 14 days. If premium is to be refunded, this will be done using <b>your</b> original payment method. In all cases, <b>we</b> will issue <b>you</b> with a new <b>Certificate</b> .
<b>Change in Country of Residence</b>	<b>You</b> must advise <b>us</b> in writing or by email if <b>you</b> will be changing <b>your main Country of Residence</b> and provide <b>your</b> new contact details. There are some countries where the <b>Insurer</b> may not be able to provide cover for regulatory or insurance licensing reasons.	
<b>Return to Home Country</b>	<b>You</b> must advise <b>us</b> in writing or by email if <b>you</b> will be returning to <b>your Home Country</b> and provide <b>us</b> with <b>your</b> new contact details. Cover will automatically be cancelled 90 days after <b>your</b> return to <b>your Home Country</b> .	
<b>Adding a Dependant</b>	If <b>you</b> wish to include <b>your</b> spouse or any <b>dependant</b> children to <b>your Plan</b> , <b>you</b> must complete and return an Addition of Dependant Form or <b>Full Medical Underwriting Application Form</b> . All children must be aged 17 years or under, or between 18 and 24 years if they are still in full-time education. Proof must be provided of full-time education. Once <b>you</b> are in receipt of the invoice, this must be paid within 14 days.	<b>We</b> will calculate the additional premium due to add the <b>dependant</b> from the date <b>we</b> receive the Addition of Dependant form/ <b>Full Medical Underwriting Application</b> Form until the <b>Expiry Date</b> /end of the quarterly period, if <b>you</b> pay <b>your</b> premium by quarterly instalments. <b>Your dependant(s)</b> must have the same <b>cover level</b> as <b>you</b> . <b>We</b> will send <b>you</b> an invoice for the additional premium which must be paid within 14 days. <b>We</b> will issue each new <b>dependant</b> with a <b>Certificate</b> when <b>we</b> receive the premium due. If premium is not paid within 14 days, cover will not be in place for the <b>dependant(s)</b> .

## 2.10 HOW TO MAKE CHANGES TO YOUR PLAN (CONTINUED)

	WHAT ACTION YOU WILL NEED TO TAKE	WHAT ACTION WE WILL TAKE
<b>Adding a Newborn</b>	If <b>you</b> wish to include <b>your</b> newborn baby to <b>your Plan</b> , <b>you</b> must complete and return an Addition of Dependant Form within 14 days of the date of birth. Once <b>you</b> are in receipt of the invoice, this must be paid within 14 days.	<b>We</b> will calculate the additional premium to add the newborn from their date of birth until the <b>Expiry Date</b> /end of the quarterly period, if <b>you</b> pay <b>your</b> premium by quarterly instalments. The newborn must have the same <b>cover level</b> as <b>you</b> . <b>We</b> will send <b>you</b> an invoice for the additional premium. Once the premium has been paid <b>we</b> will issue the newborn with a <b>Certificate</b> . If the premium is not paid within 14 days, cover will not be in place for the Newborn.
<b>Removing a Dependant</b>	If <b>you</b> would like to cancel cover for a <b>dependant</b> during the <b>Certificate Period</b> <b>you</b> must send <b>your</b> request to <b>us</b> in writing or by email.	<b>We</b> will cancel cover for <b>your dependant</b> on the date that <b>we</b> receive <b>your</b> notification. A proportionate premium refund will be paid if no <b>claims</b> have been paid for any person on <b>your Plan</b> in the current <b>Certificate period</b> . <b>We</b> will calculate the refund from the date that <b>we</b> cancel cover for <b>your Dependant</b> until the <b>Expiry Date</b> /end of quarterly period if <b>you</b> pay <b>your</b> premium by quarterly instalments. A cancellation fee of £25/\$50/€38 will be deducted from any refund due. The premium will be refunded using the original method of payment.
<b>Death of a Dependant</b>	Please notify <b>us</b> as soon as practicably possible if a <b>dependant</b> on <b>your Plan</b> dies. <b>You</b> may need to provide <b>us</b> with details related to their death and a copy of the death certificate. If <b>your dependant</b> died outside their <b>Home Country</b> and <b>Repatriation or Local Burial</b> is required, please contact the <b>Assistance Company</b> as soon as practicably possible.	If <b>Repatriation or Local Burial benefit</b> is shown on the <b>Certificate</b> , the <b>Assistance Company</b> will help with making these arrangements. A proportionate premium refund will be made if no <b>claims</b> have been paid and the <b>Repatriation or Local Burial benefit</b> has not been used in the current <b>Certificate Period</b> . It will be refunded using the original method of payment. <b>We</b> will calculate the refund from the date of death until the <b>Expiry Date</b> /end of quarterly period if <b>you</b> pay <b>your</b> premium by quarterly instalments. If the main applicant dies and <b>dependants</b> are included in the <b>Plan</b> , the <b>Plan</b> will continue until the next <b>Expiry Date</b> .
<b>Death of the Main Applicant</b>	In the event of <b>your</b> death, <b>we</b> will need to be notified as soon as practicably possible by <b>your</b> next of kin or legal representative. Information regarding the circumstances surrounding <b>your</b> death should also be provided and a copy of the death certificate may be required. If <b>you</b> died outside <b>your Home Country</b> and <b>Repatriation or Local Burial</b> is required, the <b>Assistance Company</b> should be contacted as soon as practicably possible.	

## 2.11 EXTENDING YOUR PLAN

Upon the expiry date of **your Plan**, **you** can apply for an extension of cover of either 3, 6, 9 or 12 months, providing that a new contract has been agreed within 60 days of the initial contract end date.

**You** will be sent a reminder by email that **your Plan** is due to expire. It is **your** responsibility to contact **us** if **you** require an extension.

An extension will be offered subject to the terms and conditions of the **Plan** and the premium in force at the time.

**Your** extension premium can be paid in full or quarterly. **We** must receive **your** full annual premium or first quarterly premium including any taxes and administration fees where applicable before or on the **expiry date**.

If **you** elect to pay **your** premium in full, **you** must pay by bank transfer or by credit/debit card (Visa/MasterCard/American Express). All charges as a result of making a bank transfer must be paid by **you**. **We** will only pay for charges that occur for receiving the funds into **our** bank account.

If **you** elect to pay **your** premiums on a quarterly basis, **you** will need to complete the payment authorisation form with **your** credit/debit card details and return this to **us** prior to **your Expiry Date**.

Children can continue to be covered under **your Plan** and will be charged the appropriate child rate as long as they are aged less than 18 years old or 24 years old if they are in full time education. If they are aged between 18 and 24 years and in full-time education **you** will need to provide **us** with proof of enrolment into an educational institute.

Once **your Plan** has been extended **you** will receive a **Certificate** of Insurance for each person covered under **your Plan**.

## 2.12 TERMINATION OR CANCELLATION OF YOUR PLAN

**Your Plan** may be cancelled during the **Cooling off Period** if **you** provide notice to **us** in writing or by email that **you** wish to cancel **your Plan** within 30 days from the **Start Date**. **We** will give **you** a full refund of the premium paid, providing that no **claim** has been made on **your Plan**.

If **you** wish to cancel **your Plan** after the **Cooling off Period**, **you** must notify **us** of **your** request to cancel the **Plan** in writing or by email. **We** will only cancel the **Plan** from the date that **we** receive the request. Requests for backdated cancellations will not be accepted. **We** will give **you** a proportionate refund of the premium paid for the current **Certificate period**, less an administration charge of £25/\$50/€38, if no **claims** have been made by **you** and/or **your dependants** during the current **Certificate period**.

**We** are entitled to cancel **your Plan**, if there is a valid reason to do so, including for example:

- (i) any failure by **you** to pay the premium; or
- (ii) a change in risk which means **we** can no longer provide **you** with insurance cover; or
- (iii) non-cooperation or failure to supply any information or documentation **we** request, such as details of a **claim**;

by giving **you** fourteen (14) days' notice in writing. Any return of premium due to **you** will be calculated at a proportional daily rate depending on how long the **plan** has been in force unless **you** have made a **claim** in which case the full annual premium is due.

## 2.13 RETURN TO HOME COUNTRY

**Your Plan** will automatically cancel if you reside in **your Home Country** for a period of 90 consecutive days.

## 2.14 INFORMATION YOU HAVE GIVEN US

In deciding to accept this **plan** and in setting the terms including premium **we** have relied on the information which **you** have provided to **us**. **You** must take care when answering any questions **we** ask by ensuring that any information provided is accurate and complete.

