CARE

Individual Health

Classic Plan

gbg | AKD insurance

2022

WELCOME

Welcome and Thank You for your interest in DCare International Medical Insurance from AKD Insurance, 5 Rafael Santi, 1st Floor Office 101, 6052 Larnaca, Cyprus and insured by GBG Insurance Limited, Fourth Floor, Albert House, South Esplanade, St Peter Port, Guernsey GY1 1AW.

The Policy is intended to provide you with details of the insurance plan. Do not hesitate to contact us should you require further clarification or have questions concerning the benefits.

We look forward to providing you with this valuable medical insurance protection and servicing you this year.

REACH US 24 HOURS A DAY, 7 DAYS A WEEK

PRE-AUTHORIZATION, CLAIMS SERVICES, & OTHER MEDICAL INSURANCE ASSISTANCE:

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AKD Insurance is a trading name that is owned and used for the operations of A.K Demetriou Insurance Agents, Sub – Agents & Consultants Ltd

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1. SCHEDULE OF BENEFITS

PLAN CONDITIONS
Area of Coverage **Refer to the Certificate of Coverage for the Area of Coverage included under this Policy.**
Area 1: Worldwide Coverage including the United States (maximum continuous stay of three months in the United States) What the Plan pays in the United States: The Insurer maintains a Preferred Provider Network. When an In-Network provider is used, benefits are paid at 100%. When an Out-of-Network provider is used, benefits are reimbursed at 80%, OR Area 2: Worldwide Coverage excluding the United States
Emergency Treatment Outside Area of Coverage: Coverage for a Medical Emergency Outside the Area of Coverage is provided for a period of 30 days from entry by the Insured Person.

COST SHARING OBLIGATIONS UNDER THE PLAN	
Currency	EUR
Maximum annual benefit per person (all sections combined)	2,000,000
Annual Deductible This is the amount of Allowable Charges each Insured pays on an annual basis before the plan pays benefits.	As per stated on your Certificate of Insurance
Plan Pays* The Plan pays benefits at the Allowable Charge	100%
Other Items You Are Responsible to Pay** In addition to the Coinsurance cost share, you are responsible to pay for charges exceeding the Allowable Charge, any Deductible and charges exceeding the Annual Maximum Benefit, charges incurred within a Waiting Period, and any other charges deemed not covered under the plan.	

INPATIENT TREATMENT AND DAY CARE TREATMENT		
Accommodation (private room) and meals, including • Nursing care • Inpatient consultation by a Physician or Specialists fee • Medicines and drugs • ICU and coronary care unit • Laboratory, and diagnostic tests • Medical appliances & prosthetics	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Benefits are provided for private room and board, special diets, and general nursing care. Benefits are also provided for treatment in the Intensive Care or Coronary Care Unit if it is the most appropriate place for the Insured to be treated, the care provided is an essential part of the Insureds treatment, and the care provided is routinely required by patients suffering from the same type of Illness or Injury, or receiving the same type of treatment. We will pay costs if: ▪ Treatment is Medically Necessary for the Insured Person to be treated on an Inpatient or Day Care basis, ▪ The stay in the Hospital is for a medically appropriate period of time, and ▪ The treatment received is provided or managed by a Physician or Specialist Inpatient hospital confinements primarily for purposes of receiving non-acute, long term Custodial Care, Respite Care, maintenance of a Chronic condition, or assistance with Activities of Daily Living (ADL), are not eligible expenses.		

Parent Accommodation	**Plan Pays*** 100%	**You Pay*** 0%
Benefit Description Benefits are provided for overnight hospital accommodation for the parent of a hospitalized insured Dependent under the age of 16. The cost of meals for the parent will also be covered.		

Cash benefit per night Annual Maximum Benefit: 30 days	**Plan Pays*** 125 / day
Benefit Description Benefits are provided for a cash payment payable for each night spent in any hospital that is free of charge that is part of the health system where eligible treatment, covered under this Policy, is received by an Insured but no charge for services is incurred.	

SURGICAL BENEFITS (INPATIENT/OUTPATIENT)		
Inpatient or Outpatient	**Plan Pays*** 100%	**You Pay**** 0%
Surgery/Surgeon and Anesthesiology Services	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Benefits are provided for covered surgical services received in a Hospital, Outpatient facility, Physician's office or other approved facility. Surgical services include: use of operation room and recovery room, operative and cutting procedures, treatment of fractures and dislocations, surgical dressings, and other Medically Necessary services.		

EMERGENCY SERVICES		
Emergency room, Emergency medical services	**Plan Pays*** 100%	**You Pay**** 0%
Road ambulance costs (Local) Ground ambulance (to the nearest hospital)	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Benefits are provided for Medically Necessary Local Ambulance Services to transport the Insured: from the scene of an Accident or Injury to a hospital, from one hospital to another, or from the Insured's home to a hospital.		

Emergency dental treatment in the first 48 hours after the Accident • Annual Maximum Benefit: 350	**Plan Pays*** 100%	**You Pay**** 0%
Emergency dental treatment occurring more than 48 hours after the Accident • Annual Maximum Benefit: 150	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Treatment after an extraoral accident, for immediate pain relief. We will pay up to the amount shown for treatment necessary as a result of an extraoral impact to sound, natural teeth following an accident/injury for the immediate relief of pain the Insured Person suffers as the direct result of an Accident occurring during the period of insurance. Damage to teeth caused by chewing foods or a toothache, does not qualify as an emergency.		

OUTPATIENT TREATMENT – whether followed by Inpatient treatment or not:		
Medical practitioner and Specialist consultations & treatment ▪ Annual Maximum Benefit: 1250 Prescribed medications, dressings and Durable Medical Equipment ▪ Annual Maximum Benefit: 2,000	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Insurer provides benefits for medical visits to a Physician or Specialist. Benefits are limited to one visit per day per Insured Person. We may elect to pay more than one visit to different Physicians on the same day if the Physicians or Specialists are of different specialties. Services for routine physical examinations, including related diagnostic services and routine foot care are not covered, except as specifically provided for in this Policy. Prescription medications refer to medications which are prescribed by the physician and which would not be available without such prescription. Only a 90-day supply of a prescription may be filled at any one time and use of generic medications is required, where they are reasonably available. Dressings and Durable Medical Equipment must be prescribed by a physician. Durable Medical Equipment requires pre-authorization.		

Outpatient diagnostic testing and advanced medical imaging • Echocardiography, ultrasound, endoscopy (e.g. gastroscopy, colonoscopy, cystoscopy), X-Rays, and Laboratory • MRI, CT, PET, and other biological imaging procedures	**Plan Pays*** 100%	**You Pay**** 0%

Outpatient consultations and physiotherapy 90 days pre and post surgery • Annual Maximum Benefit: 50 per visit,and a maximum of 25 visits	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Benefits are provided for Outpatient consultations and physiotherapy when received for a period of 90 days prior to in-patient or day-patient admission for covered surgery and up to 90 days after leaving the Hospital		

Alternative medical treatment Chiropractic, osteopathy, acupuncture, homeopathy or Traditional Chinese Medicine ▪ Annual Maximum Benefit: 175	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Benefits are provided for chiropractic, osteopathy, acupuncture, homeopathy, and Traditional Chinese Medicine, where such is provided as a treatment for an Illness or Injury covered under the Policy and treatment is provided by a certified Specialist. The benefit also includes Traditional Chinese Medicine herbs and homeopathic remedies.		

Physiotherapy • Annual Maximum Benefit: 750 and a maximum of 45 visits	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Benefits are provided for Medically Necessary physiotherapy services rendered to an Insured Person. Services must be pursuant to a Physician's written treatment plan, which contains short-term and long-term goals. The		

services must either; produce significant improvement in the Insured's condition in a reasonable period of time, and be of such a level of complexity and sophistication and the condition of the patient must be such that the required therapy can be safely and effectively performed, and be necessary to the establishment of an effective maintenance program.

Physical rehabilitation (Inpatient treatment only) • Annual Maximum Benefit: 45 days	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Physical rehabilitation in a Rehabilitation Centre on condition that the rehabilitation immediately follows Inpatient treatment (i.e.-within 15 days of discharge from the Hospital) covered by this Policy to the maximum shown above. Benefits must be Pre-Authorized with supporting medical documentation from the Specialist describing the intended treatment plan.		

Home nursing Annual Maximum Benefit: 100 per visit, and a maximum of 30 days	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description The costs for nursing at home shall be paid to the maximum shown above on the condition that the home nursing is: ▪ necessary to replace hospital nursing, ▪ immediately follows Inpatient treatment covered by the Policy, ▪ prescribed by a Specialist for medical reasons as distinct from domestic reasons, ▪ under the direction of a Specialist, ▪ performed by a fully qualified nurse, ▪ not related to pregnancy, childbirth or maternity care.		

