Long-Term

International Health Plan

POLICY GUIDE
2025–2026

April International

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CONTENTS

POLICY GUIDE 2025–2026

April International

1. INTRODUCTION

Welcome to April International UK. The Long-Term 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** available under your selected cover level 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 available under your selected cover level, 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 to the **treatment** of medical conditions that are in existence before **your Plan start date**, unless accepted by **us** under a **Continued Personal Medical Exclusions Application Form**.

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. Please inform **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.** Please keep this guide and **your certificate** in a safe place - **you** may need to refer to it if you have to make a **claim**.

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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. If **you** require an alternative format **you** should contact **us**.

2.2 ELIGIBILITY

The Long-Term International Health Plan (the **Plan**) is designed for **expatriates** of any nationality living or working outside of their **Home Country**. The **Plans** are also available to some **local nationals** who require international health insurance where this is agreed in writing by **us.**

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

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

If the main applicant is a child under the age of eighteen (18), **we** will charge the young adult premium rate (age eighteen (18) to twenty-five (25)).

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 eighteen (18) years old (or twenty-four (24) years old if in full-time education). **We** will require proof of education for **dependent** children aged between eighteen (18) and twenty-four (24) years old.

Newborn children are eligible for cover from birth. If **your** baby is born via surrogacy they are eligible for cover 60 days after birth and will be subject to medical underwriting. At least one parent must be covered under a policy for at least eighteen (18) months before the baby is eligible to be added to the **plan. Your plan** must also include the **Area of Cover** where the expected birth is taking place. Please refer to the **How to Make Changes to Your Plan** section of this Guide.

You must complete and sign a **Moratorium** or **Full Medical Underwriting Application Form** providing details for all persons to be covered by the **Plan**. If **you** are aged over sixty-five (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 sixty-five (65) years on the **start date** of **your Plan you** are eligible for cover on a **Moratorium Underwriting**, **Full Medical Underwriting (FMU) or Continued Personal Medical Exclusions Underwriting (CPME)** basis.

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

The **Full Medical Underwriting and Continued Personal Medical Exclusions underwriting** options are not available if **you** purchase a **Plan** online through **our** website.

If **you** select **Moratorium Underwriting you** must complete the **Moratorium Application Form**. **Moratorium Underwriting** means that **you** will not be covered for any **pre-existing medical conditions**. After two (2) 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 (2) years.

If **you** select **Full Medical Underwriting you** must complete the **Full Medical Underwriting Application Form**. **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**.

If you select **Continued Personal Medical Exclusions Underwriting you** must complete the **Continued Personal Medical Exclusions Underwriting Application Form**. **CPME underwriting** allows **you** and any **dependants** to carry forward any existing **specific exclusions** or **Moratorium** from **your** previous international private medical insurance policy that was in place immediately prior to the **start date** of **your Plan**. It is essential that **you** understand that this relates to **specific exclusions** only. The conditions, exclusions and benefit limitations that are detailed in this policy guide and **your Certificate** of insurance will apply from **your** new **start date** under this **Plan**.

We will review the information provided on the **Continued Personal Medical Exclusions Underwriting Application Form** to ascertain whether **your Continued Personal Medical Exclusions Underwriting Application Form** will be accepted. **You** must therefore ensure that **your Continued Personal Medical Exclusions Underwriting Application Form** is fully and accurately completed and submitted together with a copy of **your** previous **Certificate** of Insurance. An additional **premium** may be charged for this type of underwriting upon acceptance.

The **start date** and **cover level** as detailed on your previous **Certificate** of insurance will determine whether **waiting periods** will be applied under your new **Plan**. The **start date** must follow on from the expiry of your previous international private medical insurance and there should be no break in cover from your previous insurer.

2.4 THE INSURER

The **Insurer** of **your Plan** is AXA XL Insurance Company UK Limited or AXA XL 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 cover level as **you**. Only **benefits** outlined under the cover level **you** have selected will be available to **you** and/or **your dependants**.

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**.

If **you** have selected a **Voluntary Excess** on **your Application Form**, this will also apply to **your dependants**.

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 under the cover level you have selected.

2.6 EXCESS

An **excess** applies to some **Plan benefits** and these are shown on the schedule of benefits provided with **your Certificate**.

An **excess** is the portion of costs which will be paid by **you**. The **excess** will be applied as stated on **your Certificate** and will apply for each **Certificate period**.

An **excess** will be the fixed amount of costs to be paid by **you**.
An **excess** may be applied per **claim** or per **benefit** and will be stated on the schedule of benefits provided with **your Certificate**. Where an **excess** is applied per **claim**, if the **claim** continues into a new **Certificate period**, then an **excess** will also apply for the new **Certificate period**. The **excess** is individually applied to each person named on a **Certificate**. **You** will be reimbursed for eligible **treatment** costs that exceed the **excess** shown on **your Certificate.**

If **you** have selected a **Voluntary Excess**, this is applied once per **Certificate period.** The **Voluntary Excess** is individually applied to each person who is named on a **Certificate,** and across all **benefits** shown on the schedule of benefits provided with **your Certificate,** except for **Emergency Medical Evacuation.** Once the aggregate amount of eligible **treatment** costs exceeds the **Voluntary Excess** shown on **your Certificate you** will be reimbursed for subsequent eligible **treatment** costs. Any other **excess** shown on **your Certificate** will be applied after the **Voluntary Excess** has been deducted.

2.7 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 thirty (30) days from the date that **you** signed **your Application Form**.

You will receive a **Certificate** for each person named on the **Application Form**, together with an **Insurance Identification Card** which includes contact details for the **Assistance Company**.

2.8 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 annually, quarterly or monthly. If **you** have selected to pay **your** premiums on a quarterly or monthly basis, **you** must provide **us** with valid credit/debit card details on **your Application Form**.

Annual 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 or monthly premiums can be paid by credit/debit card only (Visa/Mastercard/American Express). If **you** apply for the **Plan** through **our** website, the full annual, first quarterly or monthly premium payment must be paid by credit/debit card when **you** submit **your Application Form**. All future instalment premiums will automatically be debited, on the **instalment date**, from the credit/debit card details provided until such time as the annual premium has been paid. If the card details that **you** have provided are due to expire before the remaining quarterly or monthly 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 annual, first quarterly or monthly 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 **you** apply for the **Plan** through **our** website, the **Plan** will start on the date the premium transaction is successful or on a future date specified by **you.**

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.

2.9 HOW TO MAKE CHANGES TO YOUR PLAN

	WHAT ACTION YOU WILL NEED TO TAKE	WHAT ACTION WE WILL TAKE
Change to Contact Details	If any of **your** contact details change, **you** must provide **us** with **your** new contact details as soon as practicably possible.	**We** will confirm receipt of the changes and update **our** records
Change of Cover Level *Only allowed at an* ***Anniversary Date***	At the **Anniversary Date we** will provide **you** with a **renewal offer** based on **your** existing **cover level**. If **you** wish to make a change to **your cover level/ voluntary excess**/currency of **your Plan**, **you** must notify **us** in writing or by email prior to the **Anniversary Date.**	**We** will provide **you** with a revised **renewal offer** reflecting the change in **cover level/voluntary excess/**currency. **You** and **your dependants** must have the same **cover level/voluntary excess/** currency. If **you** change **your cover level** to one that includes more comprehensive benefits, any **waiting periods** will start from the date of the change in **cover level**. The **benefits** on the schedule of benefits provided with **your Certificate** will be displayed in the currency in which **you** pay **your** premium
Change to Voluntary Excess *Only allowed at an* ***Anniversary Date***		
Change to Currency of Plan *Only allowed at an* ***Anniversary Date***		