If **we** establish that **you** deliberately or recklessly provided us with untrue or misleading information **we** will have the right to:

- (a) treat this **plan** as if it never existed;
- (b) decline all **claims**; and
- (c) retain the premium.

If **we** establish that **you** carelessly provided **us** with untrue or misleading information **we** will have the right to:

- (i) treat this **plan** as if it never existed, refuse to pay any **claim** and return the premium **you** have paid, if **we** would not have provided **you** with cover;
- (ii) treat this **plan** as if it had been entered into on different terms from those agreed, if **we** would have provided **you** with cover on different terms;
- (iii) reduce the amount **we** pay on any **claim** in the proportion that the premium **you** have paid bears to the premium **we** would have charged **you**, if **we** would have charged **you** more.

**We** will notify **you** in writing if (i), (ii) and/or (iii) apply.

If there is no outstanding **claim** and (ii) and/or (iii) apply, we will have the right to:

- (1) give **you** thirty (30) days' notice that **we** are terminating this **plan**; or
- (2) give **you** notice that **we** will treat this **plan** and any future **claim** in accordance with (ii) and/or (iii), in which case **you** may then give us thirty (30) days' notice that **you** are terminating this **plan**.

If the **plan** is terminated in accordance with (1) or (2), **we** will refund any premium due to **you** in respect of the balance of the **certificate period**.

## 2.15 FRAUD

If **you**, or anyone acting for **you**, makes a fraudulent **claim**, for example a loss which is fraudulently caused and/or exaggerated and/or supported by a fraudulent statement or other device, **we**:

- (a) will not be liable to pay the **claim**; and
- (b) may recover from **you** any sums paid by **us** to you in respect of the **claim**; and
- (c) may by notice to **you** treat this **plan** as having been terminated with effect from the time of the fraudulent act.

If **we** exercise our right under (c) above:

- (i) **We** shall not be liable to **you** in respect of a relevant event occurring after the time of the fraudulent act. A relevant event is whatever gives rise to our liability under this **plan** (such as the occurrence of a loss, the making of a **claim**, or the notification of a potential **claim**); and.
- (ii) **We** need not return any of the premium paid.

## 3. PLAN DEFINITIONS

**ACCIDENT** means any sudden and unforeseen event occurring during **your certificate period**, resulting in bodily injury to **you**, the cause or one of the causes of which is external to **your** own body and occurs beyond **your** control.

**APPLICATION FORM** is the form that **you** complete for **you/your dependants** prior to the **start date** of your **Plan**.

**AREA OF COVER** means the **Area of Cover** selected by **you** on the **Application Form** and shown on **your Certificate**. Area One is Worldwide excluding the USA and Caribbean. The Caribbean includes Anguilla, Antigua, Aruba, Bahamas, Barbados, Bermuda, Bonaire, Cayman Islands, Cuba, Curacao, Dominica, Dominican Republic, Grenada, Guadalupe, Haiti, Jamaica, Martinique, Montserrat, Puerto Rico, St Kitts-Nevis, Saba, St Barthelemy, St Lucia, St Martin, St Vincent, Trinidad & Tobago, Turks & Caicos and Virgin Islands. Area Two is Worldwide.

**ASSISTANCE COMPANY** is the Company who **you** must contact to obtain **pre-authorisation** of any **treatment** for **benefits** where this is stated in the **Benefit Definition**. The **Assistance Company** is operational 24 hours a day, 365 days a year.

**BENEFIT** means any **benefit** defined under the **Benefit** Definitions section of this guide, shown in the **Benefit** Table and shown on **your Certificate**. Any **benefit** not shown on **your Certificate** is not covered.

**CERTIFICATE** is the **Certificate** of Insurance issued to **you** and/or **your dependants** and forms part of the contract between **you** and **us**. The **Certificate** should be read in conjunction with this Policy Guide.

**CERTIFICATE PERIOD** is the period of cover shown on **your Certificate**, unless **your Certificate** was cancelled by **you** or **us** prior to the **expiry date**.

**CHRONIC CONDITION** means a disease or illness which has no known cure and/or which is likely to continue and/or keep recurring and which needs prolonged supervision, monitoring or **treatment**. The **treatment** of **Chronic Conditions** is only covered under the **benefits** shown on **your Certificate**.

**CLAIM** means a course of **treatment** to treat a diagnosed medical condition and/or a **claim** for Dental Care or Wellbeing **benefits**.

**CO-INSURANCE** means the portion of costs for which **you** and/or **your dependants** are liable for. The **co-insurance** will be applied as specified on the **Certificate**.

**COOLING OFF PERIOD** means the period of 30 days from the **start date** of **your Plan**, during which **you** may decide that the **Plan** is not suitable for **your** requirements. If **you** provide notice to **us** in writing or by email that **you** wish to cancel **your Plan** from the **start date**, **we** will give **you** a full refund of the premium paid, provided that no **claim** has been made on **your Plan**.

**COUNTRY OF RESIDENCE** means the country that **you** have declared on **your Application Form** as the country which will be **your** main residence for the duration of **your Plan**. This is shown on **your Certificate** as the **Country of Residence**. **You** must tell us if you change **your** temporary/permanent **Country of Residence**.

**COVER LEVEL** means the Bronze, Silver or Gold **Plan** selected by **you** on **your Application Form**.

**DEPENDANTS** mean **your** spouse or partner, and also **your** (un) married children (including step-children, foster children and legally adopted children) providing that the child is not more than 18 years old at the **start date** or **anniversary date** of the **Plan** (or up to age 24 if you can provide proof that the child is continuing in full-time education).

**EXPIRY DATE** means the date that cover under **your Plan** ceases and is shown on **your Certificate**.

**FULL MEDICAL UNDERWRITING** means that **you** provide **us** with a detailed medical history on the **Full Medical Underwriting Application Form** to enable **us** to decide whether to accept or decline **your** application and whether **we** need to apply any **specific exclusions** to **your Plan**.

**HOME COUNTRY** means the country of which **you** hold a passport. Where **you** hold more than one passport the **Home Country** will be taken to mean the nationality which **you** have declared on **your Application Form**. **Your Dependants** will have the same **Home Country** as **you**, irrespective of their nationality.

**HOSPITAL** is any institution which is legally licensed as a medical or surgical **hospital** in the country in which it is located and whose main activities are not those of a spa, hydro clinic, sanatorium, nursing home, or home for the aged. It must be under the constant supervision of a resident **Physician**.

**INPATIENT** means when **you** are admitted to a **Hospital** for a period of not less than 24 hours.

**INPATIENT CARE** means the medical **treatment** provided to **you** when **you** are admitted as a registered **inpatient** in a **Hospital**

**INSTALMENT DATE** means the date on which any instalment premium payment is due to be paid.

**INSURER** means the **Insurer** of **your Plan** and will be shown on **your Certificate**.

**LIFETIME LIMIT** means the limit that applies for the full period that **you** have a **Plan**, irrespective of the number of times the **Plan** is extended.

**MORATORIUM UNDERWRITING** means **you/your dependants** cannot **claim** for **pre-existing medical conditions** under **your Plan**.

Any **pre-existing medical conditions** are excluded from cover if **you** completed a **Moratorium Application Form**. After two years of continuous cover, a **pre-existing medical condition** may become eligible for cover (unless the condition or **benefit** is specifically excluded) if, for a continuous period of two years, **you** have not:

- > **Suffered any symptoms.**
- > **Consulted any medical practitioner for check-ups, follow up examinations, medical treatment or advice.**
- > **Been prescribed or taken medicine including over the counter drugs, special diets, injections, physiotherapy for that condition or any related condition.**

**OVERALL AGGREGATE LIMIT** is the total combined limit of all **benefits** that may be claimed in any one **Certificate period** by **you**, and will be shown on **your Certificate**.

**PLAN** means the **Plan** which **you** have selected on **your Application Form** and **you** will be covered for the **Benefits** included in that **Plan** as shown on **your Certificate**.

**PHYSICIAN/THERAPIST** means a legally licensed medical practitioner/therapist recognised by the law of the country where **treatment** is provided and who, in rendering such **treatment**, is practising within the scope of his/her licensing and training.

**PRE-AUTHORISATION** means the procedure that **you** must follow for **treatment** received under the specified **Plan benefits** shown in the **Benefit** Table, and any **claim** that is likely to exceed £2,500/\$4,250/€3,500.