Preventive care • Annual Maximum Benefit: 300 (12 month waiting period applies)(Deductible does not apply)	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description The following benefits are provided. • Costs for Male, Female and Child Wellness Health check-up per Period of Insurance which may include a cervical smear, mammogram, cancer screening, cardiovascular examination, neurological examination, breast ultrasound, blood tests and vital signs test including for example blood pressure, cholesterol, or liver function tests. • Costs for Vision tests limited to 1 test per Period of Insurance • Costs for Hearing tests limited to 1 test per Period of Insurance		

OTHER BENEFITS: INPATIENT/OUTPATIENT TREATMENT		
Cancer Care	**Plan Pays*** 100%	**You Pay**** 0%
Following the diagnosis of cancer, We will pay for costs for a treatment including, radiotherapy, chemotherapy, and oncology, including consultations, diagnostic tests, prescription drugs, stem cell transplants from either blood or bone marrow, dressings, durable medical equipment and reconstructive surgery. Costs for wigs will be paid up to 150 Lifetime Maximum.		

Chronic conditions Including consultations, treatment, medications, and hospital costs **Inpatient or Day Care** • Annual Maximum Benefit: 50,000 **Outpatient** • Annual Maximum Benefit : 2,000	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Including consultations, treatment, medications and hospital costs. Expenses for all chronic conditions as an in-patient are paid subject to the Inpatient and Day Care treatment benefits, out-patient treatment are subject to the Annual Maximum Benefit. **The Benefits provided under this section do not cover any Chronic Condition which was diagnosed and pre-existed in the 24 months period before the Effective Date.**		

Organ transplant	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Transplants of Kidney, Liver, Heart, Lung, or Heart and Lung in respect of the Insured being the recipient and not the organ donor. Treatment must be received in an institution recognized for these procedures by a competent government authority.		

Psychiatric care - Outpatient Annual Maximum Benefit: 1,500 Lifetime Benefit: 5,000	**Plan Pays*** 100%	**You Pay**** 0%
Psychiatric care – Inpatient or Day Care Annual Maximum Benefit: 30 days (12 month waiting period applies)	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Medical expenses necessarily and reasonably incurred in respect of psychiatric treatment up to the Annual Maximum Benefit shown as an Inpatient, Day Care, or Outpatient. For Day Care treatment, each visit will count as one day. All treatment must be prescribed by a qualified Physician and treatment carried out by a registered mental health Specialist.		

HIV/AIDS Annual Maximum Benefit: 10,000 (12 month waiting period applies)	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Care or medical treatment which arises directly or indirectly from Human Immune deficiency Virus or HIV related illness, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC) and any similar infections, illnesses, injuries or medical conditions arising from these conditions, where the condition was contracted as a direct result of blood transfusion received after the Insured Person's inclusion under the Policy. No benefits shall be payable within first 12 months from the Insured Person's Effective Date of coverage.		

Kidney Dialysis Annual Maximum Benefit: 100,000	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description ▪ Kidney failure means end stage renal failure presenting as chronic, irreversible failure of both kidneys to function as a result of which renal dialysis is initiated. ▪ If an Insured is diagnosed with kidney failure, We will provide for the Medically Necessary treatment of kidney dialysis performed at a Hospital or at a legally registered dialysis center on an in-patient, day-patient or Out-patient basis. ▪ Travel and accommodation expenses incurred in connection with such treatment will not be covered.		

Congenital Conditions-12 mth waiting period applies **Insured Persons ages 18 or older** • Annual Maximum Benefit: 35,000 **Insured Persons under age 18** • Annual Maximum Benefit: 10,000	**Plan Pays*** 100%	**You Pay**** 0%
Benefit description: The Policy covers medically necessary expenses for congenital conditions up to the Annual Maximum Benefit.		

Hospice and palliative care Annual Maximum Benefit: 180 days	**Plan Pays*** 100%	**You Pay**** 0%
Benefit Description Hospice is a program approved by Us to provide a centrally administered program of palliative and supportive services to terminally ill persons and their families. Terminally ill means the patient has a prognosis 6 months or less. Services are provided by a medically supervised interdisciplinary team of professionals and volunteers. Covered services are available in home, Outpatient and Inpatient settings up to the amount listed . Admission to a hospice program is made on the basis of patient and family need. The Hospice care: ▪ Must relate to a covered medical condition that has been the subject of a prior valid claim with Us, with a diagnosis of terminal illness from a Physician or Specialist; ▪ Benefit is payable once approved by Us.		

Hormone replacement therapy • Annual Maximum Benefit: 500	**Plan Pays*** 100%	**You Pay**** 0%
Benefit description: The Policy covers the early onset of menopause where the Insured person is under 40. For members over 40 hormone replacement tablets and patches are covered up to 500.		

MATERNITY BENEFITS		
Maternity Care Annual Maximum Benefit: 1,500 (12 month waiting period applies)(Deductible does not apply)		
Prenatal care, childbirth and postnatal care	**Plan Pays*** 100%	**You Pay**** 0%
Complications	**Plan Pays*** 100%	**You Pay**** 0%

Benefit Description

The following Maternity Care Benefits are covered and are applicable to any condition related to pregnancy, including but not limited to pre-natal and post-natal care, childbirth, miscarriage, premature birth, and complications of pregnancy. The benefits are only available to the Insured Employee or spouse. Maternity benefits for an Insured Dependent are not covered. Please note there is a 12 month waiting period for this benefit.

Obstetrical Services

Services are covered as set forth in the Schedule of Benefits and are limited to the following:

- Hospital services rendered in a licensed Hospital or approved birthing center (including anesthesia, delivery, Caesarean section, pre-natal and post-natal care) for any condition related to pregnancy, including but not limited to childbirth and miscarriage.
- Obstetrical services (including prenatal, delivery and post-natal care) and anesthesia services by physicians.
- Pre-natal vitamins are covered during the term of the pregnancy only, if prescribed by a physician.

Newborn Infant vaccination: **Annual Maximum Benefit: 100**	**Plan Pays*** 100%	**You Pay**** 0%

Benefit Description

We will pay for the recommended vaccinations for Newborn Infants, providing they are enrolled under the Policy, from birth through one year according to WHO Recommended Routine Immunizations for Children of this age. This benefit is available for infants born under a Covered Pregnancy only.

Newborn Infant benefit, first 31 days; (for covered pregnancy only) Annual Maximum Benefit: 200,000	**Plan Pays*** 100%	**You Pay**** 0%

Benefit Description

Born Under a Pregnancy Covered Under the Policy

Medical expenses for newborn infants including congenital or birth defects are covered if notification is received by the Insurer within 31 days of birth for enrollment as an Insured Dependent. Newborn infant's coverage without notification during the first 31 days will not exceed the amount shown in the Schedule of Benefits. Charges for Hospital nursery services and professional services for the newborn infant are covered separately from the mother's maternity benefits and are subject to the amount in accordance with the Policy and the Schedule of Benefits.

DENTAL BENEFITS	Not Covered

OPTICAL BENEFITS	Not Covered

MEDICAL ASSISTANCE & REPATRIATION	
GBG Virtual Care	Included

Benefit Description

The Insured has access to a global remote program for primary care services delivered remotely or by a mobile application. This is a non-insurance option and not intended to replace the health insurance benefits provided by this Policy. For more details, refer to the separate informational flyer.

Emergency assistance	Plan Pays* 100%	You Pay** 0%

Benefit Description
In the event of a medical condition, when a physician designated by HealthWatch in consultation with a local attending physician, determines that it is medically necessary for the Insured Person to be sent to the nearest location where appropriate medical care is available, HealthWatch will arrange and meet the costs of the transport by scheduled airline using economy class travel ticket as soon as reasonably practical.

Emergency evacuation	Plan Pays* 100%	You Pay** 0%

Benefit Description
Benefits are provided in the event of an Emergency that requires medical evacuation, HealthWatch must approve and arrange such emergency medical air transportation. Failure to arrange transportation through HealthWatch will result in non-payment of evacuation expenses. HealthWatch, on behalf of Us, retains the right to decide the medical facility to which the Insured Person shall be transported. Approved medical evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment. If the Insured Person chooses not to be treated at the facility and location arranged by HealthWatch, then transportation expenses shall be the responsibility of the Insured

Sea and Offshore Evacuation If an Insured Person is injured or becomes ill at sea (i.e. cruises, yachting, etc.), We will not cover any costs until the Insured Person is on land. This means any costs involved from an evacuation from sea to land will not be covered under this Policy. Once on land, this Policy will cover medical costs and further evacuation, according to the Policy coverage and terms provided the Insured Person is in an area covered by the Policy.

Return of mortal remains or local burial • Maximum Benefit: 25,000	Plan Pays* 100%	You Pay** 0%

Benefit Description
Benefits are provided for a benefit for either repatriation of mortal remains, or local burial. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar personal burial preferences. The necessary clearances for the return of an Insured Person's mortal remains by air transport to the Home Country must be coordinated by HealthWatch.