2.9 HOW TO MAKE CHANGES TO YOUR PLAN (CONTINUED)

	WHAT ACTION YOU WILL NEED TO TAKE	WHAT ACTION WE WILL TAKE
Change to Area of Cover Only *allowed once per* ***Certificate Period***	**You** must advise **us** in writing or by email if **you** would like to change **your Area of Cover** and from which date this should be effective. Only one (1) change to **your Area of Cover** can be made in any one (1) **Certificate period**. **You** can also make a change on **your Anniversary Date**. **We** cannot change your **Area of Cover** if **you** intend to reside in the USA for a period of more than three (3) consecutive months or if **you** intend to travel to the USA for the purpose of receiving medical **treatment**.	**We** will confirm **our** acceptance of the change and advise if there is any additional premium to be paid or refunded if a change in **Area of Cover** is required. **We** will send **you** an invoice and payment must be made within fourteen (14) days. If premium is to be refunded, this will be done using **your** original payment method. In all cases, **we** will issue **you** with a new **Certificate**, and a new **Insurance Identification Card** if **your Area of Cover** has changed. If the change is made from **your Anniversary Date**, **we** will provide **you** with a revised **renewal offer**.
Change in Country of Residence	**You** must advise **us** in writing or by email if **you** will be changing **your** main **Country of Residence** and provide **us** with your new contact details. There are some countries where the **Insurer** may not be able to provide cover for regulatory or insurance licensing regulations. If the **Insurer** is unable to continue the contract, **they** will provide protection for ninety (90) days from the date of change of residence after which the policy will automatically lapse.	
Return to Home Country	**You** must advise us in writing or by email if **you** will be returning to **your Home Country** and provide us with **your** new residency address. Cover will automatically be cancelled for USA nationals if they reside in their **Home Country** for more than three (3) consecutive months. Cover will also be cancelled if you return to a country under financial sanctions.	
Adding a Dependant	If **you** wish to include **your** spouse or any **dependant** children to **your Plan**, **you** must complete and return an Addition of Dependant Form or **Full Medical Underwriting Application Form**. All children must be aged seventeen (17) years or under, or between eighteen (18) and twenty-four (24) years if they are still in full-time education. Proof must be provided of full-time education. Once **you** are in receipt of the invoice, this must be paid within fourteen (14) days.	**We** will calculate the additional premium due to add the **dependant** from the date **we** receive the Addition of Dependant Form/**Full Medical Underwriting Application Form** until the **Anniversary Date** or the end of the quarterly or monthly period, if **you** pay **your** premium by quarterly or monthly instalments. **Your dependant**(s) must have the same **cover level** and **voluntary excess** (if applicable) as **you**. **We** will send **you** an invoice for the additional premium which must be paid within fourteen (14) days. **We** will issue each new **dependant** with a **Certificate** and an **Insurance Identification Card** when **we** receive the premium due. If premium is not paid within fourteen (14) days, cover will not be in place for the **dependant**(s).
Adding a Newborn	If **you** wish to include **your** newborn baby to **your Plan**, this should be arranged within one (1) month of the date of delivery, by completing and returning an Addition of Dependant Form. If **your** newborn baby is born via surrogacy, they are eligible for cover 60 days after birth. **You** will need to complete and return a Full Medical Underwriting Addition of Dependant Form which will be reviewed and may be accepted with or without **specific exclusions**. Once **you** are in receipt of the invoice, this must be paid within fourteen (14) days.	**We** will calculate the additional premium to add the newborn from their date of birth/60 days after date of birth, until the **Anniversary Date**/end of the quarterly or monthly period, if **you** pay **your** premium by quarterly or monthly instalments. The newborn must have the same **cover level** and **voluntary excess** (if applicable) as **you**. **We** will send **you** an invoice for the additional premium. Once the premium has been paid **we** will issue the newborn with a **Certificate** and **Insurance Identification Card**. If the premium is not paid within fourteen (14) days, cover will not be in place for the Newborn.

2.9 HOW TO MAKE CHANGES TO YOUR PLAN (CONTINUED)

	WHAT ACTION YOU WILL NEED TO TAKE	WHAT ACTION WE WILL TAKE
Removing a Dependant	If **you** would like to cancel cover for a **dependant** during the **Certificate Period you** must send **your** request to **us** in writing or by email.	If **you** have paid the annual premium for **your plan, we** will cancel cover for **your dependant** on the date that **we** receive **your** notification. If no **claims** have been made by **you**/**your dependants** during the current **Certificate period**, **we** will calculate a proportionate refund of the premium paid from the date we cancel cover for **your dependant** until the **anniversary date**. An cancellation fee of £50/$75/€65 will be deducted from any refund due to **you**. If the proportionate refund calculation is less than the cancellation fee then no refund will be provided. The premium will be refunded using the original method of payment. If **you** have paid for **your** premium in instalments (monthly or quarterly), **we** will cancel **your dependant** from the next instalment due date. No proportionate refund will be provided if **you** pay **your** premium in instalments.
Death of a Dependant	Please notify **us** as soon as practicably possible if a **dependant** on **your Plan** dies. **You** may need to provide **us** with details related to their death and a copy of the death certificate. If **your dependant** died outside their **Home Country** and **Repatriation or Local Burial** is required, please contact the **Assistance Company** as soon as practicably possible.	The **Assistance Company** will help with making arrangements for **Repatriation or Local Burial** where required. If **you** have paid the annual premium for **your** plan and no **claims** have been made by **you**/**your dependants** during the current **Certificate period** and the **Repatriation or Local Burial benefit** has not been used, **we** will calculate a proportionate refund of the premium paid from the date of death until the **anniversary date**. The premium will be refunded using the original method of payment. If **you** have paid for **your** premium in instalments (monthly or quarterly), **we** will cancel **your dependant** from the next instalment due date. No proportionate refund will be provided if **you** pay **your** premium in instalments. If the main applicant dies and **dependants** are included in the **Plan**, the **Plan** will continue until the next **Anniversary Date**. **We** will issue a **renewal offer** showing the **dependant** as the main applicant and a new policy number will be given.
Death of the Main Applicant	In the event of **your** death, **we** will need to be notified as soon as practicably possible by **your** next of kin or legal representative. Information regarding the circumstances surrounding **your** death should also be provided and a copy of the death certificate may be required. If **you** died outside **your Home Country** and **Repatriation or Local Burial** is required, the **Assistance Company** should be contacted as soon as practicably possible.	

2.10 RENEWING YOUR PLAN

The **Plan** can be renewed on each **Anniversary Date** of the **Start Date**, subject to the terms and conditions of the **Plan** and the premiums in force at the time of each **Anniversary Date** and any variations that **we** will advise **you** of in writing prior to the **Anniversary Date**.

We will send **you** a **renewal offer** prior to **your Anniversary Date** which will include details of any changes that have been made to the **Benefits** and **Plan** terms and conditions. The premium due on the **Anniversary Date** will depend on **you** and/or **your dependants'** age on the **Anniversary Date**.

If **you** wish to make any changes to **your Plan** with effect from the **Anniversary Date**, **you** must notify **us** in writing, by email or by telephone and **we** will provide **you** with a revised **renewal offer**.

Your renewal premium can be paid annually, quarterly or monthly. **We** must receive **your** full annual premium or first quarterly premium including any taxes where applicable before or on **your Anniversary Date**.

If **you** elect to pay **your** premiums annually, **you** must pay the full amount by bank transfer, through **our** online premium payment facility 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 or monthly basis, **you** will need to complete the payment authorisation form with **your** credit/debit card details and return this to **us** prior to **your Anniversary Date.**

If **you** elect to pay **your** premium using **our** online renewal payment facility **you** must do so by using an acceptable credit/debit card (Visa/MasterCard/American Express).

We will renew **your Plan** when **we** receive the premium. By paying the premium **you** are agreeing to any changes that have been outlined in **your renewal offer.**

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 eighteen (18) years old or twenty-four (24) years old if they are in full time education. If they are aged between eighteen (18) and twenty-four (24) years and in full-time education **you** will need to provide **us** with proof of enrolment into an educational institute.

If a child aged between eighteen (18) and twenty-four (24) years is no longer in full-time education, they are no longer eligible for cover under **your Plan**. They can apply for a **Plan** in their own right by completing and signing an **Application Form** and paying the appropriate adult premium. Providing that the premium is paid on or before the **Anniversary Date** and there is no break in cover, they will maintain their original **Start Date**.

Once **your Plan** has been renewed **you** will receive a **Certificate** of Insurance and **Insurance Identification Card** for each person covered under **your Plan**.

2.11 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 fourteen (14) 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**.

Your Plan may be terminated with effect from any **Anniversary Date**

by either party. **We** will not invoke cancellation as a result of **your** age or health record whilst **you** are insured under the **Plan**.

If **you** do not wish to renew **your Plan**, **you** must notify **us** in writing or by email prior to **your Anniversary Date**.

If **you** wish to cancel **your Plan** at a date other than the **anniversary date**, **you** must notify **us** of **your** request to cancel the **Plan** in writing or by email. If **you** have paid the annual premium for **your plan**, **we** will only cancel the **Plan** from the date that the request is received by **us** and cannot accept any requests for cancellation dates that are before the receipt date. If no **claims** have been made by **you/ your dependants** during the **Certificate period**, **we** will calculate a proportionate refund of the premium paid for the **Certificate period**. A cancellation fee of £50/$75/€65 will be deducted from any refund due to **you**. If the proportionate refund calculation is less than the cancellation fee then no refund will be provided. If a **claim** has been made by **you/your dependants** during the **certificate period,** then no refund will be provided.