**PRE-EXISTING MEDICAL CONDITIONS** are any known medical conditions (or related conditions) that have, within a two year period immediately prior to the first **Start Date** of the **Plan**, one or more of the following characteristics;

- > It has been diagnosed.
- > It has needed medical **treatment** (including drugs, medication that can be purchased without a prescription, special diets, injections or other procedures or investigations).
- > Medical advice has been sought including routine medical examinations and check-ups.
- > Medical advice should have been sought if recognised clinical advice had been followed.
- > It has undiagnosed symptoms, whether recognised or not.

**REASONABLE AND CUSTOMARY CHARGES** means the charges that would typically be made for the treatment **you** receive in the location where **your treatment** is received. **We** will only pay up to the charges typically made for that **treatment** in that location. If there is any dispute relating to **reasonable and customary charges**, **we** will identify the amount typically charged by obtaining three quotations for the disputed **treatment** and **we** will settle costs based on an average of the three quotations.

**SPECIFIC EXCLUSIONS** means any exclusion that is applied to **your Plan** and has been accepted by **you** if **you** completed a **Full Medical Underwriting Application Form** at the start of **your Plan**. The **specific exclusions** are in addition to the **Plan** exclusions and will be shown on **your Certificate**.

**START DATE** means the date that **your Plan** originally commences.

**TREATMENT** means medical care and services provided to diagnose, relieve or treat an illness, disease or injury and/or dental care received by a qualified **Physician** or qualified Dental Practitioner.

**YOU/YOUR** means the person whose name appears on the **Certificate**.

**US, WE, OUR** means April International UK Limited, acting on behalf of the **Insurer**. **We** outsource **our** 24 hour assistance service to a specialist organisation who acts on **our/the Insurer's** behalf.

**WAITING PERIOD** means the period during which no **benefit** is payable for **treatment** costs incurred when a **waiting period** is shown in the **Benefit** Table and/or on **your Certificate**. **You** must be covered by the same **Plan** for the full duration of the specified **waiting period** before **you** are entitled to make a **claim** for that **benefit**.



## 4. BENEFIT DEFINITIONS

**ACCIDENT AND EMERGENCY ROOM TREATMENT** means **treatment** performed in a **hospital** casualty ward or emergency room immediately following an **Accident** or following the sudden onset of a serious medical condition.

**ARTIFICIAL HAIR BENEFIT** means the cost of a wig/hairpiece that **you** may require following a course of cancer **treatment**.

**CANCER COUNSELLING** means the costs relating to any counselling sessions that **you** attend with a registered and qualified Counsellor or Psychologist following **your** diagnosis of cancer.

**CHRONIC CONDITION TREATMENT** means the **treatment** received for a **Chronic Condition**.

**COMPASSIONATE HOME TRAVEL** means the cost of a return economy air ticket to **your home country** if a close family member dies during the **Certificate period**. This **benefit** is only available after **you** have completed one year of continuous cover. A close family member means **your** spouse/partner, parent, brother, sister, child (including (un) married child, step-child, foster-child and legally adopted child) or grand-child.

**COMPLEMENTARY THERAPIES** means consultations provided to **you** by registered and properly qualified Osteopaths, Chiropractors, Homeopaths and Acupuncturists. The **treatment** must be recommended and ordered by **your Physician**.

**COMPLICATED PREGNANCY AND CHILDBIRTH** means the **treatment** costs relating to pre-natal and post-natal care and childbirth where **your Physician** has certified that a surgical procedure, or **treatment** requiring a period of **inpatient care**, is required during the pregnancy, and where a normal delivery would endanger the life of the mother and or child(ren). **Pre-authorisation** must be obtained from the **Assistance Company** for this **benefit**. It is only available for pregnancies whose expected date of delivery is at least one year after the **start date** of a **Plan** that includes this **benefit**. This **benefit** does not include the costs of any medical **treatment** provided to the newborn. Any limits shown on **your Certificate** are per pregnancy.

**DAYCARE TREATMENT** means any surgical or medical procedures that **you** receive which are provided on an outpatient basis but where you require a period of recovery in a **hospital** bed.

**DENTAL TREATMENT FOLLOWING AN ACCIDENT** is the **treatment** required to restore or replace **your** sound natural teeth lost or damaged in an **Accident** which takes place within 90 days of the **Accident**. This **benefit** does not provide cover for damage to teeth caused by biting or chewing.

**EMERGENCY MEDICAL EVACUATION** means the medically required expense of emergency transportation and medical care en route to transport **you**, if **you** have a critical medical condition to the nearest **Hospital** where appropriate care and facilities are available, and not necessarily to **your Home Country**. The **Assistance Company** should be contacted to approve and arrange all **Emergency Medical Evacuations**. In dire emergencies in remote or primitive areas where the **Assistance Company** cannot be contacted in advance, the **Emergency Medical Evacuation** must be reported as soon as possible. **We** will pay the transportation costs for one other person to accompany **you** on an **Emergency Medical Evacuation** where **Inpatient Care** is required following **Emergency Medical Evacuation**, or where the **Emergency Medical Evacuation** is for a child who is not more than 18 years old.

**EMERGENCY NON-MEDICAL EVACUATION** means the costs of evacuation by any means of transportation to a place of safety when, in the opinion of the crisis management specialist company, Red24, **your** life is in danger as a result of sudden political or civil unrest, or in the event of a natural disaster. A natural disaster is a major adverse event or force of nature that has catastrophic consequences such as earthquake, flood, forest fire, hurricane, tornado, tsunami and volcanic eruption.

**EMERGENCY MEDICAL EVACUATION – SUPPLEMENTARY EXPENSES** means the accommodation costs of a companion who has accompanied **you** on an approved **Emergency Medical Evacuation** up to the limits shown on **your Certificate**. The costs

of a one-way economy air ticket to return **you** and **your** companion back to **your country of residence** following an approved **Emergency Medical Evacuation** are covered. If **you** received **Inpatient Care** we will also cover taxi costs for **your** companion to and from the **hospital** and accommodation costs for **you**, following **Inpatient Care**, up to the limits shown on **your Certificate**.

**EXTERNAL PROTHESES, MEDICAL AIDS AND DEVICES** mean devices or aids that are medically prescribed as part of the recuperation process immediately following **Inpatient Care, Daycare Treatment or Accident or Emergency Room Services**.

**HIV/AIDS BENEFIT** means the cost of **treatment** arising from, or related to, Human Immunodeficiency Virus (HIV and/or HIV-related illness, including Acquired Immune Deficiency Syndrome, (AIDS) or AIDS related complex (ARC). If **you** are HIV positive, **we** will only pay up to the **HIV/AIDS benefit** limit for the **treatment** of the following conditions: Candidiasis (thrush), Cervical Cancer, CMN (cytomegalovirus), Cryptococcal meningitis, Cryptosporidiosis, HIV-associated brain impairment, Kaposi's sarcoma, Lymphoma, Mycobacterium avium intracellulare, Pneumonia including PCP (Pneumocystis pneumonia), Thrombocytopenia, Toxoplasmosis and Tuberculosis. This **benefit** is subject to a **lifetime limit** as shown on **your Certificate**. This **benefit** is only available after **you** have completed two years of continuous cover under a **Plan** which includes this **benefit**.

**HORMONE REPLACEMENT THERAPY (HRT)** means consultations and **Prescription Drugs**, patches or implants for the sole purpose of treating a hormone imbalance medical condition. It does not provide cover for HRT used to treat the symptoms of menopause.

**HOSPICE CARE** means the costs of accommodation and palliative care provided to **you** in a registered Hospice, if **you** have received a terminal prognosis, up to a maximum limit shown on **your Certificate**, when medically prescribed by a **Physician**.

**HOSPITAL CASH BENEFIT** is an alternative cash benefit which may be paid to **you** where **treatment** is provided to **you** in a government **Hospital** where no charge is made. The maximum payable is 30 days in any one **Certificate period**. **You** must obtain **Pre-authorisation** from the **Assistance Company** for this **benefit**.