ADDITIONAL TRAVEL & ACCOMMODATION COSTS	
Accompanying travel & expenses • Annual Maximum Benefit: 2,500	**Plan Pays*** 100%

Benefit Description
The additional travel and accommodation costs necessarily and reasonably incurred for one close business associate, relative or friend of an Insured Person to:

- accompany an Insured Person to the nearest appropriate hospital or treatment facility in the case of an emergency evacuation;
- accompany the remains of the Insured Person to his/her Home Country in the event of death.

The return costs to the overseas location will also be covered provided that all such costs are incurred within the period of insurance. Accommodation expenses will be paid up to the Annual Maximum Benefit per person per occurrence, for a maximum of 15 days and costs are subject to Usual, Reasonable and Customary charges.

2. GENERAL PROVISIONS

Any words in this Policy in the masculine gender shall be interpreted as including the feminine gender whenever appropriate.

The Insurer shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit under this Policy to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, the United Kingdom or the United States of America

GBG Insurance Limited is an insurance company incorporated in Guernsey with registration number 42729 and licensed by the Guernsey Financial Services Commission to conduct insurance business under the Insurance Business (Bailiwick of Guernsey) Law, 2002 as amended.

This Policy has been originally drafted in English. For all purposes, this English language version of this Policy shall be the original, governing instrument and understanding of the parties. In the event of any conflict between this English language version of the Policy and any subsequent translation into any other language, this English language version shall govern and control.

2.1 Basis of the Policy

The declarations of the Policyholder serve as the basis for the Policy. If any information is incorrect or incomplete, or if any information has been omitted, the Policy may be rescinded, cancelled, or modified.

2.2 Entire Policy and Changes

This Policy, Certificate of Insurance, Schedule of Benefits, the Policyholder application form, and riders make up the entire contract between the parties.

No change may be made to this Policy unless it is approved by the Insurer. A change will be valid only if it is evidenced in writing and signed by the Insurer. No agent or other person may change this Policy or waiver any of its provisions.

The Policyholder understands and agrees that the Policy purchased is written on an annual basis and Premium is due for the Policy Period, regardless of the Premium Payment Mode agreed to by the Insurer as shown on the Certificate of Insurance.

3. ELIGIBILITY

3.1 Eligibility for Primary Insured and Dependents

The following eligibility criteria must be met for the Primary Insured, Dependent spouse and children:

Each Insured may be an expatriate or local national residing in Cyprus or Greece, and
The Primary Insured or Dependent spouse have not attained age eighty (80) at the time the Policy is issued.

A Dependent Spouse is eligible provided they are the Primary Insured's legal spouse (or partner of the same or opposite sex who has been living with the Insured Person for more than six continuous months) who is not legally separated from the Insured Person.

In the case of children, they must be:
1. under age nineteen (19) and unmarried; or
2. under age twenty-eight (28), unmarried and in full-time further education or conscripted for national service when included under this Policy.

Dependent children may remain covered under this Policy until the first Annual Renewal Date following their nineteenth (19th) birthday or twenty-eight (28th) birthday where in full time education, unmarried or on national service, at which time their insurance cover under the Policy will end and they shall no longer be an Insured Person under the Policy and have no entitlement to any Benefits under the Policy.

Termination of the insurance of the Primary Insured shall also cancel all coverage for all Insureds, except in the case of death.

Subject to the above, a Primary Insured or Dependent spouse may remain covered regardless of age provided:

1. The Insured continues to be insured under this Policy without a break in cover;
2. The Insured continues to remain an expatriate or local national;
3. The Insured continues to meet the definition of eligibility:
4. The Insured continues to pay the required Premium;
5. This Policy remains in force;
6. The Policyholder continues to make the required Premium payment.

If the Insurer decides to cancel the Policy, one (1) months' notice in writing will be provided prior to Annual Renewal Date.

3.2 Residency

The residence of the Policyholder and all Dependents is assumed to be the residence disclosed on the application. If the Policyholder or insured Dependents are living full-time outside of the location disclosed in the application the Insurer must be notified as soon as practicably possible in writing of their full-time residence. Additional Policy conditions and surcharges in Premium may apply.

The Policyholder is required to notify Us as soon as practicably possible if any of the Insured Persons become a permanent resident of the United States (US). Permanent resident shall mean a person residing in the US who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in the US, and 'US' shall include all territories of the US. Coverage for US citizens or permanent residents of the US residing in the US will terminate at the end of the Policy Period following relocation to the US.

4. PREMIUM, CANCELLATION, COOLING OFF, AND POLICY PROVISIONS

4.1 Premium Payment

This Policy is written on an annual basis and all premiums are payable before coverage under this Policy is provided. Premium payment is due upon receipt of the invoice sent by us or confirmation of your direct debit mandate received by you. We may allow for Premium to be paid on an approved payment cycle, as reflected on the Certificate of Insurance. Payment must be in the currency approved and any other forms of currency shall not be accepted and will be considered as non-payment of Premium. All coverage under this Policy is subject to the timely payment of Premium.

4.2 Late Payment Provision

A period of 31 days will be allowed for payment of any premium due after the initial Premium payment. If any premium due has not been received by Us after 31 days, We will suspend all coverage in effect from the first day of the 31-day period. If Premium is received during the timeframe outlined in the notice of delinquency, coverage will resume without interruption in coverage. If the Premium due is not paid, We may act in accordance with Cancellation and Cooling-Off Period Provisions.

All unpaid Premium through the date of cancellation, and any other Premium adjustments assessed because of cancellation, are the obligation of the Policyholder.

4.3 Cancellation and Cooling- Off Period Provisions

Your Right to Cancellation During the Cooling-Off Period

You may cancel this Policy by notifying Us in writing, by E-mail, or by telephone within 30 days of either; the date You receive this Policy or, the Effective Date of this Policy, whichever is later. A full refund of Premium paid will be made unless You have made a claim for benefits in which case the full annual Premium is due.

Your Right to Cancellation After the Cooling-Off Period

You may cancel this Policy after the cooling-off period by notifying Us in writing, by E-mail, or by telephone. The Premium refund, if any, due to the Policyholder shall be calculated at a proportional daily rate depending on how long the Policy has been in force unless You have made a Claim in which case the full annual premium is due.

4.4 Policy and Rate Modifications

The Policy term begins on the Effective Date of the Policy as shown on the Certificate of Insurance and ends at midnight, 365 days later. The Policy terms and rates shall be guaranteed for one year. We have the right to change the Policy terms or Premium on the Renewal Date. We will notify the Policyholder of any such change to Policy terms or rates, at least 30 days before the change is made.

4.5 Duration of Coverage

Benefits are paid to the extent that an Insured Person receives any of the treatments covered the Schedule of Benefits following the Effective Date, including any additional Waiting Periods and up to the date such individual no longer meets the definition of Insured Person.

4.6 Waiver of Terms or Conditions

The waiver of a term or condition by Us in relation to an individual case will not prevent Us from relying on such term or condition thereafter.

4.7 Denial of Liability

Neither the Insurer nor the Policyholder is responsible for the quality of care received from any institution or individual. This Policy does not give the Insured any claim, right or cause of action against Insurer or Policyholder based on an act of omission or commission of a Hospital, Physician or other provider of care or service.

4.8 Transfer

If the Policyholder dies, the oldest Insured Person over the age of 18 years may, at their discretion, elect to assume all responsibilities of the Primary Insured, including payment of Premium. The Policy will be re-issued to such Insured Person and named as the Primary Insured.

4.9 Information You Have Given Us

In deciding to accept this Policy 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 carelessly provided Us with untrue or misleading information We have the right to: treat this Policy as if it never existed, decline to pay claims, add a surcharge to Premium, or re-issue the Policy and apply different terms. We will notify You in writing if any such action is applied.

4.10 Change in Circumstances

You must tell Us as soon as practicably possible of any change in the information You have provided to Us which happens before or during any Policy Period.

When We are notified of a change We will tell You if this affects Your Policy. For example We may

cancel Your Policy in accordance with the Cancellation and Cooling-Off Provisions, amend the terms of Your Policy or require You to pay more for Your insurance. If You do not inform Us about a change it may affect any claim You make or could result in Your insurance being invalid.

4.11 Geographic Area of Coverage

Please refer to the Certificate of Insurance to determine the "Area of Coverage" that applies to this Policy. If "Emergency Treatment Outside Area of Coverage" is available, benefits are provided for a Medical Emergency in such territories up to 30 days from the Insured Person's entry into such territory.

A Medical Emergency is defined as a sudden, unexpected, and unforeseen event caused by an Illness or Injury that manifests itself by symptoms of sufficient severity that a prudent layperson would reasonably expect that a failure to receive immediate medical attention would place the health of the Insured Person in serious jeopardy. A Medical Emergency excludes the following;

- Treatment related to the condition that existed prior to arrival in a country outside the Area of Coverage
- Routine medical treatment
- Treatment that could have been postponed until return within the Area of Coverage
- Treatment that has been planned in advance
- Treatment arising from circumstances that could have been reasonably anticipated by the Insured,
- Maternity treatment

Co-payments and Policy terms and exclusions apply. This Policy will cover costs for the immediate relief and stabilisation of a Medical Emergency There are no benefits for continued care or Hospitalisation beyond the treatment and stabilisation of the acute symptom.