If **you** have paid for **your** premium in instalments (monthly or quarterly), and **you** request for **your plan** to be cancelled from a date other than the **anniversary date**, we will cancel **your plan** from the next instalment due date. No proportionate refund will be provided if **you** pay **your** premium in instalments.

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.

2.12 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** fourteen (14) 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** fourteen (14) days' notice that **you** are terminating this **Plan**.

In accordance with Termination or Cancellation of your plan provision.

2.13 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 (1) of the causes of which is external to **your** own body and occurs beyond **your** control.

ANNIVERSARY DATE means the annual anniversary of **your** first **start date**.

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 the schedule of benefits provided with **your Certificate**. Any **benefit** not shown on the schedule of benefits provided with **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 the schedule of benefits provided with **your Certificate**.

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

CONTINUED PERSONAL MEDICAL EXCLUSIONS (CPME) means that **you** have provided **us** with a copy of your previous certificate of insurance (from an international private medical insurance provider) that was in place immediately prior to the **start date** of **your plan** and that **we** have agreed to carry forward any existing underwriting, **specific exclusions** or **Moratorium** and no further medical underwriting is required.

COOLING OFF PERIOD means the period of fourteen (14) 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 a period of at least six (6) months during **your Certificate Period**. This is shown on **your Certificate** as the **Country of Residence**. Please inform **us** if **you** change **your** temporary/permanent **Country of Residence**. The **Insurer** may accept the change with or without an amendment to the premium or terms and conditions. If the **Insurer** is unable to continue the contract, **they** will provide insurance protection for ninety (90) days from the date of change of residence after which the policy will automatically lapse.

COVER LEVEL means the International, International Plus, Executive or Executive Plus Plan and any **Voluntary Excess** selected by **you** on **your Application Form** or at a subsequent **Anniversary Date**.

DENTAL PRACTITIONER means a legally licensed dental practitioner recognised by the law of the country where **treatment** is provided and who in rendering such **treatment**, is practicing within the scope of his/her licensing and training, but does not include **you** or a member of **your** family.

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 eighteen (18) years old at the **start date** or **anniversary date** of the **Plan** (or up to age twenty-four (24) if **you** can provide proof that the child is continuing in full-time education). If **you** wish to add your baby born via surrogacy, the expected delivery date must be at least eighteen (18) months after the start date of **your plan** and **your plan** must include the **Area of cover** where the expected birth is taking place.

EXCESS means the portion of costs for which **you** and/or **your dependants** are liable for. The **excess** will be applied as specified on the **Certificate**.

EXPATRIATE means a person who is resident outside of their **Home Country**.

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 (1) 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 twenty-four (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 quarterly or monthly premium payment is due to be paid.

INSURANCE IDENTIFICATION CARD is a digital card issued to **you/your dependants** for each **Certificate period** and includes the name, policy number and expiry date of the **Plan**.

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/renewed on an **Anniversary Date**.

LOCAL NATIONAL means an individual whose **Country of Residence** is the same as the **Home Country**.

MEDICALLY NECESSARY/REQUIRED means healthcare services that a **physician** provides to **you** for the purposes of evaluating, diagnosing or treating an illness or injury and that meets accepted standards of medicine, provided that the service is appropriate in terms of type, frequency, extent and duration and is considered effective for **your** illness or injury.

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 (2) 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 (2) 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 (1) **Certificate period** by **you**, and will be shown on the schedule of benefits provided with **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 the schedule of benefits provided with **your Certificate**.

PHYSICIAN means a legally licensed medical doctor qualified in medicine and 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, but not include **you** or a member of **your** family.

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/$2,500/€2,500.

PRE-EXISTING MEDICAL CONDITIONS are any known medical conditions (or related conditions) that have, within a two (2) year period immediately prior to the first **Start Date** of the **Plan**, one (1) 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 (3) quotations for the disputed **treatment** and **we** will settle costs based on an average of the three (3) quotations.

RENEWAL OFFER is the offer made by **us** to **you** prior to the **Anniversary Date** of the **Benefits** and terms and conditions available to **you** if **you** wish to continue with **your Plan** after the **Anniversary Date**.

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

START DATE means the date that **your Plan** originally commences, and any subsequent **Anniversary Date** if the renewal premium is paid.

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.**

VOLUNTARY EXCESS is the amount of covered expenses, as selected on **your Application Form**, which **you** will pay each **Certificate period**, before any **benefits** can be claimed from the **Plan**. If the **benefit** claimed also has an **excess** this amount will be applied after the **voluntary excess** has been applied. The maximum **voluntary excess** amount that can be selected on the Executive or Executive Plus plans

is £1,000/$2,000/€1,500.

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 the schedule of benefits provided with **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 legally licensed Counsellor or Psychologist following **your** diagnosis of cancer.

CANCER GENETIC TESTING means the costs of tests for BRCA1 and BRCA2 genes, for breast, ovarian, prostate and pancreatic cancer and familial adenomatous polyposis (FAP) for colorectal cancer. This **benefit** is only available if you have been referred by a licensed **Physician** and you have a parent, sibling or child with breast cancer or FAP or their genetic testing indicates the presence of a hereditary cancer syndrome. This **benefit** is only available after **you** have completed one (1) year of continuous cover under a **plan** which includes this **benefit**. The costs of such testing will not be covered when they are available free of charge in the public healthcare system of the country where **you** are receiving treatment.

CANCER PREVENTATIVE TREATMENT means the costs of surgery required for the specific reason of preventing cancer. This **benefit** includes cover for mastectomy (to remove breasts), oophorectomy (to remove ovaries) and colectomy (to remove all or part of the bowel). This **benefit** is only available if **you** have been referred by a licensed **Physician** and **you** have a parent, sibling or child with breast, ovarian or colorectal cancer or their genetic testing indicates the presence of a hereditary cancer syndrome, or your genetic testing indicates the presence of a hereditary cancer syndrome. This **benefit** is only available after **you** have completed one (1) year of continuous cover under a **plan** which includes this **benefit**. The costs of such surgeries will not be covered when they are available free of charge in the public healthcare system of the country where **you** are receiving **treatment**.

CHILD ROUTINE HEALTH SCREENING means the costs of routine preventative and developmental checks for children up to and including 5 years old. This benefit does not include childhood **vaccinations.**

CHINESE MEDICINE means consultations and medicines provided to **you** by a registered and legally licensed Chinese Medicine Practitioner.

CHRONIC CONDITION TREATMENT means the **treatment** received for a **chronic condition**.

COMPASSIONATE HOME TRAVEL means if a close family member dies during the **Certificate period, we** will pay for the cost of a return economy air ticket to the country they have died in. A close family member means **your** spouse/partner, parent, mother-in-law, father-in-law, brother, sister, child (including (un) married child, step-child, foster-child and legally adopted child), grand-child or grandparent.

COMPLEMENTARY THERAPIES means consultations provided to **you** by registered and legally licensed 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). **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 eighteen (18) months 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 limit shown on the schedule of benefits provided with **your Certificate** is per pregnancy and applies from the date **you** notify us of **your** pregnancy for the whole duration of the pregnancy. If **you** upgrade **your Plan** at an **anniversary date** to a higher **benefit** limit or the current **benefit** limit increases, this will not apply to the existing pregnancy. If **you** change the currency of **your plan** at **your anniversary date**, the new **benefit** limit will not apply to the existing pregnancy.

COMPLICATIONS OF PREGNANCY means **treatment** of a medical condition arising during the antenatal stages of pregnancy or during childbirth. **Treatment** will be provided to **you** by a specialist or consultant for the following diagnosed conditions: Ectopic pregnancy, miscarriage, toxaemia, hydatidiform mole, retained placenta and eclampsia. This **benefit** is only available for pregnancies whose expected date of delivery is at least eighteen (18) months after the **start date** of a **Plan** that includes this **benefit**.

CONGENITAL AND HEREDITARY CONDITIONS means **treatment** required to relieve the symptoms of, or correct a congenital or hereditary medical condition. A congenital condition is an abnormality, deformity, disease, illness, or injury that is present at birth. A hereditary condition is an abnormality, deformity, disease, or illness that is only present because it has been passed down through generations of **your** family. If the condition manifests in a newborn baby, then the baby must be enrolled onto their parent(s) **plan** and be provided with a **Certificate** of Insurance in order to use this **benefit.**

DAY-PATIENT 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 ninety (90) days of the **Accident**. This **benefit** does not provide cover for damage to teeth caused by biting or chewing.