**HOSPITAL SERVICES** means all required medical **treatment** provided to **you** when **you** are admitted as a registered **inpatient** in a **Hospital** for a period of not less than 24 hours, and only when appropriate diagnostic procedures and/or **treatments** are not available as **Outpatient Services**. **You** must obtain **Pre-authorisation** from the **Assistance Company** for this **benefit**. **Hospital Services** include **reasonable and customary charges**, in the area where **treatment** is provided, for **Hospital** accommodation up to the cost of a single-bedded room, intensive care unit accommodation, meal charges, the use of all **hospital** medical facilities, and all medical **treatment** and medical services ordered by a **Physician**. **Hospital Services** excludes any costs relating to **Oncology, Organ and Bone Marrow Transplant and stem cell treatment and Normal and Complicated Pregnancy and Childbirth**, except ectopic pregnancy.

**INPATIENT PSYCHIATRIC TREATMENT** means medical **treatment** provided to **you** when **you** are admitted as a registered **inpatient** in a recognised psychiatric unit of a **Hospital**, and the **treatment** is provided by a registered Psychiatrist. **You** must obtain **Pre-authorisation** from the **Assistance Company** for this **benefit** and the **benefit** is limited to a maximum of 30 days per **Certificate period**. This **benefit** is only available after **you** have completed one year of continuous cover under a **Plan** which includes this **benefit**.

**INTERNAL PROTHESES, MEDICAL AIDS AND DEVICES** means any implant, medical aid or device which is implanted intra-operatively.

**LOCAL ROAD AMBULANCE SERVICES** means the costs for medically required transportation to a local **Hospital** for emergency or **Inpatient Care**.

**MRI, CT and PET Scans** means the cost of magnetic resonance imaging (MRI), computerised tomography (CT) and positron emission tomography (PET) ordered by a treating **Physician**.

**NEWBORN CARE** means medical **treatment** received by a newborn child from the date of birth until 30 days following discharge from

**Hospital**, provided that an **Application Form** has been completed for the child within 14 days of birth and a **Certificate** has been issued for the newborn child. No other **benefits** are available to the newborn until 30 days following discharge from **Hospital** when the selected **Plan benefits** will apply.

**NORMAL PREGNANCY AND CHILDBIRTH** means the **treatment** costs relating to pre-natal and post-natal care and childbirth, of the mother only, where no special obstetric procedure is required. **You** must obtain **Pre-authorisation** from the **Assistance Company** for this **benefit**. This **benefit** is only available for pregnancies whose expected date of delivery is at least one year after the **start date** of a **Plan** that includes this **benefit**. This **benefit** does not include the costs of any medical **treatment** provided to the newborn. Any limits shown on **your Certificate** are per pregnancy

**NURSING AT HOME** means medical services and **treatment**, excluding home help, provided by a government licensed nurse in **your** home when prescribed by a **Physician** and related directly to an illness, injury or medical condition for which **you** have received and are receiving **treatment** which is covered by **your Plan**. This **benefit** will be limited to 26 weeks in any one **Certificate period**.

**ONCOLOGY, CHEMOTHERAPY AND RADIOTHERAPY** means consultations, diagnostics tests, and **treatment** that **you** receive under **Inpatient Care**, **DayCare Treatment** or **Outpatient Services** that are related specifically to the diagnosis and **treatment** of malignant disease (cancer).

**ORGAN AND BONE MARROW TRANSPLANTS AND STEM CELL TREATMENT** means cover for kidney, heart, heart-lung and liver and bone marrow transplants and stem cell **treatment** (both autologous and donor provided). Expenses relating to the acquisition of transplant materials and donor's expenses are not covered.

**OUT OF AREA COVER** means short-term cover available for emergency medical conditions or acute episodes of existing medical conditions covered by **your Plan**, when travelling outside the **Area of Cover** selected by **you** which is shown on **your Certificate**. Cover is only available outside **your** selected **Area of Cover** for a maximum aggregate period of 60 days in any one **Certificate period**, up to the limits shown on **your Certificate**, provided that **you** did not make the trip specifically for the purpose of, or with the intention of, obtaining medical **treatment**.

**OUTPATIENT SERVICES** means medical **treatment** provided to **you** when **you** are not a registered **inpatient** in a **Hospital**, or any other facility for medical care. **Outpatient Services** includes services provided by or ordered by a **Physician** who is licensed as a General Practitioner, Specialist or Consultant, laboratory testing, radiographic and nuclear medicine procedures used to diagnose and treat medical conditions. **Outpatient Services** also includes **Complementary Therapies**, **Physiotherapy** and **Prescription Drugs**.

**OUTPATIENT PSYCHIATRIC TREATMENT** means the **treatment** of any psychological or psychiatric disorder by a Consultant Psychiatrist, when **you** have been referred by a **Physician**. It includes the **treatment** of anxiety, stress, clinical depression and phobic states and therapy performed by a behavioural or clinical psychologist, provided the therapy is ordered by a Consultant Psychiatrist. This **benefit** is only available after **you** have completed one year of continuous cover under a **Plan** which includes this **benefit**.

**PARENTAL ACCOMMODATION** means the **hospital** accommodation costs for **you** to stay in a **Hospital** with a child aged 17 years and under who is receiving **Inpatient Care** under the **Plan**.

**PHYSIOTHERAPY** means treatment provided by a licensed Physiotherapist and ordered by a **Physician**. This **benefit** is limited to the number of sessions as stated on **your Certificate**.

**POST HOSPITAL TREATMENT** means **Outpatient Services** that are related to an eligible **Claim** submitted by **you** for **Inpatient Care**, provided that **Outpatient Services** are received within 90 days of **your** discharge from **Hospital**.

**PRESCRIPTION DRUGS** means medications and medical supplies whose sale and use is legally restricted to the order of a **Physician**, and does not include items that may be purchased without a **Physician's** prescription.

**RECONSTRUCTIVE SURGERY** means a surgical procedure(s) which is required to restore appearance/function of **your** body following an **Accident** or illness which occurred after the **start date** of **your Certificate**, and the original **treatment** was covered by the **Plan**. The **Reconstructive Surgery** must take place within two years of the original **Accident** or illness.

**REHABILITATION CARE** means **Inpatient Care** or **Treatment** where the purpose is to restore health and mobility after an **Accident**, injury or illness to a state in which **you** can be self-sufficient. This **benefit** is subject to a **Lifetime Limit** as shown on **your Certificate**.

**REPATRIATION OR LOCAL BURIAL** is the expense of preparation and air transportation of **your** mortal remains from the place of death to **your Home Country**, or the preparation and **Local Burial** or cremation of **your** mortal remains if **you** die outside **your Home Country**. Such arrangements must be made by the **Assistance Company**. This **benefit** is not available to persons who were aged 65 or over at the **Start Date**.

**ROUTINE DENTAL TREATMENT** is all routine dental care such as dental inspection, preservation and relief of pain including simple fillings, X-Rays, **treatment** of gums, operative and gnathological procedures, and dentures. Dentures include restoration of the function of dental prostheses and the installation of new prostheses, crowns, bridges and pivot teeth. Orthodontic **treatment** is available for **dependants** up to the age of 17 years. Cover is only available if **you** have attended for dental inspection and concluded all required **treatment** in the one year period immediately prior to **your Start Date**, or immediately prior to claiming **Routine Dental Treatment benefit** under the **Plan**, whichever is the later. The **benefit** is limited to the amount shown on **your Certificate**.

**ROUTINE HEALTH SCREENING** means the costs of routine health checks, tests and examinations for the early detection of illness and disease. This **benefit** provides cover for cardiovascular and neurological tests, PAP smear test, mammogram and prostate screening. This **benefit** is only available if **you** are aged over 21 years and after you have completed one year of continuous cover under a **Plan** which includes this **benefit**.

**VACCINATION BENEFIT** means vaccinations which are medically required for the the purpose of travel (including anti-malaria medication) and vaccinations for the prevention of disease or illness for children aged up to 16, for Diphtheria, Tetanus, Whooping Cough (pertussis), Polio, Mumps, Rubella (German Measles), Meningitis C, Pneumococcal, Streptococcus pneumonia, Hib and Human Papillomavirus (HPV).

## 5. BENEFIT TABLE

This table gives a summary of the **benefits** covered by each **Plan**. Please refer to each **Benefit** Definition for a full explanation of the cover provided under each **benefit**.