4.12 Pre-Existing Conditions Limitation

The terms and conditions for Pre-Existing Conditions specific to this Policy are outlined on the Certificate of Coverage. All Pre-Existing Conditions must be disclosed on the application for coverage. Based upon the Insurer's review of such conditions, coverage may be issued either in accordance with the Policy provisions, or separate terms and conditions may be applied. Non-disclosed pre-existing conditions are never covered.

5 PRE-AUTHORIZATION REQUIREMENTS AND EMERGENCY SERVICES

HealthWatch provides the following services and all members must receive HealthWatch approval prior to receiving certain treatment and should be contacted for the following services:

- Preauthorization
- Emergency Services / Medical Evacuation
- Locating preferred providers
- Case management

Through this process, HealthWatch will:

- verify coverage of members
- determine whether the services or supplies are covered
- ensure treatment is medically necessary
- minimize the out-of-pocket cost to the member

We retain the right to refer any pre-authorised claims to HealthWatch, which will then be responsible for establishing and monitoring the scope and nature of the care provided. When We elect to refer a claim to HealthWatch, in order for treatment to continue to be eligible for reimbursement under the Policy, the member will be required to follow the procedures indicated by this department.

HealthWatch will guide you to appropriate facilities and will evaluate the medical necessity of the recommended treatment. The intention of this process is not to substitute for the medical judgment of your physician, as the ultimate decision for treatment is up to the patient. Regardless of the decisions taken by the patient, coverage under this Policy is subject to all stated limitations and exclusions as well as a consideration of the medical necessity of the proposed treatment and the effective management of health care costs.

Treatment is approved and monitored by HealthWatch, which will be the sole determinant of the nature and scope of coverage. For contact information, please see below.

For Pre-authorization/Emergency Med. Assistance/Case Management

Tel: +357 24 636 300 or +302 313 084 328
Fax: +302 310 808 099
Email: dcare@healthwatch.gr

Certain designated services and treatment obtained in certain geographical locations(for example USA) require Pre-Authorization. Failure to Pre-Authorize when required will result in a 40% co-payment applied to the normal benefit. Any penalty will be applied to the entire episode of care and there will be no Out-of-Pocket maximum. You must obtain a letter of authorization, prior to the performance of those services. In order to appeal the application of the 40% Co-payment, you will need to provide proof of Pre-Authorization.
Notwithstanding the requirement to Pre-Authorize, Pre-Authorization approval does not guarantee payment of a claim in full, as additional Co-payments and Out-of-Pocket expenses may apply. Benefits payable under the Policy are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Policy.
For treatment that is required immediately through it being of a life-threatening nature or due to an Accident you must contact HealthWatch using the contact information above.

Emergency Treatment must be received within 48 hours of the admission or procedure. In instances of an emergency, the Insured should go to the nearest Hospital or provider for assistance even if that hospital or provider is not part of the Preferred Provider Network.

Co-pay may be waived if the situation is determined by the Insurer to be an eligible medical emergency.

In the event of an emergency that requires medical evacuation, contact the HealthWatch 24-hour Department, in advance in order to approve and arrange such emergency medical air transportation. The Operations Center, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. **Approved medical evacuations will be to the nearest medical facility capable of providing the necessary medical treatment only.** The HealthWatch contact information can be located on the Insured's Member Identification Card. In the event of an emergency,

The following services require Pre-Authorization worldwide:

- Inpatient Admissions and/or treatments including inpatient psychiatric care;
- Surgery (Inpatient);
- Accidental Dental treatment (for emergency dental repair of natural sound teeth damaged in an Accident);
- Purchase or rental of Durable Medical Equipment, including, but not limited to, Insulin Pumps and supplies;
- Home Health Care;
- Organ transplants;
- Physical rehabilitation;
- Physiotherapy when more than 10 sessions are required;
- RSV Immunization/and other medications priced in excess of € 1,000 per refill;
- All Cancer treatments/therapies;
- Hemodialysis and Peritoneal Dialysis for Renal Failure;
- Substance Abuse treatments/therapies;

- Any condition, including Chronic Conditions that do not meet the above criteria, but are expected to accumulate over €3,000 of medical treatment per Policy year;
- Emergency evacuation/repatriation or return of mortal remains services.

To obtain a **Pre-Authorization** and verification of Network utilization the Insured Person, the Provider, or the Insured Person's representative must call **HealthWatch**

HealthWatch offers a 24/7 assistance service to answer any medical emergency around the world no matter the time or day. Case managers, nurse case managers, and the HealthWatch Medical Director work as a team to manage all aspects of a case from initial referral until the patient returns home. They coordinate admissions, Pre-Authorize services, and coordinate discharge planning. They provide patient advocacy while monitoring costs.

HealthWatch case management services include coordination of treatment, assistance to patient and family Insureds, monitoring and review of treatment, and coordination of Air Ambulance needs if necessary. HealthWatch should be contacted immediately when there is any medical issue. Your claim reimbursement will be maximized, and they will help to handle many of the issues that come up during an illness, accident, or emergency illness.

6 PROVIDER ACCESS

Worldwide Provider Network
HealthWatch maintains a Worldwide Provider Network for the ease and convenience of Insured Persons accessing medical care around the world and to help manage the overall cost of the Policy. These facilities are known for the care they provide in their local territory.

7 SPORTS AND OTHER ACTIVITIES

The Policy covers **leisure sports and activities** meaning such activities that are for relaxation or fun, do not require any special training, and do not heighten the risk of Injury or death to an individual. Examples of such covered activities include but are not limited to: kayaking, snorkeling, paddle boarding, sailing, white water rafting levels 1-3, and scuba diving to 15 meters if PADI qualified (or equivalent) or with a PADI qualified instructor (or equivalent)...

This Policy does not cover **hazardous or extreme sports and activities** meaning any activity requiring an increased skill set and higher level of training to safely participate, and that if not properly executed could result in risk of Injury or death. Examples of such excluded activities include but are not limited to: bungee jumping, base jumping, parachuting, scuba diving to depths deeper than 15 meters and if not PADI qualified (or equivalent) or with a PADI qualified instructor (or equivalent), race car driving, off-piste skiing, and rock climbing.

This Policy does not cover **professional sports and activities** meaning any activity where a participant receives compensation, sponsorship or prize money for their performance.

HealthWatch is available to provide clarification if a specific sport or activity would be covered under the Policy and should be contacted prior to engagement.

8 CLAIMS: HOW TO FILE A CLAIM, CLAIMS STATUS, AND COMPLAINTS PROCEDURE

Benefits will be paid on a Usual, Customary, and Reasonable (UCR) basis, subject to Policy exclusions, limitations, and conditions for the charges listed, if they are:

- Incurred as a result of Illness or accidental bodily Injury
- Medically Necessary

- Ordered by a Physician or Specialist
- Delivered in an appropriate medical setting

Claims may be submitted to Us directly by the Provider or medical care facility. It is recommended they be submitted within 90 days.

Medical, Prescription Medication and Dental Claims
Claim forms should be submitted only when the medical service Provider does not bill Us directly, and when you have Out-of-Pocket expenses to submit for reimbursement. In order for claims payment to be made, claims must be submitted in a form acceptable to Us as per the below.

To claim, email to: dcare@healthwatch.gr

Reimbursement Options
Claims reimbursements will be made to the Insured Person by:
- Direct to your bank account
- Cheques will only be sent to the Insured where electronic payment is not possible

Coordination of Benefits
When you or your Insured Dependents have coverage under another insurance contract for the same benefits, the benefits available under this Policy will be reduced to avoid duplication of benefits available under the other contract including benefits that would have been payable had you filed a claim for them.

Subrogation
If you or your Insured Dependents receive benefits under this Policy that result from an event for which a third party is or may be liable, you and your Dependents have certain obligations and We have certain subrogation and reimbursement rights.

Releasing Necessary Information
It may be necessary for Us to request a complete medical file on you or an Insured Dependent for purpose of claims review or administration of the Policy. It may also be necessary to share such information with a medical or utilization review board, or a reinsurer. The release of such confidential medial information will only be with written consent of the Insured.

Fraudulent Claims
If any claim under this Policy is in any respect fraudulent or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and, if appropriate, recoverable.

COMPLAINTS PROCEDURE
We are committed to providing Insured's with an exceptional level of service and customer care. Sometimes things can go wrong or there may be occasions when the service provided to you was not adequate. When this happens, please contact us and give us the opportunity to correct the situation and earn back your trust.

Who to Contact?
The most important factors in getting your complaint dealt with as quickly and efficiently as possible are:
- Be sure you are talking to the right person; and
- That you are providing the necessary information.