EMERGENCY MEDICAL EVACUATION means expenses of **medically required** emergency transportation and medical care en route to transport **you**, if **you** have a critical, life-threatening eligible medical condition that requires immediate inpatient or day-patient treatment. Transportation will be 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 pre-authorise all **Emergency Medical Evacuation** requirements. The **Assistance Company** will decide the most appropriate method of transportation and will not cover any travel costs which are against the advice of their medical team or where the medical facility does not have appropriate facilities to treat the eligible medical condition. In extreme emergency cases or 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 (1) other person to accompany **you** on an **Emergency Medical Evacuation** where Inpatient care is required following the **Emergency Medical Evacuation**, or where the E**mergency Medical Evacuation** is for a child who aged eighteen (18) years or younger.

When adequate **treatment** is not available locally we will pay for one return economy air ticket to transport you out of country, to the nearest **Hospital** where appropriate care and facilities are available, for **medically necessary treatment** that cannot be sought locally. Supplementary expenses for insured member and companion as per the schedule of benefits provided with **your Certificate**. This is limited to inpatient, day-patient, and cancer **treatment** only. You must contact us in advance to pre-authorise the costs so that we can determine the eligibility of the condition and whether the transport costs are medically necessary and to confirm that **treatment** is not available locally.

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, Crisis24 **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 accommodation and travel costs to and from the medical facility for you and a companion who has accompanied you on an approved **Emergency Medical Evacuation** up to the limits shown on the schedule of benefits provided with **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.

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

HEARING CARE means the costs of hearing tests by an audiologist and a contribution towards the costs of a hearing aid when prescribed by an audiologist (including a fitting consultation). This **benefit** is only available after **you** have completed one (1) year of continuous cover under a **Plan** which includes this **benefit**.

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 only available after **you** have completed two (2) 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 the schedule of benefits provided with **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 for the whole **claim**. The maximum payable is thirty (30) days in any one (1) **Certificate period**. **You** must obtain **Pre-authorisation** from the **Assistance Company** for this **benefit**.

HOSPITAL SERVICES means all required medical **treatment** provided to **you** by a **physician** when **you** are admitted as a registered **inpatient** in a **Hospital** for a period of not less than twenty-four (24) consecutive 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 private single standard 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**, and **complications of pregnancy**.

INFERTILITY AND MISCARRIAGE INVESTIGATIONS means the necessary tests and investigations into the cause of infertility and/or repeated miscarriage when **your Physician** believes there are symptoms and/or evidence to suggest a medical cause. The tests and/or investigations must be ordered by a **Physician**. This **benefit** is only available after you have completed two (2) years of continuous cover under a **plan** which includes this **benefit**.

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 thirty (30) days per **Certificate period**. This **benefit** is only available after **you** have been completed one (1) year of continuous cover under a **Plan** which includes this **benefit**.

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

KIDNEY DIALYSIS means **treatment** for renal failure caused by an injury or illness. **Treatment** must be received as an **inpatient** or as **day-patient treatment** in a **hospital**, or in a medically licensed dialysis centre. This does not include **treatment** required as a result of alcohol or substance abuse.

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

MENOPAUSE HORMONE REPLACEMENT THERAPY means consultations and **Prescription Drugs**, patches or implants when required to alleviate the symptoms of early menopause, where onset and **treatment** commence below the age of 40 years.

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 baby from their date of birth until thirty (30) days following discharge from **Hospital** and does not include routine newborn baby check-ups or **treatment** for **congenital and hereditary conditions**. No other **benefits** are available to the newborn until thirty (30) days following discharge from **hospital** when the full selected **plan benefits** will apply. The baby must be enrolled onto their parent(s) **plan** and be provided with a **Certificate** of Insurance in order to use this benefit. If **your** newborn baby is born via surrogacy, they are eligible for cover 60 days after birth. This benefit does not form part of the parent(s) plan.

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 eighteen (18) months 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 limit shown on the schedule of benefits provided with **your Certificate** is per pregnancy and applies from the date **you** notify us of **your** pregnancy for the whole duration of the pregnancy. If **you** upgrade **your Plan** at an **anniversary date** to a higher **benefit** limit or the current **benefit** limit increases, this will not apply to the existing pregnancy. If **you** change the currency of **your plan** at **your anniversary date**, the new **benefit** limit will not apply to the existing 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**.

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

OPTICAL CARE means the costs of eyesight examinations by a legally licensed Optometrist or an Ophthalmologist and a contribution towards the costs of lenses to correct vision and eyeglass frames (including a fitting consultation). This **benefit** is only available after **you** have completed one (1) year of continuous cover under a **Plan** which includes this **benefit**

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 sixty (60) days in any one (1) **Certificate period**, up to the limits shown on the schedule of benefits provided with **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 Services** excludes any costs that are not in respect of an illness, disease or injury. Outpatient home consultations can only be considered if **you** are medically incapable of attending a medical facility and this has been confirmed by **your** treating **physician**. Elective outpatient home consultations will only be reimbursed at the costs of a standard outpatient consultation that takes place at a medical facility, in the location where **treatment** is received.

OUTPATIENT SURGERY means the costs of a surgical procedure performed by a licensed **Physician** in a surgery, **hospital**, day-patient facility or outpatient department that does not require a period of recovery in a **hospital** bed. This does not include the costs of any pre or post-surgical costs such as, but not limited to consultations, diagnostic tests and **prescription drugs**.

OUTPATIENT PSYCHIATRIC SERVICES means medical **treatment** (including **Prescription Drugs**) provided to **you** by a **Physician** who is licensed as a General Practitioner, Specialist or Consultant for any psychological or psychiatric disorder as well as **treatment** of anxiety, stress, depression, panic attacks or phobic states.

OUTPATIENT PSYCHIATRIC THERAPIES means the **treatment** of any psychological or psychiatric disorder by a Consultant Psychiatrist. It includes the **treatment** of anxiety, stress, clinical depression, panic attacks and phobic states and therapy performed by a behavioural or clinical psychologist, provided the therapy has been referred by a **Physician**.

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

PHYSIOTHERAPY means treatment provided by a legally licensed Physiotherapist and ordered by a **Physician**. This **benefit** is limited to the number of sessions as stated on the schedule of benefits provided with **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 ninety (90) days of **your** discharge from **Hospital**.

PRE HOSPITAL TREATMENT means **outpatient services** that are related to an eligible **claim** which is received within fifteen (15) days prior to being admitted to **hospital** for planned **Inpatient** or **Day-patient treatment.**

PRESCRIPTION DRUGS means medications and medical supplies whose sale and use is legally restricted to the order of a **Physician** and is not available without a **Physician**'s prescription. This 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 **medically necessary treatment** received as an **inpatient,** carried out under the constant supervision of a specialist in a recognised rehabilitation unit of a **hospital** immediately following **inpatient treatment** for an illness or injury covered by **your plan.** Providing that the purpose of the **treatment** is to restore health and mobility after an **accident,** injury or illness to a state in which you can be self-sufficient. To be self-sufficient means restoring **your** ability to do independent daily activities of living without the need for outside medical help. This **benefit** is subject to a **Lifetime Limit** as shown on the schedule of benefits provided with **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**.

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 to children aged seventeen (17) years and under and includes the costs of appliances to correct the position of natural teeth. The **benefit** is limited to the amount shown on the schedule of benefits provided with **your Certificate.** This **benefit** is only available after **you** have completed six (6) months of continuous cover under a **plan** which includes this **benefit**.

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, screening blood tests, vital signs, PAP smear test, mammogram and prostate screening. This **benefit** is only available if **you** are aged eighteen (18) years and over and after **you** have completed one (1) year of continuous cover under a **Plan** which includes this **benefit**.

SECOND MEDICAL OPINION means a detailed report including recommendations for the best approach towards optimal recovery. A licenced **Physician** will review your medical history, along with any proposed **treatment** to provide reassurance and confidence in your diagnosis or **treatment** recommendation. This is provided through our partner Teladoc Health.

TELECONSULTATION means medical consultation provided to **you** by telephone. Teleconsultations provides you access to licensed General **Physicians** via telephone for non-emergency medical advice. This is provided through our partner Teladoc

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

VITAMINS & MINERALS means cover for vitamins and/or minerals as prescribed by a licensed **Physician** for a diagnosed deficiency.

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**.

Pre-authorisation is required for all claims where the costs are likely to exceed £2,500/$2,500/€2,500 and for all claims under benefits marked *. If pre-authorisation is not obtained, this may impact the settlement of all eligible costs and you may incur a proportion of the costs.