PLAN BENEFITS	BRONZE	SILVER	GOLD
Overall Aggregate Limit each Certificate period	£1,000,000 \$2,000,000 €1,500,000	£1,000,000 \$2,000,000 €1,500,000	£1,000,000 \$2,000,000 €1,500,000

**PRE-AUTHORISATION IS REQUIRED FOR ALL CLAIMS WHERE THE COSTS ARE LIKELY TO EXCEED £2,500/\$4,250/€3,500 AND FOR ALL CLAIMS UNDER BENEFITS MARKED\*. IF PRE-AUTHORISATION IS NOT OBTAINED, A PENALTY OF £1,000/\$1,700/€1,400 WILL BE DEDUCTED FROM YOUR CLAIM SETTLEMENT**

INPATIENT TREATMENT BENEFITS			
<b>Hospital Services*</b> > Accommodation and meal charges > All Inpatient Treatment ordered by a Physician > Physician, Surgeon and Anaesthetist Fees > Intensive Care Unit charges	Full Refund	Full Refund	Full Refund
<b>Hospital Cash Benefit*</b> Where Inpatient Treatment is provided free of charge	£250/\$500/€375 per night Max 30 days	£250/\$500/€375 per night Max 30 days	£250/\$500/€375 per night Max 30 days
<b>Parental Accommodation</b> When an insured child up to age 17 years is an Inpatient	Full Refund	Full Refund	Full Refund
<b>Daycare Treatment</b> Where a period of recovery is required in a hospital bed	Full Refund	Full Refund	Full Refund
<b>Inpatient Psychiatric Treatment*</b> Treatment in a psychiatric unit, available after one year of cover	Full Refund Max 30 days	Full Refund Max 30 days	Full Refund Max 30 days
<b>Reconstructive Surgery</b> To restore appearance/function following an Accident or illness that occurred whilst covered by your Plan	Full Refund	Full Refund	Full Refund
<b>Accident and Emergency Room Treatment</b>	Full Refund	Full Refund	Full Refund
<b>Organ and Bone Marrow Transplant and Stem Cell Treatment*</b> For kidney, heart, heart-lung, liver, bone marrow and stem cell. Acquisition and donor costs are excluded	Up to £100,000/\$200,000/€150,000	Up to £100,000/\$200,000/€150,000	Up to £100,000/\$200,000/€150,000
<b>Internal Prostheses, Medical Aids and Devices</b> Which are required intra-operatively	Full Refund	Full Refund	Full Refund
<b>Hospice Care</b> Palliative care in a hospice	Full Refund Max 15 days	Full Refund Max 15 days	Full Refund Max 15 days
<b>Local Road Ambulance Services</b>	Full Refund	Full Refund	Full Refund

POST HOSPITAL TREATMENT BENEFITS			
<b>Post Hospital Treatment</b> Consultations and treatment received within 90 days of receiving Inpatient Care	Up to £500/\$1,000/€750	Covered under Outpatient Services	Covered under Outpatient Services
<b>Rehabilitation Care</b> To restore health and mobility after injury or illness	£100,000/\$200,000/€150,000 lifetime limit	£100,000/\$200,000/€150,000 lifetime limit	£100,000/\$200,000/€150,000 lifetime limit
<b>External Prostheses, Medical Aids and Devices</b> Which are medically required following Inpatient Care, Daycare Treatment or Accident and Emergency Room Treatment	Up to £250/\$500/€375	Up to £500/\$1,000/€750	Up to £750/\$1,500/€1,125

CANCER TREATMENT			
<b>Oncology, Chemotherapy and Radiotherapy*</b> Consultations, diagnostics and treatment received under Inpatient Care, Daycare Treatment or Outpatient Services	Full Refund	Full Refund	Full Refund
<b>Cancer counselling</b> Following a cancer diagnosis with a registered psychologist/counsellor	Up to £1,000/\$2,000/€1,500	Up to £1,000/\$2,000/€1,500	Up to £1,000/\$2,000/€1,500
<b>Artificial Hair Benefit</b> Wig costs, available following cancer treatment	Up to £1,000/\$2,000/€1,500	Up to £1,000/\$2,000/€1,500	Up to £1,000/\$2,000/€1,500

EMERGENCY MEDICAL EVACUATION BENEFITS			
<b>Emergency Medical Evacuation*</b> Evacuation costs for acute medical conditions where local medical facilities are inadequate	Full Refund	Full Refund	Full Refund
<b>Emergency Medical Evacuation – Supplementary Expenses*</b> Cost of travel to place of origin Hotel accommodation costs for companion Taxi costs for companion Accommodation Costs following Inpatient Care	Economy air ticket Up to 12 nights Up to £500/\$1,000/€750 Up to 7 nights	Economy air ticket Up to 12 nights Up to £500/\$1,000/€750 Up to 7 nights	Economy air ticket Up to 12 nights Up to £500/\$1,000/€750 Up to 7 nights
<b>Emergency Non-Medical Evacuation*</b> Evacuation to a safe location in the event of life-threatening situations resulting from political or civil unrest Evacuation to a safe location in the event of a natural disaster	Full Refund	Full Refund	Full Refund

<b>Compassionate Home Travel*</b> In the event of the death of a close family member, available after one year of cover	One return economy air ticket	One return economy air ticket	One return economy air ticket
<b>Repatriation or Local Burial*</b> Where death occurs outside the Home Country. Not available if you are aged over 65	Up to £7,500/\$15,000/€11,250	Up to £7,500/\$15,000/€11,250	Up to £10,000/\$20,000/€15,000

## OUTPATIENT TREATMENT BENEFITS



<b>MRI, CT, PET Scans</b>	Full Refund	Full Refund	Full Refund
<b>Hormone Replacement Therapy</b> When not related to the menopause	Full Refund	Full Refund	Full Refund
<b>Outpatient Services</b> > General Physician fees > Specialist and Consultant fees > Prescription Drugs and Dressing > X-Rays, diagnostic and pathology tests	Not Covered	Full Refund	Full Refund
<b>Physiotherapy</b> Up to 20 sessions			
<b>Complementary Therapies</b> Osteopathy, Chiropractic, Homeopathy and Acupuncture			
<b>Outpatient Psychiatric Treatment</b> When referred by a Physician, available after one year of cover	Not Covered	Not Covered	Up to £750/\$1,500/€1,125 20% co-insurance
<b>Nursing at Home</b> When medically necessary and prescribed by a Physician	Full Refund Up to 26 weeks	Full Refund Up to 26 weeks	Full Refund Up to 26 weeks

## DENTAL CARE BENEFITS



<b>Dental Treatment following an Accident</b> To restore or repair sound natural teeth	Full Refund	Full Refund	Full Refund
<b>Routine Dental Treatment</b>	Not Covered	Not Covered	Up to £500/\$1,000/€750 20% co-insurance

## MATERNITY CARE BENEFITS



<b>Normal Pregnancy and Childbirth</b> Available after one year of cover	Not Covered	Not Covered	Up to £5,000/\$10,000/€7,500 per pregnancy
<b>Complicated Pregnancy and Childbirth</b> Available after one year of cover	Not Covered	Not Covered	Up to £10,000/\$20,000/€15,000
<b>Newborn Care</b> Available when a newborn child is enrolled within 14 days	Up to £5,000/\$10,000/€7,500	Up to £5,000/\$10,000/€7,500	Up to £5,000/\$10,000/€7,500

## WELL BEING BENEFITS



<b>Routine Health Screening</b> Preventative health checks available after one year of cover	Not Covered	Not Covered	Up to £300/\$600/€450 20% co-insurance
<b>Vaccination Benefit</b> Childhood and travel-related vaccinations	Up to £200/\$400/€300	Up to £200/\$400/€300	Up to £200/\$400/€300

## ADDITIONAL BENEFITS



<b>HIV/AIDS Benefit</b> Available after two years of cover	Up to £10,000/\$20,000/€15,000 Lifetime limit	Up to £10,000/\$20,000/€15,000 Lifetime limit	Up to £10,000/\$20,000/€15,000 Lifetime limit
<b>Chronic Condition Treatment</b>	Covered within listed benefits	Covered within listed benefits	Covered within listed benefits
<b>Out of Area Cover</b> For emergencies and acute episodes of existing covered medical conditions	Up to £20,000/\$40,000/€30,000 Max 60 days	Up to £30,000/\$60,000/€45,000 Max 60 days	Up to £40,000/\$80,000/€60,000 Max 60 days

## ADDITIONAL SERVICES



<b>Red 24</b>	Included	Included	Included
<b>Bloodcare Foundation</b>	Included	Included	Included
<b>Best Doctors</b> Second Opinion Service	Included	Included	Included

## 6. WHAT IS NOT COVERED

The **Plan** does not provide cover for the following services, **treatment**, conditions, activities, and their related expenses and no **claims** will be met for the following:

### GENERAL EXCLUSIONS

- > **Pre-Existing Medical Conditions**, except as provided for under **Moratorium Underwriting**
- > The first £1,000/\$1,700/€1,400 of any claim for **Hospital Services, Hospital Cash Benefit, Inpatient Psychiatric Treatment, Organ and Bone Marrow Transplant and Stem Cell Treatment, Oncology, Chemotherapy and Radiotherapy**, or any claim that is likely to exceed £2,500/\$4,250/€3,500 if **Pre-Authorisation** was not sought prior to incurring the costs.
- > Any costs incurred outside your **Area of Cover**, except as defined under **Out of Area cover**.
- > Services or **treatment** in any long term care facility, spa, hydroclinic, sanatorium, nursing home or home for the aged that is not a **Hospital**.
- > Any costs relating to **Nursing at Home** that is for domestic reasons and not required for medical reasons.
- > Routine medical examinations (including annual routine diagnostic procedures other than when they form part of **Routine Health Screening** and this **benefit** is shown on **your Certificate**), including the issue of medical certificates and attestations, and examinations as to suitability for employment or travel.
- > Routine eye and ear examinations, including the cost of spectacles, contact lenses and hearing aids.
- > **Treatment** relating to birth defects and congenital illnesses (including hereditary conditions).
- > Tests and **treatment** relating to infertility and any form of assisted reproduction.
- > **Treatment** of any psychological or psychiatric disorders, and **treatment** (including Prescription Drugs) of anxiety, stress, depression and phobic states, except as defined under **Inpatient Psychiatric Care** and **Outpatient Psychiatric Care** and these **benefits** are shown on **your Certificate**.
- > **Treatment**, diagnostic procedures (including sleep study) and **Prescription Drugs** for sleep disorders, including but not restricted to sleep apnoea, sleep related breathing problems, snoring or insomnia.
- > All elective cosmetic surgery and subsequent complications related to the surgery.
- > Costs resulting from self-inflicted injury, suicide, abuse of alcohol, drug addiction or abuse, and **treatment** of sexually transmitted diseases.
- > Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV positive, unless **HIV/AIDS Benefit** is included on **your Certificate** and **you** are HIV positive we will only pay up to the **HIV/Aids benefit** limit for the **treatment** of the following conditions: Candidiasis (thrush), Cervical Cancer, CMN (cytomegalovirus), Cryptococcal meningitis, Cryptosporidiosis, HIV-associated brain impairment, Kaposi's sarcoma, Lymphoma, Mycobacterium avium intracellulare, Pneumonia including PCP (Pneumocystis pneumonia), Thrombocytopenia, Toxoplasmosis and Tuberculosis
- > Costs resulting from racing of any form other than on foot, and all professional sports.
- > **Treatment** by a family member and any autotherapy including Prescription Drugs.
- > **Treatment** that is not scientifically recognised, or established practice, or unproven or experimental, as considered by the relevant professional body.
- > **Treatment** and/or disabilities, costs and expenses resulting from participation in war, riots, strikes, lockouts, civil commotion, rebellion, revolution, insurrection, terrorism, military or usurped power or any illegal act, including resultant imprisonment.
- > **Treatment** resulting from the release of weapon(s) of mass destruction (nuclear, chemical or biological) whether such involve(s) an explosive sequence(s) or not.
- > Injury or illness while serving as a member of a police or military force or unit.
- > All costs directly or indirectly caused by or contributed to or arising from:
  - ionising radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel;
  - the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
- > All costs for **treatment** in respect of medical expenses incurred after the expiry date of the **Certificate**.
- > All expenses of cryopreservation
- > All expenses of introduction or re-introduction of living cells or living tissue, except as defined under **Organ and Bone Marrow Transplants and Stem Cell Treatment** and this **benefit** is included on **your Certificate**.
- > All organ transplantation costs, except as defined under **Organ and Bone Marrow Transplants and Stem Cell Treatment** and this **benefit** is included on **your Certificate**.
- > Costs in respect of **Hormone Replacement Therapy (HRT)** related to the treatment and symptoms of menopause.
- > **Treatment** for learning difficulties, hyperactivity, attention deficit disorder, speech therapy and developmental, social or behavioural problems.
- > Contraception, sterilisation or any **treatment** of sexual problems (including impotence, whatever the cause).
- > All expenses relating to vitamins, minerals and other supplements, including homeopathic remedies, irrespective of whether these have been prescribed or not.
- > Any costs relating to **treatment** for, or as a result of, obesity, such as slimming aids, drugs, slimming classes or obesity surgery (including gastric bands/sleeves).
- > Any costs relating to medical **treatment** required as a direct result of not following the medical advice given by a **Physician**.
- > Any costs incurred during a **benefit waiting period**.

### EMERGENCY MEDICAL EVACUATION EXCLUSIONS

- > All transportation costs occurred during trips specifically made for the purpose of obtaining medical **treatment** if not part of an approved **Emergency Medical Evacuation**, except as defined under **Local Road Ambulance Services**.
- > All **Emergency Medical Evacuation** costs for which **you** did not obtain **Pre-Authorisation** in advance by the **Assistance Company**, except as defined under **Emergency Medical Evacuation**.

### DENTAL CARE EXCLUSIONS

- > All dental **treatment** except as defined under **Dental Treatment Following an Accident** and **Routine Dental Treatment** and these **benefits** are shown on **your Certificate**.
- > All elective dentures and elective cosmetic **dental treatment**.
- > The costs of precious metals used in dental **treatment**.

## MATERNITY CARE EXCLUSIONS

- > All abortions, except where there is an immediate threat to the life of the mother.
- > All elective caesarean section deliveries.
- > All costs relating to pregnancy and childbirth, other than ectopic pregnancy, unless **Normal Pregnancy and Childbirth** and/or **Complicated Pregnancy and Childbirth** are shown on your **Certificate**.

**You** must provide a separate fully completed **claim** form for each medical condition that has been signed by the treating **Physician**. **You** must provide full supporting documentation, original invoices and receipts as soon as practicably possible. **We** will not provide reimbursement of any invoices/receipts received by **us** which are more than 180 days old.

When **you** receive **treatment** for a condition/**benefit** covered by the **Plan**, **you** are eligible to **claim** from the start of the course of **treatment** until the **treatment** is concluded or until the expiry of **your Certificate**, or the termination of **your Plan**, whichever is earlier. Where a **benefit** is claimed for **treatment** received and **you** subsequently **claim** for a new course of **treatment**, which is not in any way connected with the former **treatment**, the subsequent **Claim** will be regarded as a new **Claim**.

**We** will pay up to the limits shown in **your Certificate** for expenses incurred as a direct result of **you** suffering bodily injury, sickness, disease or being pregnant (where **Normal and Complicated Pregnancy benefit** is included in **your Certificate**) during the **Certificate period**.

## 7. CLAIMS

### 7.1 HOW TO MAKE A CLAIM

**You** must provide **us** with written notice, which can be by post or email, of a claim as soon as practicably possible after the start of **treatment**.

**You** must give **us** notice of a **claim** as soon as practicably possible even when the supporting documentation is not yet available.

**You must contact the Assistance Company to obtain pre-authorisation before any costs are incurred for all claims under the following benefits; Hospital Services (inpatient treatment), Inpatient Psychiatric Treatment, Organ and Bone Marrow and Stem Cell Treatment, Oncology, Chemotherapy and Radiotherapy, all Emergency Medical Evacuation benefits and Normal and Complicated Pregnancy and Childbirth and any other claim likely to exceed £2,500/\$4,250/€3,500 in any one Certificate period. In the case of an emergency admission to a Hospital, the 24 hour Assistance Company must be notified of your admission as soon as practicably possible.**

**IF YOU FAIL TO CONTACT THE 24 HOUR ASSISTANCE COMPANY FOR PRE-AUTHORISATION IT WILL RESULT IN YOU BEING RESPONSIBLE FOR THE FIRST £1,000/\$1,700/€1,400 OF EACH CLAIM**

**IF YOU FAIL TO CONTACT THE 24 HOUR ASSISTANCE COMPANY PRIOR TO INCURRING COSTS FOR EMERGENCY MEDICAL EVACUATION CLAIMS YOUR CLAIM WILL NOT BE PAID, WITH THE EXCEPTION OF A DIRE EMERGENCY WHERE THE 24 HOUR ASSISTANCE COMPANY COULD NOT BE CONTACTED IN ADVANCE, BUT WERE INFORMED AS SOON AS PRACTICABLY POSSIBLE AFTER THE EVACUATION.**