When You Contact Us
Please provide the following information:
Your name, telephone number, and email address;
Your Policy and/or claim number and the plan of benefits (medical) you are insured for; and
Please explain clearly and concisely the reason for your complaint.

Step One: Making a Complaint

If your complaint relates to:

1. The sale of the Policy you purchased or any information you were given during the sales process:

If you purchased the Policy using a broker or other intermediary, please contact them first.

If you purchased the Policy directly from us either from a local representative, using the website, or through a group plan of benefits, please contact us in the first instance directly at:

AKD Insurance Agents, Sub-Agents & Consultants Ltd
5, Rafael Santi
1st Floor Office 101
6052 Larnaca, Cyprus
Tel: +357 24 822 622, Fax: +357 24 822 623
Email: dcare@akdinsurance.eu

2. A claim for benefits, the terms and conditions of the Policy, or other benefit related information:

Complaints related to a claim denial should be submitted as soon as possible.

We will review the information and provide an acknowledgment of receipt within a period not exceeding 10 working days from receipt of the complaint unless the response itself is provided to the complainant within that period. We undertake to respond to each complainant without unnecessary delay and in all cases within a period of 30 days as from the date of receipt of his/her complaint, except where the complexity of the request requires an extensive analysis, in which case we will indicate the causes of the delay and the foreseeable date of its response.

If You are not happy with Our final response, or actions, and feel that the matter has not been resolved to Your satisfaction, then You may be able to take the matter further as set out below:

1.You may be entitled to refer the matter to The Financial Ombudsman of the Republic of Cyprus who can advise You on how to proceed further and may be able to help in resolving the problem.

Postal Address: PC 25735, 1311 NICOSIA, PO. 226722, 1647 Nicosia, Cyprus
Email address: director@financialombudsman.gov.cy
Website: http://www.financialombudsman.gov.cy/
Phone 0035722848900
Fax 0035722660584

2. As GBG Insurance Limited is a Guernsey insurance company, You may also be entitled to refer the dispute to the Channel Islands Financial Ombudsman (CIFO):

If we can't respond fully to your complaint within three months after you contact us, or you are unhappy with our final response, you can refer your complaint to CIFO

You must contact CIFO about your complaint within six months of the date of our final response to your complaint or CIFO may not be able to review your complaint. You must also contact CIFO within six years of the event complained about or (if later) two years of when you could reasonably have been expected to become aware that you had a reason to complain.

You can contact CIFO at:
Channel Islands Financial

Ombudsman
PO Box 114
Jersey, Channel Islands
JE4 9QG

Email: complaints@ci-fo.org
Website: www.ci-fo.org
Guernsey local phone: +44 (0)1481 722218
International phone: +44 1534 748610

Online Sales
If you, as the Insured, are a consumer under the Online Dispute Resolution (ODR) regulation (Regulation (EU) 524/2013) and purchased the Policy online, you may also make a complaint via the EU's online dispute resolution (ODR) platform. The website for the ODR platform is: http://ec.europa.eu/odr

9 NOTICE OF PRIVACY PRACTICES

9.1 AKD insurance Limited

AKD Insurance, the Insurer, & HealthWatch are registered under their local data protection legislation and are listed on the appropriate Data Protection Registers.

AKD Insurance, the Insurer, & HealthWatch are committed to meeting their obligations under the applicable local privacy legislation.

AKD Insurance, the Insurer, & HealthWatch will observe the law in all collection and processing of data and will meet any subject data access request in compliance with the law. In particular The Data Protection (Bailiwick of Guernsey) Law, 2017 and the General Data Protection Regulation (EU) (2016/679) ("GDPR")

Data will only be used for the purposes stated in the company's literature or purposes relevant to carrying out the company's responsibilities under the insurance and/or reinsurance contract and, where required, other overriding requirements such as criminal investigations.

All necessary steps will be taken in the collection and storage of any sensitive data to ensure that the data is secure and all staff will do their utmost to keep all data accurate, up-to-date and secure.

AKD Insurance & HealthWatch are committed to making staff aware of the requirements under relevant privacy legislation. All staff are aware that personal or sensitive data can only be disclosed in limited circumstances. For further information, please visit AKD Insurance privacy Policy at https://akdinsurance.eu/id-_priv0010.html.

9.2 GBG Insurance Limited

GBG Insurance Limited is part of the Global Benefits Group. This Fair Processing Notice will explain how our organisation uses the personal data we collect from you.

When you submit any information to us for the purpose of requesting information from us; about, or obtaining, our products or services; or otherwise, including any personal information, we will use the information in our insurance business to conduct our business and perform our legal obligations, including:

i) verifying your identity;
ii) preventing, investigating or reporting fraud or potential fraud, money laundering, terrorism, misrepresentation, security incidents, sanctions violations or any crime, all in accordance with applicable law and regulations;

iii) assessing, establishing and managing claims and arranging or entering into any appropriate settlements;
iv) managing, reporting and auditing our business operations;
v) recovering debt;
vi) developing, improving and protecting our products, services, website, systems and relationships with you;
vii) carrying out research, risk management and statistical analyses;
viii) establishing, exercising or defending legal claims; and
ix) meeting regulatory and compliance requirements.

With your permission, we may also use your contact details (including email address) to send you information about our products and services or other products and services provided by us or one of our group companies. We may share your information for the purposes outlined above with:

(i) our group companies;
(ii) brokers, other insurers and underwriters;
(iii) healthcare professionals;
(iv) law enforcement authorities;
(v) other government authorities;
(vi) fraud prevention agencies; and
(vii) third parties involved in any aspect of claims management including surveyors, loss adjusters, claims agents, solicitors and private investigators;
(viii) parties that may have a financial interest in the insurance Policy or claim;
(ix) other service providers that may process your personal information on our behalf (for example, IT service providers that host or support our business and may have data that includes your personal information); and
(x) others with your consent or in accordance with applicable law and regulations.

Such parties may become data controllers in respect of your personal information. Because we operate as part of a global business, we may transfer your personal information outside the UK or European Economic Area for these purposes.

If you have provided information about another person, in doing so you confirm that you have such person's consent to provide the personal information to us, that you have told such person that you have provided the information to us and how we will use the personal information as described in this notice.

To the extent you have provided your consent, and your consent provides the basis for our use of the information, you may withdraw your consent at any time by contacting us as described below.

More details about how we use your personal information may be found on our website at https://www.gbg.com/#/AboutGBG/PrivacyPolicy. The website also provides additional information about your data protection rights, how you may access and update your personal information and other choices you have about how we use your personal information (including how to object to processing or withdrawing your consent at any time). If you have any questions regarding this notice, please contact:

The Data Protection Officer:

GBG Insurance Limited
Fourth Floor, Albert House,
South Esplanade,
St Peter Port,
Guernsey GY1 1AW
Email address: dataprotection@gbg.com

10 GENERAL POLICY CONDITIONS

1. The Insured Person shall take all reasonable precautions to prevent anything happening which may give rise to a claim under this Policy.
2. If an event takes place on the strength of which payment may be claimed by virtue of this cover the Insured Person must notify this immediately to HealthWatch giving all particulars and the Policy number.
3. In the event of Illness or Accident the Insured Person shall be obliged to cooperate in the speediest possible recovery by following the doctor's advice, and in any medical examination desired by Us, or any observation in a hospital designated by it, all this for account of Us.
4. The Insured Person shall declare to Us (in the application form), all material facts that are likely to affect this insurance. Failure to do so may prejudice entitlement to claim. If an Insured Person is uncertain as to what constitutes a material fact, then it should be disclosed to Us. We reserve the right to alter the Policy terms or cancel cover for an Insured Person following a change of risk.
5. When an Insured Person undergoes medical treatment for Injury or Illness, he/she may claim from the commencement of treatment until such time as it is medically confirmed that treatment is no longer necessary or the expiry of period of insurance for which the premium has been paid, whichever is earlier. When a claim is made for Medical Expenses and the Insured Person subsequently claims for an unrelated Injury or Illness that is not in any way connected with the former Injury or Illness the subsequent claim will be regarded as a new claim.
6. We shall have the right through their medical representatives to examine any Insured Person who is the subject of a claim under this Policy whenever and as often as they may reasonably require within the duration of such claim.
7. We shall have the right to require an autopsy in the case of death provided that such autopsy is not forbidden by law.
8. HealthWatch or a medical representative of Us shall have full authority to obtain all medical advice and information for administration of the claim.
9. In the event of any payment under this Policy, the Insurer shall be subrogated to all the Insured Person's rights of recovery therefore against any person or organisation and the Insured Person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Insured Person shall do nothing after loss to prejudice such rights.
10. 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 Policy 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 Policy (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.
11. Neither We nor the Policyholder is responsible for the quality of care received from any institution or individual. This Policy does not give the Insured any claim, right or cause of action against Insurer or Policyholder based on an act of omission or commission of a Hospital, Physician or other provider of care or service.
12. This Policy is governed by, and shall be construed in accordance with, the laws of the country stated in the Schedule of Benefits.
13. This Policy has been originally drafted in English. For all purposes, this English language version of this Policy shall be the original, governing instrument and understanding of the parties. In the event of any conflict between this English language version of the Policy and any subsequent translation into any other language, this English language version shall govern and control.