	INTERNATIONAL	INTERNATIONAL PLUS	EXECUTIVE	EXECUTIVE PLUS
Overall Aggregate Limit each Certificate period	£1,000,000/$2,000,000/€1,500,000			
INPATIENT TREATMENT BENEFITS				
Hospital Services* › Accommodation and meal charges › All Inpatient Treatment ordered by a Physician › Physician, Surgeon and Anaesthetist Fees › Intensive Care Unit charges	Paid in Full			
Hospital Cash Benefit* Where inpatient treatment is provided free of charge	£250/$500/€375 per night. Max thirty (30) days.			
Parental Accommodation When an insured child aged seventeen (17) years and under is an inpatient	Paid in Full			
Day-patient Treatment Where a period of recovery is required in a hospital bed	Paid in Full			
Inpatient Psychiatric Treatment* Treatment in a psychiatric unit of a hospital, available after one (1) year of cover	Paid in Full. Max thirty (30) days.			
Reconstructive Surgery To restore appearance/function following an accident or illness that occurred whilst covered by your Plan	Paid in Full			
Rehabilitation Care Treatment received as an inpatient to restore health and mobility after injury or illness	£100,000/$200,000/€150,000 lifetime limit			£200,000/ $400,000/€300,000 lifetime limit
Accident and Emergency Room Treatment	Paid in Full			
Organ and Bone Marrow Transplant and Stem Cell Treatment* For kidney, heart, heart-lung, liver, bone marrow and stem cell. Acquisition and donor costs are excluded.	Paid in Full			
Kidney Dialysis Treatment received as an inpatient or as day-patient treatment	Up to £100,000/$200,000/€150,000			
Internal Prostheses, Medical Aids and Devices Which are required intra-operatively	Paid in Full			
Hospice Care Palliative care in a hospice	Paid in Full. Max fifteen (15) days.			
Local Road Ambulance Services	Paid in Full			
PRE & POST HOSPITAL TREATMENT BENEFITS				
Pre-Hospital Treatment Consultations and treatment received within fifteen (15) days prior to receiving Inpatient or day-patient treatment	Up to £250/$500/€375	Covered under Outpatient Services		
Post Hospital Treatment Consultations and treatment received within ninety (90) days of receiving Inpatient Care	Up to £500/$1,000/€750	Covered under Outpatient Services		
External Prostheses, Medical Aids and Devices Which are medically required following Inpatient Care, Day-patient 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	Up to £1,000/$2,000/€1,500
CANCER TREATMENT				
Oncology, Chemotherapy and Radiotherapy* Consultations, diagnostics and treatment received under Inpatient Care, Day-patient Treatment or Outpatient Services	Paid in Full			
Cancer Genetic Testing Available after one (1) year of cover	Not Covered		Up to £1,250/$2,500/€1,875 Lifetime limit	Up to £2,500/$5,000/€3,750 Lifetime limit
Cancer Preventative Treatment Available after one (1) year of cover	Not Covered		Up to £15,000/$30,000/€22,500 Lifetime limit	Up to £25,000/$50,000/€37,500 Lifetime limit
Cancer counselling Following a cancer diagnosis with a registered psychologist/counsellor	Up to £1,000/$2,000/€1,500			
Artificial Hair Benefit Wig costs, available following cancer treatment	Up to £1,000/$2,000/€1,500			

EMERGENCY MEDICAL EVACUATION BENEFITS	INTERNATIONAL	INTERNATIONAL PLUS	EXECUTIVE	EXECUTIVE PLUS
Emergency Medical Evacuation* Evacuation costs for critical, life-threatening medical conditions where local medical facilities are inadequate	Paid in Full			
Emergency Medical Evacuation – Supplementary Expenses* › Cost of travel to place of origin › Accommodation costs › Hospital travel expenses	Economy air ticket Up to fourteen (14) nights Up to £500/$1,000/€750			
Emergency Non-Medical Evacuation* › 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	Paid in Full			
Compassionate Home Travel* In the event of the death of a close family member	One (1) return economy air ticket			
Repatriation or Local Burial* Where death occurs outside the Home Country	Up to £7,500/$15,000/€11,250		Up to £10,000/$20,000/€15,000	Paid in Full
TELEHEALTH				
Teleconsultation Access to licensed doctors around the world via phone for non-emergency conditions	Included	Included Full Refund up to £100/$200/€150 for prescription drugs following consultation		
Second Medical Opinion Access to a network of 50,000 medical specialists	Included			
OUTPATIENT TREATMENT BENEFITS				
MRI, CT and PET Scans When referred by a Physician	Full Refund			
Hormone Replacement Therapy When not related to the menopause	Full Refund			
Outpatient Surgery	Up to £5,000/$10,000/€7,500	Full Refund		
Outpatient Services › General Physician fees › Specialist and Consultant fees › Prescription Drugs and Dressings › X-Rays, diagnostic and pathology tests	Not Covered	Full Refund £50/$100/€75 excess per claim A claim is considered to be a course of treatment per diagnosed medical condition. **The Plans can be enhanced with a Nil Excess per Claim option by paying an additional premium.**		
Physiotherapy Up to twenty (20) sessions, when referred by a Physician				
Complementary Therapies Osteopathy, Chiropractic, Homeopathy and Acupuncture, when referred by a Physician				
Chinese Medicine Consultations and medications provided by a registered Chinese Medicine Practitioner	Not Covered		Up to £200/$400/€300	Up to £400/$800/€600
Vitamins & Minerals When prescribed by a medical practitioner	Not Covered		Up to £120/$240/€180	Up to £240/$480/€360
Nursing at Home When medically necessary and prescribed by a Physician	Paid in Full Max thirty (30) days.			
MENTAL HEALTH BENEFITS				
Outpatient Psychiatric Services › General Physician and Consultant fees › Prescription Drugs	Not Covered	Full Refund £50/$100/€75 excess per claim A claim is considered to be a course of treatment per diagnosed medical condition. **The Plans can be enhanced with a Nil Excess per Claim option by paying an additional premium.**		
Outpatient Psychiatric Therapies › Counselling, Cognitive Behavioural Therapy and Psychotherapy › When referred by a Physician	Not Covered	Up to £1,000/$2,000/€1,500	Up to £2,000/$4,000/€3,000	Up to £3,000/$6,000/€4,500
DENTAL CARE BENEFITS				
Dental Treatment following an Accident To restore or repair sound natural teeth	Full Refund			
Routine Dental Treatment Available after six (6) months of cover	Not Covered	Up to £300/$600/€450	Up to £750/$1,500/€1,125	Up to £1,250/$2,500/€1,875