TYPE OF CLAIM	WHAT YOU NEED TO DO	WHAT WE WILL DO
<p><b>OUTPATIENT AND DENTAL CLAIMS</b> If <b>you</b> receive any medical or dental <b>treatment</b> on an outpatient basis</p>	<p><b>You</b> must take a <b>claim</b> form with <b>you</b> when <b>you</b> receive medical or dental <b>treatment</b> so that the <b>Physician/Dentist</b> can complete Section C or D on the <b>claim</b> form. <b>You</b> should complete Sections A, B and E. A separate <b>claim</b> form is required for each medical condition. Please ensure that all questions are fully answered – ticks and dashes will not be accepted and may delay the settlement of <b>your claim</b>. If the <b>claim</b> form is not fully completed <b>we</b> will return it to <b>you</b>. <b>We</b> do not pay for any charges related to the completion of a <b>claim</b> form.</p> <p>The fully completed <b>claim</b> form along with the original invoices and/or receipts should be sent to <b>us</b> at the following address:</p> <p style="text-align: center;">April International UK Minster House 42 Mincing Lane London, EC3R 7AE United Kingdom</p> <p>If the <b>claim</b> is less than £1,000/\$1,700/€1,400 <b>you</b> can submit the <b>claim</b> form and copies of the invoices and/or receipts by email to:</p> <p style="text-align: center;">claims@april-international.co.uk</p> <p><b>You</b> must retain the original documents as <b>we</b> reserve the right to request them.</p> <p><b>We</b> must receive notification of a <b>claim</b> as soon as practicably possible after the start of <b>treatment</b>. <b>We</b> will not pay any invoices that are more than 180 days old.</p>	<p>Once <b>we</b> have reviewed the documentation provided, <b>we</b> will send to <b>you</b> an Explanation of Benefits and make payment of the covered expenses directly into <b>your</b> chosen bank account. <b>Claims</b> can be settled in any currency that <b>you</b> choose (providing that such currency can be freely purchased by <b>our</b> Bank) and not necessarily in the currency of the bills submitted or the currency of <b>your Plan</b>. On submission of <b>your</b> first <b>claim</b> <b>you</b> must provide <b>us</b> with <b>your</b> full bank account details (including IBAN and SWIFT/BIC where required) so that <b>we</b> can arrange for settlement of <b>your claim</b>. <b>We</b> will apply the exchange rate applicable on the date that <b>we</b> process the <b>claim</b>. If <b>you</b> have a <b>co-insurance</b> on <b>your Plan</b>, this will be deducted from the eligible costs before any reimbursement is made. <b>We</b> will pay for any bank charges incurred in submitting the funds into <b>your</b> account. <b>We</b> will not pay for any charges made by <b>your</b> bank for receiving the funds. If the <b>claim</b> settlement is for an amount which is less than £50/\$100/€75 <b>we</b> reserve the right to hold these funds on account until such time as <b>you</b> submit another <b>claim</b> for settlement.</p>

## 7.1 HOW TO MAKE A CLAIM (CONTINUED)

TYPE OF CLAIM	WHAT YOU NEED TO DO	WHAT WE WILL DO
<p><b>CLAIMS REQUIRING PRE-AUTHORISATION</b> If <b>your claim</b> is likely to exceed £2,500/\$4,250/€3,500 or if <b>you</b> are claiming for <b>benefit</b> under <b>Hospital Services (inpatient treatment), Inpatient Psychiatric Treatment, Organ and Bone Marrow and Stem Cell Treatment, Oncology, Chemotherapy and Radiotherapy, all Emergency Medical Evacuation benefits and Normal and Complicated Pregnancy and Childbirth</b></p>	<p><b>You</b>, or <b>your</b> representative must contact the <b>Assistance Company</b> as soon as practicably possible:</p> <p>Telephone +44 (0) 1243 621130 Fax: +44 (0) 1243 773169 Email: april-international@cegagroup.com</p>	<p>The <b>Assistance Company</b> will contact <b>you</b> or <b>your</b> treating <b>Physician</b> to obtain the required medical information so that they can confirm that the required <b>treatment</b> is covered by <b>your Plan</b>. For any <b>inpatient treatment</b> they will issue a Guarantee of Payment to the provider of <b>your</b> medical care confirming what will be covered by the <b>Plan</b>. The <b>Hospital/Physician</b> will send the medical bills directly to the <b>Assistance Company</b> who will arrange for direct settlement with the <b>Hospital/provider</b> of medical care. If <b>you</b> have a <b>co-insurance</b> on <b>your Plan</b> this will be deducted from the payment made and <b>you</b> will be responsible for pay the costs not covered directly to the <b>Hospital/provider</b> of medical care</p>
<p><b>EMERGENCY MEDICAL EVACUATION</b> When <b>you</b> have an emergency, critical or life-threatening medical condition and local medical facilities may not be available to provide the medical <b>treatment</b> required</p>	<p><b>You</b> must provide them with the following information on the person who will be receiving <b>treatment</b>:</p> <ul style="list-style-type: none"> <li>&gt; Full Name</li> <li>&gt; Date of Birth</li> <li>&gt; <b>Certificate</b> Number</li> </ul> <p>&gt; Name and contact details of Treating Physician</p> <ul style="list-style-type: none"> <li>&gt; Details of the medical condition</li> <li>&gt; Details of the <b>Hospital</b>, if the claim is for <b>inpatient treatment</b>.</li> </ul>	<p>The <b>Assistance Company</b> will contact <b>you</b> or <b>your</b> treating <b>Physician</b> to obtain the required medical information so that they can assess your medical condition and decide if medical evacuation is required, by what means of transportation and where would be the best place for <b>you</b> to receive the required medical <b>treatment</b>. They will make arrangements for transportation to the required medical facility. They will also decide if a medical escort is required. The <b>Assistance Company</b> will settle any costs directly with the airline/evacuation company/provider of medical care.</p>
<p><b>REPATRIATION OR LOCAL BURIAL</b> If <b>you</b> or <b>your</b> covered <b>dependants</b> die outside <b>your Home Country</b> whilst covered by the <b>Plan</b></p>	<p>In the event of dire emergencies in remote or primitive areas where the <b>Assistance Company</b> cannot be contacted in advance, an <b>Emergency Medical Evacuation</b> must be reported as soon as practicably possible.</p>	<p>The <b>Assistance Company</b> will ask for medical information in relation to the death and will ask for a copy of the death Certificate. They will also confirm if <b>Repatriation or Local Burial</b> is covered by <b>your Plan</b> and assist <b>you</b> with making any arrangements for repatriation of the mortal remains. <b>We</b> will arrange to pay the providers directly up to the limits shown on <b>your Certificate</b>.</p>
<p><b>NON-MEDICAL EVACUATION</b> When there is a life threatening situation resulting from political or civil unrest, or <b>your</b> life is in danger as a result of a natural disaster</p>		<p>The <b>Assistance Company</b> will refer <b>your</b> case to RED24 who will make contact with <b>you</b> to assess <b>your</b> situation. RED24 will make any appropriate arrangements to move <b>you</b> to a place of safety and <b>we</b> will make settlement directly with them for any costs incurred</p>
<p><b>BEST DOCTOR SERVICE</b> If <b>you</b> are receiving medical <b>treatment</b> that is covered by <b>your Plan</b> and <b>you</b> require a second medical opinion on the proposed treatment Plan</p>	<p>Contact Best Doctors directly +44 (0) 203 608 9377</p> <p><b>You</b> will need to provide <b>your</b> full name, date of birth and <b>Certificate</b> number. This is a completely confidential service and will not have any impact on <b>your Plan</b>.</p>	<p><b>You</b> will speak to a case handler who will collect all of the relevant information regarding <b>your</b> medical diagnosis. They will ask for <b>your</b> permission to contact <b>your</b> treating <b>Physician</b> and request <b>your</b> medical reports. These reports are then sent to a specialist in the field of <b>your</b> medical condition. The specialist will assess the information and provide <b>you</b> with their findings in a confidential document that <b>you</b> can present to <b>your</b> treating <b>Physician</b>. <b>We</b> will not receive a copy of the report. If <b>you</b> feel that the treatment they have recommended is the route <b>you</b> would like to take then <b>we</b> will confirm whether the <b>treatment</b> is covered by <b>your Plan</b>.</p>

## 7.2 DUAL INSURANCE

If at the time of submitting a **claim**, **you** have more than one insurance policy in force, **we** will only pay **your claim** on a proportionate basis if **you** are entitled to reimbursement from any other source in respect of the same bodily injury, sickness, disease, death or expense. The **Insurer** of **your Plan** has the right to make a **claim** on any other insurance policy that **you** have in force.