11 EXCLUSIONS AND LIMITATIONS

The Insurer shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit under this Policy to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, the United Kingdom or the United States of America

Unless stated otherwise on the Schedule of Benefits, the following are excluded from coverage under this Policy.

1. Only those benefits stated within the Schedule of Benefits shall be operative.

2. Medical treatment for a Pre-existing Condition declared on the health statement, or in respect of Chronic Conditions or Kidney Dialysis before the 12-month Waiting Period has expired. Medical treatment for HIV/AIDS before the 12-month Waiting Period has expired. Maternity benefits before the 12-month Waiting Period has expired. Dental benefits Classes 1-4 before the 3-month Waiting Period has expired.

3. Charges in Excess of Usual, Customary, and Reasonable: Any portion of any charge in excess of the Usual, Customary, and Reasonable amount for the particular service or treatment for the specific geographical area.

4. The amount of the Policy excess/deductible or co-insurance/co-pay, as stated on the Certificate.

5. Charges Incurred before the Effective Date and after the Expiration Date: Claims and costs for medical treatment occurring before the effective date of coverage (including waiting periods) or after the expiration date of the Policy are not covered. This includes any portion of a covered prescription to be used after the expiration of the current Policy Period.

6. Illegal Activities: Illnesses and Injuries and their associated medical costs resulting or arising from or occurring during the commission or perpetration of a violation of law.

7. Charges Reimbursable by Another Entity: Services, supplies, or treatment that are provided by or payment is available from: a) Workers' Compensation law, occupational disease law or similar law concerning job related conditions of any country; or; b) Another insurance company or government; or c) A government entity due to an epidemic or public emergency.

8. Any expenses relating to search and rescue operations to find an Insured Person in mountains, at sea, in the desert, in the jungle and similar remote locations including air/sea rescue charges for evacuation to shore from a vessel or from the sea.

9. Non-Covered Treatments: Treatment of any Illness or Injury, or charges relating to such that is: a) Not ordered or recommended by a Physician, or, b) Not Medically Necessary, or, c) Not rendered under the scope of the Physician's licensing; or d) Not professionally recognized or is determined by Insurer to be unnecessary for proper treatment.

10. Non-Medical Care: Services related to custodial care, respite care, home-like care, assistance with Activities of Daily Living (ADL), or Milieu Therapy. Any admission to a nursing home, home for the aged, long term care facility, sanitarium, spa, hydro clinic, or similar facilities. Any admission arranged wholly or partly for domestic reasons, where the Hospital effectively becomes or could be treated as the Insured Person's home or permanent abode.

11. Experimental Services: Services, supplies or treatments, including medications, which are deemed to be experimental or investigational or that are not medically recognized for a specific diagnosis.

12. Organ Transplant Donor Expenses: Donor search and donor medical services are not covered under the transplant benefit. Storage of bone marrow, stem cell, or other tissue or cell, and all expenses for cryopreservation of more than 24 hours are also excluded.

13. Drugs and other medicines that can be purchased without a physician's prescription and routine or preventative medicines, vaccinations and check-ups including but not limited to; Restorative and nutritional products; Slimming products or weight control products, Tonics, medicinal wines, cod-liver oil products; Vitamin products; Laxatives; or Cosmetics,; Children's food and baby products other than those prescribed for a medical condition covered under the Policy.

14. Smoking Cessation: Treatments whether or not recommended by a Physician.

15. Treatment related to detoxification, rehabilitation, and all support services (e.g. Psychiatrists, support groups, addiction rehab programs).

16. Treatment of any Illness or Injury arising directly or indirectly from alcohol or other addiction, or any medications or medicines that are not taken in the dosage or for the purposed prescribed.

17. Treatment and services related to infectious diseases declared to be an outbreak, epidemic, or public emergency by the World Health Organization (WHO), Center for Disease Control and Prevention (CDC), or any other government or government agency or ruling body of the country where the outbreak or epidemic has occurred in. Additionally, such coverage is also excluded if there has been an official warning issued against travel to the area, by a State Department, Embassy, Airline or other governmental agency, prior to travel to the affected country. This exclusion will not apply if exposure occurs accidentally or unknowingly while travelling to or from areas not declared to be at risk, or if exposure occurs as a result of residing or working in the area prior to the outbreak.

18. Counselling (Non-Medical) and Testing Services: Non-medical counselling services including but not limited to marriage and family counselling, educational counseling, aptitude testing, and educational testing and services.

19. Consultations: provided by a Provider who is a member of the Insured Person's family, or made by Telephone, E-mail, internet, and telemedicine.

20. Missed appointments.

21. Expenses incurred for the provision of hearing aids, prostheses or medical appliances or corrective devices, unless deemed by the Insured Person's physician to be medically necessary following accidental bodily injury or illness covered under this Policy.

22. Cosmetic and Elective Surgery for Non-Medical Reasons: Treatments, procedures, or medications which are primarily for enhancement, improvement, or altering one's appearance, unless required due to a non-occupational Injury occurring while insured under this Policy. Medical complications arising from such treatments or procedures are also not covered.

23. Skin Conditions: Acne, rosacea, skin tags, and any other treatment to enhance the appearance of the skin, except for cystic or pustular acne.

24. Transsexual Surgery: Medical or psychological counseling, hormonal therapy in preparation for, or subsequent to, any such surgery, surgical procedures, and any other expenses related to sexual reassignment including the complications arising from such procedures.

25. Weight Related Treatment: Any expense, service, or treatment for obesity, weight control, any form of food supplement, weight reduction programs, dietary counseling, or surgical procedures related to morbid

or non-morbid obesity. Charges relating to complications arising from such treatments or surgical procedures are also excluded.

26. Exceptional Risks: Treatment related to: a) Injury sustained while participating in a hazardous or extreme sport or activity or training for any professional sport or activity.

27. Genetic Screening: Counseling, screening, testing, or treatment in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

28. Growth Hormones: Treatment related to the aging process, increasing athletic ability, and treatment for medical conditions not generally accepted by the medical community or demonstrated medical efficacy. Generally accepted therapeutic uses of growth hormones are covered for medical conditions covered by this Policy.

29. Sexual Dysfunction: Any procedures, supplies, or medications used to treat male or female sexual enhancement or sexual dysfunction such as erectile dysfunction, premature ejaculation, and other similar conditions.

30. Voluntarily induced terminations of pregnancy other than miscarriages, ectopic, stillbirths or when the mother's life is in danger.

31. The Policy shall not pay for ante-natal classes, or midwifery costs not associated with the delivery or complications which may arise as a result of a planned home birth.

32. Air travel when the Insured Person is more than 28 weeks pregnant.

33. Preparation Classes: Related to maternity or delivery of a newborn child.

34. Surrogacy: Care and treatment for an individual acting as a surrogate including the delivery of the child.

35. Fertility/Infertility Treatments and Birth Control: Any services, procedure or treatment including medications used to: a) Treat infertility including In-vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and any variations of these procedures, and any costs associated with the preparation or storage of sperm for artificial insemination. b) Vasectomies and sterilization unless Medically Necessary, and any expenses for male or female reversal of sterilization. c) Contraceptive devices including the insertion or removal of such devices.

36. Self-Inflicted Illnesses or Injuries: Treatment for any conditions as a result of self-inflicted Illnesses or Injuries, suicide or attempted suicide, while sane or insane. Treatment for any loss or expense of any nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily Injury, except in an endeavor to save human life.

37. Sleep Studies: Sleep studies and other treatments relating to sleep apnea.

38. Personal Comfort and Convenience Items: Expense for items that are provided solely for personal comfort or convenience such as television, private rooms, housekeeping services, weight loss diets, telephone charges, and take-home supplies.

39. Podiatric Care: Routine foot care, including the paring and removing of corns, calluses, or other lesions, or trimming of nails or other such services not resulting from an Illness or Injury. Orthopedic shoes or other supportive devices such as; arch supports, orthotic devices, or any other preventative services or supplies to treat the diagnosis of weak, strained, or flat feet or fallen arches.

40. High Performance Prosthetic: Devices for sports or improvement of athletic performance, and power enhancement or power-controlled devices, nerve stimulators, and other such enhancements to prosthetic devices.

41. Hair Treatment: Treatment for alopecia or hair loss including but not limited to hairplasty, hair transplants or any other procedure to stimulate hair growth, the temporary removal of hair by laser, electrolysis, waxing, or any other means.

42. Hearing Care: Routine hearing examinations are not covered under the Basic plan. All plans exclude hearing aids and the surgical implantation of or removal of bone anchored hearing devices.

43. Vision Care: Eye refractions, frames, lenses, contact lenses, fitting of frames or lenses, or vision correction surgery are not covered under the Basic, Core, Classic, and Prime plans. Routine vision examinations are not covered under the Basic plan.