MATERNITY CARE BENEFITS	INTERNATIONAL	INTERNATIONAL PLUS	EXECUTIVE	EXECUTIVE PLUS
Normal Pregnancy and Childbirth Available after eighteen (18) months of cover	Not Covered		Up to £6,000/$12,000/€9,000	Up to £10,000/$20,000/€15,000
Complicated Pregnancy and Childbirth Available after eighteen (18) months of cover	Not Covered		Up to £12,000/$24,000/€18,000	Up to £20,000/$40,000/€30,000
Complications of Pregnancy Available after eighteen (18) months of cover	Not Covered		Full Refund	
NEWBORN AND CHILD CARE BENEFITS				
Newborn Care Available when a newborn baby is enrolled on the Plan	Up to £50,000/$100,000/€75,000		Up to £75,000/$150,000/€112,500	Up to £100,000/$200,000/€150,000
Child Routine Health Screening Preventative and developmental checks for an insured child aged five (5) years and under	Not Covered		Up to £200/$400/€300	Up to £300/$600/€450
WELL BEING BENEFITS				
Routine Health Screening Preventative health checks available after one (1) year of cover	Not Covered	Up to £300/$600/€450	Up to £500/$1,000/€750	Up to £750/$1,500/€1,125
Menopause Hormone Replacement Therapy Relief of early menopause symptoms for forty (40) years and under	Not Covered			Up to £250/$500/€350
Vaccination Benefit Childhood and travel-related vaccinations	Up to £200/$400/€300			
Optical Care Eyesight examinations and a contribution towards the costs of lenses to correct vision, available after one (1) year of cover	Not Covered			Up to £300/$600/€450
Hearing Care Hearing tests and a contribution towards the costs of a hearing aid, available after one (1) year of cover	Not Covered			Up to £300/$600/€450
ADDITIONAL BENEFITS				
Infertility and Miscarriage Investigations Available after two (2) years of cover and when referred by a Physician	Not Covered			Up to £750/$1,500/€1,125
Congenital and Hereditary Conditions	Not Covered		Up to £15,000/$30,000/€22,500	Up to £30,000/$60,000/€45,000
HIV/AIDS Benefit Available after two (2) years of cover	£10,000/$20,000/€15,000			
Chronic Condition Treatment	Covered within listed benefits			
Out of Area Cover For emergencies and acute episodes of existing covered medical conditions	Up to £20,000/$40,000/€30,000 Max sixty (60) days	Up to £30,000/$60,000/€45,000 Max sixty (60) days	Up to £40,000/$80,000/€60,000 Max sixty (60) days	Up to £50,000/$100,000/€75,000 Max sixty (60) days
ADDITIONAL SERVICE PARTNERS				
Crisis24 Security Assistance	Included			
Bloodcare Foundation Providing properly screened blood	Included			
Teladoc Health Telehealth Services	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**.
- 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 or Child Routine Health screening** and these **benefits** are shown on the schedule of benefits provided with **your Certificate**), including the issue of medical certificates and attestations, and examinations as to suitability for employment or travel.
- Eyesight examinations including the cost of spectacles and contact lenses (unless **Optical care benefit** is shown on the schedule of benefits provided with **your Certificate**).
- Hearing tests, including the costs of hearing aids (unless **Hearing care benefit** is shown on the schedule of benefits provided with **your Certificate**).
- **Treatment** relating to congenital and hereditary conditions and illnesses, except as defined under **Congenital and Hereditary Conditions** and this **benefit** is shown on the schedule of benefits provided with **your Certificate**.
- Tests and **treatment** relating to infertility and any form of assisted reproduction, except as defined under **Infertility and Miscarriage Investigations** and this **benefit** is shown on the schedule of benefits provided with **your Certificate**.
- **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**, **Outpatient Psychiatric Services** or **Outpatient Psychiatric Therapies** and these **benefits** are shown on the schedule of benefits provided with **your Certificate**.
- **Treatment**, diagnostic procedures (including sleep study) and **Prescription Drugs** for sleep disorders, including for example sleep apnoea, sleep related breathing problems, snoring or insomnia.
- All elective **treatment** including procedures and diagnostic tests that are not **medically necessary**.
- All **treatment** that is not deemed to be **medically necessary/ required**
- 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 the schedule of benefits provided with **your Certificate**. If this **benefit** is included 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.
- All costs for **treatment** resulting from racing of any form other than on foot.
- All costs for **treatment** arising from an injury or illness as a result of being a professional sportsperson. A professional sportsperson is someone who is paid to participate and compete in their chosen sport.
- **Treatment** by a family member and any autotherapy including Prescription Drugs.
- Any **treatment**, procedures, drugs, equipment or device that is not scientifically recognised, established practice, experiemental or has not been proven to be effective. This includes but is not limited to treatment provided as part of a clinical trial; treatment that has not been approved by the relevant public health authority in the country where it is being received; or any drug or medicine which is prescribed for a purpose for which it has not been licensed or approved in the country where it is prescribed.
- **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 the schedule of benefits provided with **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 the schedule of benefits provided with **your Certificate**.
- Costs in respect of **Hormone Replacement Therapy (HRT)** related to the treatment and symptoms of menopause, except as defined under **Menopause Hormone Replacement Therapy** and this **benefit** is included on the schedule of benefits provided with **your Certificate**.
- **Treatment** for learning difficulties, hyperactivity, attention deficit disorder, speech therapy, occupational therapy and developmental, social or behavioural problems.
- Contraception, sterilisation or any **treatment** of sexual problems (including impotence, whatever the cause).
- All **treatment** costs as a result of visiting a dietitian, whatever the diagnosis.
- All costs relating to and including diagnosis of eating disorders.
- All expenses relating to vitamins, minerals and other supplements,including homeopathic remedies and pre or pro-biotics, irrespective of whether these have been prescribed or not except as defined under **Vitamins & Minerals** and this **benefit** is included on the schedule of benefits provided with **your Certificate.**
- All costs relating to **prescription drugs** which are available to purchase without a **Physician's** prescription even when included on a **Physician's** prescription
- Any costs relating to investigations or treatment for, or as a result of, obesity; including weight monitoring or control, slimming classes, aids and drugs or bariatric surgery (including gastric bands/sleeves) and any complications arising from bariatric surgery.
- 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**.
- Any hospital accommodation costs that are more expensive than a private standard single room as well as personal items such as telephone calls, newspapers, Wi-Fi, guest meals, toiletries or cosmetics.
- All costs relating to orthotics for example insoles.
- All costs relating to preventative treatment and medications.
- All outpatient home consultations except as defined under **outpatient services**.
- All costs relating to gender reassignment surgery and hormone **treatment** required for the transition process.
- All costs relating to genetic testing for **Cancer**, except as defined under **Cancer Genetic** testing and this benefit is included on the schedule of benefits provided with **your Certificate** and where such testing is not available free of charge in the public healthcare system of the country where you are receiving treatment.
- All costs relating to preventative cancer **treatment**, except as defined under **Cancer Preventative Treatment** and this **benefit** is

- included on the schedule of **benefits** provided with **your Certificate** and where such surgeries are not available free of charge in the public healthcare system of the country where you are receiving treatment.

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**.
- All costs relating to 'search and/or rescue' operations to find and/or rescue an insured person in mountains, at sea or other similar remote locations and costs relating to air/sea rescue operation or evacuation from any off-shore structure or ship.

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 the schedule of benefits provided with **your Certificate.**

- All elective dentures and elective cosmetic **dental treatment.**
- The costs of precious metals used in dental **treatment.**
- All costs relating to mouth guards**.**

MATERNITY CARE EXCLUSIONS

- All abortions, except where there is an immediate threat to the life of the mother, as certified by a medical practitioner.
- All elective caesarean section deliveries.
- All costs relating to pregnancy and childbirth, unless **Normal Pregnancy and Childbirth and/or Complicated Pregnancy and Childbirth** and/or **Complications of Pregnancy** are shown on the schedule of benefits provided with **your Certificate.**

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 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 one-hundred and eighty (180) days old.

You must provide us with a written response to any request for additional information regarding **your claim** as soon as practicably possible. Failure to provide us with the information we have reasonably requested within sixty (60) days of the original request, will result in the closure of **your claim** and no further action will be taken.

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 on the schedule of benefits provided with **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** selected plan) during the **Certificate period**.

Upon submission of your first **claim**, please provide us with your full bank account details for reimbursement. Your bank account details will be stored securely and used for any future reimbursements.

7.1 HOW TO MAKE A CLAIM (CONTINUED)

All treatment 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/$2,500/€2,500 in any one (1) Certificate period must be pre-authorised by the Assistance Company.

In the case of an emergency admission to a Hospital, and it is not reasonably possible for you to contact us in advance of your admission, you should notify the Assistance Company of your admission as soon as practicably possible.

In the event of an Emergency Medical Evacuation, the Assistance Company must be informed prior to incurring any costs, except in extreme emergency cases or in remote or primitive areas, where they should be informed as soon as practicably possible following the evacuation.

If you do not contact us to obtain pre-authorisation for eligible treatment that we have specified must be pre-authorised, the full settlement of all eligible costs may be impacted and you may incur a proportion of the costs.