## 7.3 RESOLVING DISPUTES

If there is a difference of medical opinion in respect of any **claim**,

this will be settled between two medical experts appointed by the two sides of the dispute. Any differences of opinion between the two medical experts will be referred to an umpire appointed in writing by the two medical experts at the time of their appointment.

## 7.4 MEDICAL EXAMINATIONS

**We/The Insurer** shall have the right and opportunity, through **our** medical representatives, to request that **you** undergo a medical examination whenever and as often as may be required within the duration of any **Claim**.

# 8. IMPORTANT INFORMATION

## 8.1 HOW TO COMPLAIN

**Our** objective is to provide **you** with a high level of service at all times. With the best of intentions **we** have to accept that there may be an occasion where **you** feel that **we** have not met this objective. Should **you** have any questions or concerns about **your Plan**, please follow the procedures below:

If **you** wish to make a formal complaint relating to the administration of **your Plan**, or this Policy Guide

If **you** wish to make a formal a complaint relating to a **claim** under **your Plan** you may do so at any time

WHAT YOU SHOULD DO		WHAT ACTION WILL BE TAKEN
<p><b>You</b> should contact April International UK Limited providing <b>your</b> Name, <b>Certificate</b> Number and full details of <b>your</b> complaint. The contact details are:</p> <p style="text-align: center;">April International UK Minster House 42 Mincing Lane London, EC3R 7AE Tel: +44 (0) 203 418 0470 Email: info@april-international.co.uk</p>		<p><b>We</b> will acknowledge receipt of <b>your</b> question or concern and provide <b>you</b> with a response within 2 working days. We will tell <b>you</b> what the next steps are if you are dissatisfied with <b>our</b> response. <b>We</b> will provide <b>you</b> with a copy of our complaints procedure in writing.</p>
IF THE INSURER IS CATLIN INSURANCE COMPANY (UK) LTD	IF THE INSURER IS CATLIN UNDERWRITING AGENCIES LIMITED	
<p><b>You</b> may refer the complaint to the Complaints Manager at Catlin Insurance Company (UK) Ltd. The address is:</p> <p style="text-align: center;">Complaints Manager Catlin Insurance Company (UK) Ltd. 20 Gracechurch Street London, EC3V 0BG Tel: +44 (0) 207 743 8487 Email: xlcatlinukcomplaints@xlcatlin.com</p> <p>Catlin Insurance Company (UK) Ltd. Is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority (Firm Reference No 423308) Further details can be found on the Financial Services Register at <a href="http://www.fca.org.uk">www.fca.org.uk</a>.</p> <p>Catlin Insurance Company (UK) Ltd - Registered Office: 20 Gracechurch Street, London, EC3V 0BG. Registered in England - Company Number 5328622.</p>	<p><b>You</b> may refer the complaint to the Complaints Manager at Catlin Underwriting Agencies Limited. The address is:</p> <p style="text-align: center;">Complaints Manager Catlin Underwriting Agencies Limited 20 Gracechurch Street London, EC3V 0BG Tel: +44 (0) 207 743 8487 Email: xlcatlinukcomplaints@xlcatlin.com</p> <p>If <b>you</b> still remain dissatisfied, it may be possible to refer the complaint to Lloyd's. Details of Lloyd's complaints procedures are set out in a leaflet "Your Complaint – How We Can Help" available at <a href="http://www.lloyds.com/complaints">www.lloyds.com/complaints</a> and are also available from Catlin Underwriting Agencies Limited at the above address or from Lloyd's at:</p> <p style="text-align: center;">Lloyd's Complaints, One Lime Street, London, EC3M 7HA.</p> <p>Catlin Underwriting Agencies is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority (Firm Reference No 204848). Further details can be found on the Financial Services Register at <a href="http://www.fca.org.uk">www.fca.org.uk</a>.</p> <p>Catlin Underwriting Agencies Limited - Registered Office: 20 Gracechurch Street, London, EC3V 0BG. Registered in England - Company Number 1815126.</p>	
		<p><b>You</b> will be provided with a response within eight (8) weeks of the <b>Insurer</b> receiving <b>your</b> complaint. The final response will state whether they accept or reject <b>your</b> complaint.</p> <p>Full reasons will be given if <b>your</b> complaint is rejected.</p>



## 8.1 HOW TO COMPLAIN (CONTINUED)

WHAT YOU SHOULD DO	WHAT ACTION WILL BE TAKEN
<p>If, after exhausting all of the above methods, <b>you</b> are still dissatisfied with the outcome of <b>your</b> complaint, or you have not received a response within eight (8) weeks, <b>you</b> may have the right to refer <b>your</b> complaint to the Financial Ombudsman Services, whose details are:</p> <p>The Financial Ombudsman Service Exchange Tower London, E14 9SR</p> <p>From within the United Kingdom: Tel: 0800 0234 567 (free for people phoning from a "fixed line", for example, a landline at home) Tel: 0300 1239 123 (free for mobile-phone users who pay a monthly charge for calls to numbers starting 01 or 02)</p> <p>From outside the United Kingdom Tel: +44 (0) 207 964 1000 Fax: +44 (0) 207 964 1001</p> <p>Email: <a href="mailto:complaint.info@financial-ombudsman.org.uk">complaint.info@financial-ombudsman.org.uk</a> Web: <a href="http://www.financial-ombudsman.org.uk">www.financial-ombudsman.org.uk</a></p> <p>The Financial Ombudsman Service can look into most complaints from consumers and small businesses. For more information, contact them on the above number or address, or view their website.</p> <p>The European Commission also provides an on-line dispute resolution (ODR) platform that allows consumers to submit their complaint through a central site, which will forward the complaint to the right Alternative Dispute Resolution (ADR) scheme. The ADR scheme for Catlin Insurance Company (UK) Ltd. and Catlin Underwriting Agencies Limited is the Financial Ombudsman Service, which can be contacted directly using the contact details above. For more information about ODR please visit <a href="http://ec.europa.eu/odr">http://ec.europa.eu/odr</a></p>	<p>They will review <b>your</b> case and provide <b>you</b> with their final decision.</p>

If **you** are dissatisfied with the outcome

### 8.2 FINANCIAL SERVICES COMPENSATION SCHEME

Catlin Insurance Company (UK) Ltd. is covered by the Financial Services Compensation Scheme. **You** may be entitled to compensation from the Scheme if **we** are unable to meet **our** obligations under this contract of insurance. If **you** are entitled to compensation under the Scheme, the level and extent of the compensation would depend on the nature of this contract of insurance. Further Information about the Scheme is available from the Financial Services Compensation Scheme (10th Floor, Beaufort House, 15 St. Botolph Street, London EC3A 7QU) and on their website: [www.fscs.org.uk](http://www.fscs.org.uk)

### 8.3 GOVERNING LAW AND JURISDICTION

The parties are free to choose the law applicable to this policy. Unless specifically agreed to the contrary the contract of insurance shall be governed by the laws of England and Wales and subject to the exclusive jurisdiction of the courts of England.

Unless otherwise agreed the language of this **Plan** shall be English.

### 8.4 LEGAL PROCEEDINGS

No action at law or equity shall be brought to recover under the **Plan** prior to expiration of 60 days after proof of **claim** has been

submitted in accordance with this Policy Guide. Nor shall any such action be brought at all unless commenced within six years from the date of the **claim**.

### 8.5 DATA PROTECTION

**You** should understand that any information **You** have provided will be processed by **Us**, in compliance with the provisions of the Data Protection Act 1998, for the purpose of providing insurance and handling **claims** and complaints, if any, which may necessitate providing such information to other parties.

### 8.6 RIGHTS OF THIRD PARTIES

A person who is not a party to this **Plan** has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this **Plan** but this does not affect any right or remedy of a third party which exists or is available apart from that Act.

### 8.7 SANCTIONS

**We** will not provide any **benefit** under **your Certificate** to the extent of providing cover, payment of any **claim** or the provision of any **benefit** where doing so would breach any sanction, prohibition or restriction imposed by law or regulation.

april international | UK

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