44. Dental Care: Dental expenses including preventive services, fillings, extractions, root canal, crowns, inlays, bridges, and orthodontic services are not covered under the Basic, Core, Classic, and Prime plans.The following is not covered under the Prime Plus and Classic Plus Dental Benefit. a) Dental services at a Hospital, including general anesthesia are not covered under the medical plan; b) False teeth and replacement of lost or stolen crowns, bridges, or dentures; c) Implants and all related services; d) Temporomandibular Joint Disorders (TMJ) or Malocclusion Temporomandibular Joint Disorders and mouth guards for teeth grinding and other treatments listed in the Dental Exclusions section of this wording.

45. In respect of Emergency dental treatment, this Policy shall not pay for injury caused by eating or drinking (even if it contains a foreign body), normal wear and tear, tooth brushing or any other oral hygiene procedure or any means other than extra-oral impact, any form of restorative or remedial work, the use of precious metals, orthodontic treatment of any kind or dental treatment performed in a hospital unless dental surgery is the only treatment available to alleviate pain.

46. War, conflict, or terrorism: The Policy will not pay for treatment as a result of injury resulting from acts of war, conflict or terrorism except sustained as an Innocent Bystander. Illness or Injuries caused by the use of nuclear, chemical, or biological weapons of mass destruction are excluded. Claims arising from any conflict where the Insured Person is an active participant or training in such activities, or has put themselves in danger, and traveling to an area of conflict are also excluded. The following activities are considered as acts of war and terrorism; War, hostilities or warlike operations (whether war be declared or not), invasion, act of an enemy foreign to the nationality of the Insured Person or the country in, or over, which the act occurs, civil war, riot, rebellion, overthrow of the legally constituted government, military or usurped power, explosions of war weapons, Murder or assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Insured Person whether war be declared with that state or not, and terrorist activity.

12 DEFINITIONS

For the purpose of this insurance Policy, the following terms shall have the stated meanings:

Accident/ Injury: Bodily injury caused solely by violent, accidental, external and visible means and not by sickness, disease or gradual physical or mental process.

Active Service/Actively at work: An employee will be considered in active service on any day if he/she is then performing in the customary manner all the regular duties of his/her employment as performed or were capable of being performed on the last regularly scheduled workday.

Acute: A disease or illness of rapid onset, severe symptoms, and brief duration including any intense symptoms, such as severe pain.

Activities of Daily Living (ADL): Activities of daily living are those activities normally associated with the day-to-day fundamentals of personal self-care, including but not limited to: walking, personal hygiene, sleeping, toilet/continence, dressing, cooking/feeding, medication and transferring (getting in and out of bed).

Admission: The period from the time that an Insured Person enters a Hospital, Extended Care Facility, or other approved medical care facility as an Inpatient until discharge.

Allowable Charge: The fee or price We determines to be the Usual, Customary and Reasonable Charge for medical care services provided to Insured Persons that are covered under the Policy. The Insured Person is responsible for the payment of any balance over the Allowable Charge. All services must be Medically Necessary. Once an allowable charge is established then the Deductible, Coinsurance, Copayments and any excess charges must be paid by the Insured Person.

Annual Maximum Benefit: The payment specified in the Schedule of Benefits, for specific services, which is the maximum amount payable by Insurer per person, per Policy Period regardless of the actual or Allowable Charge. This is after the Insured Person has met his/her obligations of Deductible, Coinsurance, Copayments and any other applicable costs.

Annual Renewal Date: The date twelve months after the inception date shown on the certificate.

Chronic Condition: An Injury or Illness which may be expected to be of long duration, and which may be marked by recurrences requiring continuous or periodic care. A Chronic Condition has one or more of the following characteristics; it continues indefinitely, it comes back or is likely to come back, is permanent, or it requires long-term monitoring, consultations, check-ups, examinations, or tests.

Coinsurance / Copayment: The proportion of costs for which the Insured Person remains responsible when specified in this Policy wording or on the Schedule of Benefits. The Insured Person must pay the coinsurance in respect of each incident, giving rise to a claim.

Complications of Pregnancy: A condition:

- Caused by pregnancy, and
- Requiring medical treatment prior to, or subsequent to termination of pregnancy, and
- The diagnosis of which is distinct for pregnancy, and
- Which constitutes a classifiably distinct complication of pregnancy.

A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

When pregnancy is not terminated, complications of pregnancy include; a) acute nephritis, b) nephrosis, c) cardiac decompensation, d) missed abortion, e) eclampsia, f) puerperal infection, g) R.H. Factor problems, h) severe loss of blood requiring transfusion, and i) other similar medical and surgical conditions of comparable severity related to pregnancy.

When pregnancy is terminated; complications include; a) non-elective cesarean section, b) ectopic pregnancy that is terminated, and c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Congenital Condition: Any abnormality, birth defect, physical anomaly and/or any other deviation from normal development present at birth, which may or may not be apparent at that time.

Country of Residence: The country in which the Insured Person lives as stated in the Application Form, or any other country which We are asked to substitute as the Insured Person's new Country of Residence so long as:

- We are informed in writing of any such permanent change in the country where the Insured Person usually lives and;
- We confirm Our agreement to continue insuring the Insured Person under this Policy on the same terms.

The Insured Person is deemed to make a permanent change in his/her Country of Residence if the Insured Person lives or intends to live in the other country for more than 183 consecutive days.

Covered Expenses: The Usual, Customary, and Reasonable charges incurred by an Insured Person, while covered under this Policy, for Medically Necessary services, treatments or supplies described under the provisions titled Medical Coverage and, if applicable, covered dental expense.

Covered Pregnancy means;

- Whose delivery date is at least 12 months after the Effective Date of coverage for the Insured mother, and
- Maternity coverage is included under the Policy, and
- The Insured meets the eligibility criteria for maternity related services.

Custodial Care includes: 1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery; and 2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and 3) rest cures, respite care and home care provided by family members. Upon receipt and review of a claim, We or an independent medical review will determine if a service or treatment is Custodial Care.

Day Care Treatment: Treatment received while an Insured Person occupies a hospital bed or is charged for hospital accommodation (and who signs an admission form or on whose behalf it is signed), but does not remain overnight.

Dentist: A physician who is recognized as a dentist by the competent authority.

Dependent: The Insured Person's legal spouse (or partner of the same or opposite sex who has been living with the Insured Person for more than six continuous months) who is not legally separated from the Insured Person, and his/her unmarried natural child, step-child, foster child or legally adopted child - provided that such child is less than 28 years old on the date the Insured Person is first included under this Policy or at any subsequent renewal of the Policy and provided they depend on the Insured Person for sole support and live with the Insured Person in a customary parent-child relationship.

Durable Medical Equipment (DME): Orthopedic braces, artificial devices replacing body parts and other equipment customarily and generally useful to a person only during an Illness or Injury and determined by Insurer on a case by case basis to be Medically Necessary including motorized wheelchairs and beds.

Effective Date: The date upon which an Insured Person's coverage will commence under this Policy, as determined by Us.

Emergency Treatment: Medical care for a Medical Emergency that is required for the immediate relief of an acute symptom or upon advice from a licensed physician cannot be delayed until your return to your Home Country.

Emergency Dental Treatment: Treatment necessary as a result of an accident/injury by an extra-oral impact, received within 48 hours from the date and time of the accident/injury for the immediate relief of pain caused by natural teeth being lost or damaged in an accident.

Expatriate: A person who resides outside of their Home Country.

Experimental and/or Investigative: are any services or supplies associated with:

- Treatment or diagnostic evaluation which is not generally and widely accepted in the practice of medicine or which does not have evidence of effectiveness documented in peer reviewed articles in medical journals.
- A drug which does not have FDA market approval;
- A medical device which does not have FDA market approval; or has FDA approval, but does not have evidence of effectiveness for the proposed use documented in peer reviewed articles in medical journals published in the United States.

We will make the final determination as to whether a service or supply is Experimental and/or Investigational.

Expiration Date: The date upon which an Insured Person's coverage will terminate under this Policy, as determined by Us.

HealthWatch: The company that provides customer service on behalf of the Insurer. They provide, 24/7 assistance service to answer any customer needs around the world, including emergency evacuation, benefit coordination, locating a network provider, and Pre-Authorization of medical services.

HIV: All diseases caused by and/or related to the HIV Virus including Acquired Immune Deficiency Syndrome (AIDS).

Home Country: The country from which the Insured Person holds a passport. If the Insured Person holds passports from more than one country, the Home Country will be the country declared to in writing as their Home Country.

Hospice: An agency which provides a coordinated plan of home and Inpatient care to a terminally ill person and which meets all of the following tests: 1) has obtained any required state or governmental license or Certificate of Need; 2) provides service 24 hours a day, 7 days a week; 3) is under the direct supervision of a Physician; 4) has a nurse coordinator who is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.); 5) has a duly licensed social service coordinator; 6) has as its primary purpose the provision of Hospice services; 7) has a full-time administrator; and 8) maintains written records of services provided to the patient.