TYPE OF CLAIM	WHAT YOU NEED TO DO	WHAT WE WILL DO
OUTPATIENT AND DENTAL CLAIMS If **you** receive any medical or dental **treatment** on an outpatient basis	**You** can submit all reimbursement **claims** through the Easy Claim app. Here's how **you** can do this: **STEP 1:** From the homepage, click "Submit your claim". **STEP 2:** Answer the questions as prompted. **STEP 3:** Upload and submit the following supporting documents: 1. Confirmation of medical symptoms/injury 2. Referral letter, if relevant 3. Itemised medical invoice 4. Itemised physician's prescription 5. Proof of payment 6. Claims form if your claim is £500 / $500 / €500 or more Alternatively, **you** can submit **your claims** directly via the Member Portal. Simply sign in here and follow the same steps. On submission of **your** first **claim**, **you** must provide **us** with **your** full bank account details (including IBAN and SWIFT/BIC where required) so that **we** can arrange for settlement of **your claim**. **You** can add or update **your** bank details via the Member Portal. **Your** bank account details will be stored securely and used for any future reimbursements. **You** must tell us if your account details change. **IMPORANT:** If **your claim** is £500 / $500 / €500 or more, **you** must complete and attach a **claims** form. A fully completed **claim** form should be submitted for each **claim**. **You** should complete Sections A and B on the claim form. The **Physician** must complete Section C on the **claim** form. A separate **claim** form is required for each medical condition. All questions must be fully answered – ticks and dashes will not be accepted and may delay settlement of the **claim**. **We** do not pay for any charges related to the completion of a **claim** form. The original documents must be retained as **we** reserve the right to request them. **We** must receive notification of a **claim** as soon as practicably possible after the start of **treatment**. Alternatively, **you** can pre-authorise medical care where **treatment** costs are likely to exceed £500/$500/€500 and request the Easy Pay card as a means to settle the treatment costs directly and avoid seeking reimbursement. Simply email **EasyPayCard@april-international.co.uk** at least 3 working days before **your** pre-planned treatment. **You** will need to include a medical report or letter from **your** treating doctor with a summary of the diagnosis/symptoms, recommended **treatment** or medical procedure, and documented evidence of the estimated costs.	**You** will be able to track the status of **your** reimbursement claims in the Easy Claim app and Member Portal. Once **we** have reviewed the documentation provided, **we** will send to **you** an Explanation of Benefits by email and make payment of the covered expenses directly into **your** chosen bank account. An Explanation of Benefits will also available in the app and Member Portal. **Claims** can be settled in any currency that **you** choose (providing that such currency can be freely purchased by our Bank) and not necessarily in the currency of the bills submitted or the currency of **your Plan**. There are some currencies **we** are not able to make settlement in. **We** will apply the exchange rate applicable on the date that **we** process the **claim**. If **you** have an **excess** on **your Plan**, this will be deducted from the eligible costs before any reimbursement is made. **We** will pay for any bank charges incurred in submitting the funds into **your** account. **We** will not pay for any charges made by **your** bank for receiving the funds.

7.1 HOW TO MAKE A CLAIM (CONTINUED)

<table>
<tr><th>TYPE OF CLAIM</th><th>WHAT YOU NEED TO DO</th><th>WHAT WE WILL DO</th></tr>
<tr><td>CLAIMS REQUIRING PRE-AUTHORISATION
If your claim is likely to exceed £2,500/$2,500/€2,500 or if you are claiming for benefit under 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</td><td>You can submit your request for pre-authorisation via the Easy Claim app.
STEP 1: From the homepage or claims page, click “Hospitalisation” and select the service you need from the following list:
- Planned Hospitalisation
- Past Hospitalisation
- Emergency hospitalisation and select “call”
STEP 2: Submit your request with the following details:
1. Date of treatment
2. Contact details
3. City of hospitalisation and provider
4. Estimated cost for medical care.
STEP 3: Attach your medical report and any other relevant supporting documents.
Once submitted, our medical assistance partner CEGA will review your request and contact you by email or phone to finalise the process.
Alternatively, contact our Assistance Company directly on the details provided below.</td><td>The Assistance Company will contact you or your treating Physician to obtain the required medical information so that they can confirm that the required treatment is covered by your Plan. For any inpatient treatment they will issue a Guarantee of Payment to the provider of your medical care confirming what will be covered by the Plan. The Hospital/ Physician will send the medical bills directly to the Assistance Company who will arrange for direct settlement with the Hospital/provider of medical care. If you have an excess on your Plan this will be deducted from the payment made and you will be responsible for pay the costs not covered directly to the Hospital/ provider of medical care</td></tr>
<tr><td>EMERGENCY MEDICAL EVACUATION
When you have an emergency, critical or life-threatening medical condition and local medical facilities may not be available to provide the medical treatment required</td><td rowspan="3">You, or your representative must contact the Assistance Company as soon as practicably possible:
Telephone +44 (0) 1243 621130
Fax: +44 (0) 1243 773169
Email: april-international@cegagroup.com
You must provide them with the following information on the person who will be receiving treatment:
› Full Name
› Date of Birth
› Policy Number
› Name and contact details of Treating Physician
› Details of the medical condition
› Details of the Hospital, if the claim is for inpatient treatment.
In the event of dire emergencies in remote or primitive areas where the Assistance Company cannot be contacted in advance, an Emergency Medical Evacuation must be reported as soon as practicably possible.</td><td>The Assistance Company will contact you or your treating Physician 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 you to receive the required medical treatment. They will make arrangements for transportation to the required medical facility. They will also decide if a medical escort is required. The Assistance Company will settle any costs directly with the airline/ evacuation company/provider of medical care.</td></tr>
<tr><td>REPATRIATION OR LOCAL BURIAL
If you or your covered dependants die outside your Home Country whilst covered by the Plan</td><td>The Assistance Company 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 Repatriation or Local Burial is covered by your Plan and assist you with making any arrangements for repatriation of the mortal remains. We will arrange to pay the providers directly up to the limits shown on the schedule of benefits provided with your Certificate. If you have a Voluntary Excess on your Plan, this will be deducted from the eligible costs before any reimbursement is made.</td></tr>
<tr><td>EMERGENCY NON-MEDICAL EVACUATION
When there is a life threatening situation resulting from political or civil unrest, or your life is in danger as a result of a natural disaster</td><td>The Assistance Company will refer your case to Crisis24 who will make contact with you to assess your situation. Crisis24 will make any appropriate arrangements to move you to a place of safety and we will make settlement directly with them for any costs incurred.</td></tr>
</table>

7.1 HOW TO MAKE A CLAIM (CONTINUED)

TYPE OF CLAIM	WHAT YOU NEED TO DO	WHAT WE WILL DO
EASY PAY CARD For pre-authorised medical care above £500 / $500 / €500	**You** can request the Easy Pay card by emailing **EasyPayCard@april-international.co.uk** at least 3 working days before **your** pre-planned **treatment**. **You** will need to include a medical report or letter from **your** treating doctor with a summary of the diagnosis/symptoms, recommended **treatment** or medical procedure, and documented evidence of the estimated costs.	**We** will review **your** claim and once authorised, immediately pre-load the card with the amount needed to pay for **your treatment**. **You** will then receive an email with a link to create **your** account and access the card. **You** can add this card to **your** digital wallet on **your** mobile phone and use it like any other standard virtual payment card. Once **you** have paid for **your treatment**, all **you** have to do is send **your** invoices to us, together with any other supporting documents, within 24 hours. You can upload **your** documents in your APRIL Easy Pay account.
TELECONSULTATION If **you** require access to a licensed General **Physician** via telephone for non-emergency medical advice	Submit a request to **our** service partner Teladoc by completing an online form here **You** will need to provide **your** full name, date of birth and policy number	A doctor will call **you** back within 3 hours of submitting the request. This is not an emergency service and below are examples of the conditions that cannot be treated: Chest pain, shortness of breath, severe abdominal pain, heavy bleeding, thoughts of suicide or self-harm, confusion, loss of consciousness, severe infection, severe pain, suspected stroke, seizures, pregnancy complications, high fever in unwell infant. If **you** are feeling unwell, **we** advise **you** to contact **your** local emergency services. It is important that **you** keep a record of any consultation notes that are sent to **you** after the **teleconsultation** has concluded
SECOND MEDICAL OPINION If **you** are receiving medical **treatment** that is covered by **your Plan** and **you** require a second medical opinion on the proposed **treatment** plan	Submit a request to **our** service partner Teladoc by completing an online form here **You** will need to provide **your** full name, date of birth and policy number This is a completely confidential service and will not have any impact on **your plan**	**Your** case will be assigned to a specialist doctor with expertise aligned to **your** diagnosis/medical condition who will request all relevant information regarding **your** medical diagnosis. They will ask for **your** permission to contact **your** treating **Physician** and request **your** medical reports. These reports are then sent to a specialist in the field of **your** medical condition. The specialist will assess the information and provide **you** with their findings in a confidential document that can presented to the treating **Physician.** **We** will not receive a copy of the report. If **you** feel that the **treatment** they have recommended is the route **you** would like to take then we will confirm whether the **treatment** is covered by **your plan**

7.2 DUAL INSURANCE

If at the time of submitting a **claim**, **you** have more than one (1) 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 (2) medical experts appointed by the two (2) sides of the dispute. Any differences of opinion between the two (2) medical experts will be referred to an umpire appointed in writing by the two (2) 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:

	WHAT YOU NEED TO DO	WHAT ACTION WILL BE TAKEN
If **you** wish to make a formal complaint relating to the administration of **your Plan**, or this Policy Guide	**You** should contact April International UK Limited providing **your** Name, **Policy** Number and full details of **your** complaint. The contact details are: APRIL International UK Walsingham House, 35 Seething Lane, London, EC3N 4AH Tel: +44 (0) 203 418 0470 Email: info@april-international.co.uk	**We** will acknowledge receipt of **your** question or concern and provide **you** with a response within two (2) working days. **We** will tell **you** what the next steps are if **you** are dissatisfied with **our** response. **We** will provide **you** with a copy of our complaints procedure in writing.
If **you** wish to make a formal a complaint relating to a **claim** under **your Plan you** may do so at any time	**IF THE INSURER IS AXA XL INSURANCE COMPANY UK LIMITED** **You** may refer the complaint to the Complaints Department at XL Catlin Services SE. The address is: Complaints Department XL Catlin Services SE, UK Branch, 20 Gracechurch Street, London, EC3V 0BG, United Kingdom Tel: +44 (0) 207 743 8487 Email: axaxlukcomplaints@axaxl.com XL Catlin Services SE acts as an agent of AXA XL Insurance Company UK Limited in connection with this policy. XL Catlin Services SE is a registered insurance intermediary authorised and regulated by the Central Bank of Ireland. Registered Office: 8 St. Stephen's Green, Dublin 2, D02 VK30, Ireland Registered in Ireland Number 659610 You can check this information on the Central Bank of Ireland's website www.centralbank.ie which includes a register of all the firms they regulate AXA XL Insurance Company UK Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority (Firm Reference No. 423308). Registered Office: 20 Gracechurch Street, London, EC3V 0BG. Registered in England Number 5328622. **You** can check this information on the FCA's website at www.fca.org.uk, which includes a register of all the firms they regulate or **you** can call the FCA on 0800 111 6768	**You** will be provided with a response within eight (8) weeks of the **Insurer** receiving **your** complaint. The final response will state whether they accept or reject **your** complaint. Full reasons will be given if **your** complaint is rejected.

	IF THE INSURER IS AXA XL UNDERWRITING AGENCIES LIMITED	
	You may refer the complaint to the Complaints Department at XL Catlin Services SE. The address is: Complaints Department XL Catlin Services SE, UK Branch, 20 Gracechurch Street, London, EC3V 0BG, United Kingdom Tel: +44 (0) 207 743 8487 Email: axaxlukcomplaints@axaxl.com XL Catlin Services SE acts as an agent of AXA XL Underwriting Agencies Limited in connection with this policy. XL Catlin Services SE is a registered insurance intermediary authorised and regulated by the Central Bank of Ireland. Registered Office: 8 St. Stephen's Green, Dublin 2, D02 VK30, Ireland Registered in Ireland Number 659610 You can check this information on the Central Bank of Ireland's website www.centralbank.ie which includes a register of all the firms they regulate If **you** still remain dissatisfied, after the Complaints Department has considered your complaint, 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 www.lloyds.com/complaints and are also available from Catlin Underwriting Agencies at the below address or from Lloyd's at: Lloyd's Complaints, One Lime Street, London, EC3M 7HA, United Kingdom Telephone +44(0) 20 7327 5693 Email: complaints@lloyds.com AXA XL Underwriting Agencies Limited is the managing agent of Syndicate 2003 AXA XL Underwriting Agencies Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority (Firm Reference No. 204848). Registered Office: 20 Gracechurch Street, London, EC3V 0BG. Registered in England Number 1815126. **You** can check this information on the FCA's website at www.fca.org.uk, which includes a register of all the firms they regulate or **you** can call the FCA on 0800 111 6768.	**You** will be provided with a response within eight (8) weeks of the **Insurer** receiving **your** complaint. The final response will state whether they accept or reject **your** complaint. Full reasons will be given if **your** complaint is rejected.
	WHAT YOU NEED TO DO	**WHAT ACTION WILL BE TAKEN**
If **you** are dissatisfied with the outcome	If, after exhausting all of the above methods, **you** are still dissatisfied with the outcome of **your** complaint, or you have not received a response within eight (8) weeks, **you** may have the right to refer **your** complaint to the Financial Ombudsman Service at: Exchange Tower London, E14 9SR Email: complaint.info@financial-ombudsman.org.uk Telephone Number: From within the United Kingdom 0800 0243 567 calls to this number are free on mobiles and landlines 0300 1239 123 calls to this number costs no more than calls to 01 and 02 numbers From outside the United Kingdom +44 (0) 20 7962 0500 Fax Number: +44 (0)20 7964 1001 Text Number 07860 027 586 Call back service 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: www.financial-ombudsman.org.uk	They will review **your** case and provide **you** with their final decision.

8.2 INSURANCE GUARANTEE SCHEMES

AXA XL Insurance Company UK Limited and AXA XL Underwriting Agencies Limited are 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 (PO Box 300, Mitcheldean, GL17 1DY) and on their website: 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 sixty (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 PRIVACY

For full information about how we process and protect your personal information please refer to our Privacy Policy which can be viewed by clicking on the site terms and conditions on our website www.april-international.co.uk.

How We Use Your Information
The personal information, provided by **you** (or anyone acting on **your** behalf), is collected by or on **our** behalf and may be used by **us**, **our** employees, agents and service providers acting under **our** instruction for the purposes of insurance administration, underwriting, claims handling, insurance mediation, research or for statistical purposes. **We** may process your information for a number of different purposes. For each purpose **we** must have a legal ground for such processing. When the information that **we** process is classed as 'special category data, **we** must have a specific additional legal ground for such processing.

Generally, **we** will rely on the following legal grounds:

- It is necessary for **us** to process **your** personal information to provide this policy and services related to it. **We** will rely on this for activities such as providing **you** with information about **your** quote, assessing **your** application, managing **your** policy, handling claims and providing other services to **you**.
- **We** have an appropriate business need to process **your** personal information and such business need does not cause harm to **you**. **We** will rely on this for activities such as maintaining **our** business records, developing, improving our products and services, and providing information about **our** products and services to **you**.
- **We** have a legal or regulatory obligation to use such personal information.
- **We** need to use such personal information to establish, exercise or defend **our** legal rights.
- **You** have provided **your** consent to **our** use of **your** personal information, including special category data.

How we share your information
In order to sell, manage and provide **our** products and services, prevent fraud and comply with legal and regulatory requirements, **we** may need to share your information with the following types of third parties:

- Insurers, Reinsurers, Regulators and Authorised/Statutory Bodies
- Fraud prevention agencies
- Crime prevention agencies, including the police
- Suppliers carrying out a service on **our** behalf
- Other insurers, business partners and agents
- Other companies within the APRIL Group

As **we** operate as part of a global business, **we** may transfer your personal information outside the European Economic Area (EEA) for these purposes where adequate protection is in place.

Marketing
We will not use **your** information or pass it on to any other person for the purposes of marketing further products or services to **you** unless **you** have consented to this.

Fraud Prevention and Detection
In order to prevent or detect fraud and money laundering we may check **your** details with fraud prevention agencies and sanction websites, who may record a search. Searches may also be made against other insurers' databases. If fraud is suspected, information will be shared with those insurers. Other users of the fraud prevention agencies may use this information in their own decision making processes.

We may also conduct credit reference checks in certain circumstances. **You** can find further details in **our** full Privacy Policy explaining how the information held by fraud prevention agencies may be used.

Automated Decisions
We may use automated tools with decision making to assess **your** application for insurance and for claims handling processes. If **you** object to an automated decision, **we** may not be able to offer **you** an insurance quotation.

Contact Us
Please contact **us** if **you** have any questions about our privacy policy or the information we hold about **you**.

8.6 INSURERS FAIR PROCESSING NOTICE

For information about how the **insurers** process **your** personal information, please see their full privacy notice at: https://axaxl.com/privacy-and-cookies.

If **you** have questions or concerns regarding the way in which the **Insurers** use **your** personal information, please contact: legalcompliance@axaxl.com.

8.7 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.

8.8 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. This means that **we** may not be able to settle any payments of claims into countries where sanctions, prohibitions or restrictions are imposed.

8.9 CYBER RISKS

Any **benefits** for bodily injury or illness caused by or arising out of a Cyber Act or a Cyber Incident are payable, subject to the terms, conditions, limitations and exclusions of this policy.

Cyber Act means an unauthorised, malicious or criminal act or series of related unauthorised, malicious or criminal acts, regardless of time and place, or the threat or hoax thereof involving access to, processing of, use of or operation of any Computer System.

Cyber Incident means:

- **any error or omission or series of related errors or omissions involving access to, processing of, use of or operation of any Computer System; or**
- **any partial or total unavailability or failure or series of related partial or total unavailability or failures to access, process, use or operate any Computer System.**

Computer System means any computer, hardware, software, communications system, electronic device (including, but not limited to, smart phone, laptop, tablet, wearable device), server, cloud or microcontroller including any similar system or any configuration of the aforementioned and including any associated input, output, data storage device, networking equipment or back up facility, owned or operated by the Insured or any other party.

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