Hospital / Clinics: Any institution under the constant supervision of a resident physician which is legally licensed as a medical or surgical hospital in the country where it is located., and which provides a day nursing service under the direction or supervision of registered professional nurses. The term Hospital does not include nursing homes, rest home, health resorts, and homes for the aged, infirmaries or establishments for domiciliary care, custodial care, care of drug addicts or alcoholics, or similar institutions.

Hospital Services: Include reasonable and customary charges, in the area where treatment is provided, for hospital accommodation up to the cost of a semiprivate room, meal charges, all hospital medical facilities, and all medical treatment and medical services ordered by a physician.

Injury: Physical harm caused by accidental and external means.

Illness: Any sickness, disease, disorder or alteration in the Insured Person's medical condition as duly diagnosed by a Physician.

Innocent Bystander: An individual who is judged to be not involved with, participating in, or related to their work, any activity associated with any war, conflict or terror related activity. This includes any hostilities or warlike operations (whether war be declared or not), invasion, civil war, riot, rebellion, overthrow of the legally constituted government, military or usurped power and any terrorist activity.

Inpatient: A person admitted to an approved Hospital or other health care facility for a Medically Necessary overnight stay.

In-Network Preferred Provider: A Provider who has contracted with Us and has agreed to accept a negotiated discount for services.

Inpatient Treatment: Treatment provided in a hospital where an Insured Person is admitted and, out of medical necessity, occupies a bed for one or more nights but not exceeding 12 months in total for any one insured event.

Insured Person (or Insured The Policyholder and any individual who meets the eligibility criteria, whose name is listed on the Certificate of Insurance, and for whom the required Premium has been paid.

Insurer: The insurance company who is liable for losses incurred under this Policy. The Insurer is GBG Insurance Limited an insurance company incorporated in the Bailiwick of Guernsey with company number 42729 and whose registered office is at Fourth Floor, Albert House, South Esplanade, St Peter Port, Guernsey GY1 1AW. Authorised and regulated by the Guernsey Financial Services Commission.

Lifetime Maximum: The maximum amount payable by Us per individual Insured Person as indicated in the Schedule of Benefits, as long as the Policy remains in force.

Local Ambulance Services: Necessary medical transportation to and from a local hospital.

Maternity Care: Prenatal care, childbirth, postnatal care, miscarriage and premature birth, and Complications of Pregnancy.

Medical Emergency: A sudden, unexpected, and unforeseen event caused by an Illness or Injury that manifests itself by symptoms of sufficient severity that a prudent layperson would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

Medical Expenses: All reasonable and necessary costs incurred in respect of medical or surgical treatment of an acute medical condition given by a physician and/or any surgeon, radiologist or other specialist to whom the Insured Person has been referred.

Medically Necessary: Those services or supplies which are provided by Hospital, Physician or other approved medical providers that are required to identify or treat an Illness or Injury and which, as determined by Insurer, are as follows:

- Consistent with the symptom, or diagnosis and treatment of condition, disease or Injury, and
- Appropriate with regard to standards of accepted professional practice, and
- Not solely for the Insured Person's convenience, the Physician's convenience or any other provider's convenience, and
- The most appropriate supply or level of service, which can be provided. When applied to an Inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an Outpatient, and
- Is not a part of or associated with the scholastic education or vocational training of the patient, and
- Is not Experimental or Investigative

Nursing at Home: The services within the Insured Person's home of a government licensed nurse prescribed by a physician for medical (as distinct from domestic) reasons.

Outpatient Treatment: Services, supplies or equipment received while not an Inpatient in a hospital, or other medical care facility, or overnight stay. Outpatient surgery is inclusive of all invasive procedures including colonoscopy and endoscopy procedures.

Out-of-Network Provider: Providers that are not part of the Preferred Provider Network.

Palliative: Treatment, the primary purpose of which is only to offer temporary relief of symptoms rather than to cure the illness or injury causing the symptoms.

Physician or Specialist: Any person who is duly licensed and meets all of the laws, regulations, and requirements of the jurisdiction in which he practices medicine, osteopathy or podiatry and who is acting within the scope of that license. This term does not include: (1) an intern, or (2) a person in training.

Policy: The agreement between the Insurer and the Policyholder. This Policy, Certificate of Insurance, Schedule of Benefits, the Policyholder application form, and riders make up the entire contract between the parties.

Policy Effective Date: The date that this Policy is first implemented, without regard to renewals thereafter.

Policyholder: The person that has completed an application, meets the eligibility criteria, whose name is listed on the Certificate of Insurance, and for whom the required Premium has been paid. The Policyholder may also be referenced as the Primary Insured, You, or Your in this Policy.

Policy Period (or Policy Year): The period of time during which this Policy is in effect, provided all Policy conditions are met. The Policy Period begins on the Policy Effective Date and ends on the Policy End Date as shown on the Certificate of Insurance.

Pre-existing Condition: Medical condition/symptoms, Injury, Illness, sickness, disease, or other physical medical, mental or nervous conditions, disorder or ailment (whether known or unknown), whether or not investigated or diagnosed or any chronic, subsequent or recurring complication or consequence associated with or arising from a medical condition, for which medical advice, diagnosis, care or treatment (including services and supplies, consultations, diagnostic test or prescription medication including drugs, medicines, special diets, injections or other forms of medication) was sought by, recommended for or received by You; whether or not You were aware or should have been aware You had the medical condition, during the 24 months prior to the commencement date of the period of insurance.

Preferred Provider Network: Providers, such as Hospital, clinic or Physician that has entered into an agreement to provide medical services at a discount to persons insured by Us.

Premium (s): The consideration owed by the Policyholder to the Insurer in order to secure benefits for its eligible Employees under this Policy.

Premium Payment Mode: The recurring cycle specified on the Certificate of Insurance upon which the Premium for this Policy is due.

Prescription Medications: Prescription Medications are medications which are prescribed by a Physician and which would not be available without such prescription. Certain treatments and medications, such as vitamins, herbs, aspirin, cold remedies, medicines, experimental or Investigative medications, or medical supplies even when recommended by a Physician, do not qualify as Prescription Medications.

Private room: The cost of a standard single private room when required as part of your treatment. This may be subject to the availability of the Provider

Product Level: The level of cover provided under this Policy.

Provider: The organization or person performing or supplying treatment, services, supplies or medications.

Rehabilitation: Therapeutic services designed to improve a patient's medical condition within a predetermined time period through establishing a maintenance program designed to maintain the patient's current condition, prevent it from deteriorating and assist in recovery.

Rehabilitation Centre: A rehabilitation center registered in accordance with the competent authorities' legislation but excluding hospitals as defined elsewhere.

Relative in the first or second degree: Spouse, parents (-in-law), children and the person with whom the Insured Person lives together on a permanent basis. Brothers (in-law), Sisters (in-law), grandparents and grandchildren.

Schedule of Benefits: The summary description of the benefits purchased by the employer, payment levels and maximum benefits, provided under this Policy. The Schedule of Benefits is part of this Policy.

Specialist (Physician, Anesthetist and Surgeon): A person suitably qualified and legally licensed to practice medicine in the country where treatment is provided and who holds a certificate of specialist training (or an equivalent which is accepted by **us**). The specialist must be practicing within the scope of his/her license and training.

Terrorist Activity: Terrorist activity means an act, or acts, of any person, or groups of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization or government.

Traditional Chinese Medicine: A comprehensive medical health care system comprised of a range of traditional therapies including, but not limited to: acupuncture, acupressure, moxibustion, herbal medicine, nutrition, and exercises (tai chi and qigong).

Travel expenses: Transport based on the lowest class of the means of transport in which travelling is done.

Usual, Customary and Reasonable (UCR): The lower of: 1) the provider's usual charge for furnishing the treatment, service or supply; or 2) the charge determined by Us to be the general rate charged by others who render or furnish such treatments, services or supplies to persons: 1) who reside in the same geographical area; and 2) whose Illness or Injury is comparable in nature and severity.
The Usual, Customary, and Reasonable charge for a treatment, service or supply that is unusual, or not often provided in the area, or that is provided by only a small number of providers in the area, will be determined by Us. We will consider such factors as: 1) complexity, 2) degree of skill needed, 3) type of specialist required, 4) range of services or supplies provided by a facility, and 5) the prevailing charge in other areas/regions.

Waiting Period: The period of time specified on the Schedule of Benefits which must pass before coverage will begin. The Waiting Period begins on the Insured's Effective Date of coverage.

War zone: An area where a war is taking place or there is some other violent conflict.

We, Us and Our: GBG Insurance Limited.

Insured by:
GBG Insurance Limited
Fourth Floor, Albert House,
South Esplanade,
St Peter Port, Guernsey
GY1 1AW.
Registration number 42729.
Authorised and regulated by the Guernsey Financial Services Commission