

OPTIMUM GLOBAL
INTERNATIONAL HEALTH INSURANCE



MEDITERRANEAN PLAN

YOUR MEMBERSHIP GUIDE & POLICY CONDITIONS
AUGUST 2009

IMPORTANT

**You are requested to read this document.
It contains important information about your Policy.**

Welcome to Optimum Global: The International Health Insurance Specialists.

Thank you for choosing Optimum Global. This document is your membership guide and forms part of your policy. It explains what you are covered for under the benefits of your plan and together with the policy schedule, benefit table and application; forms the agreement between you and Optimum Global.

We have taken every effort to ensure that all the important information you require is in this membership guide. However, if you have any other questions you are recommended to contact your usual financial adviser/intermediary, or visit our website.

Please keep this guide in a safe place. If you need another copy you can view and print online at:

www.optimumglobal.com

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DEFINITIONS

Certain words that appear in your membership guide have been defined below. These have the same meaning wherever they are used in the Policy whether they appear in bold print or begin with a capital letter.

The Company, We, Our, Us means Optimum Global Limited.

Assured, You, Your means the entity named as the Assured in the Policy Schedule in the case of a corporate policy. In the case of an individual/family policy, it means the Insured Person as shown on the Policy Schedule.

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

Annual Deductible means the accumulative total amount of medical expenses incurred by an Insured Person during any one Policy Year in excess of which the Policy will indemnify or compensate the Insured Person for medical expenses covered by the Policy.

Application Form means the forms You signed to apply for this Policy from Us, including any written statement, representation or document given to the Company which contains information We relied on in issuing this Policy. Written statements on an Application Form by a prospective Insured about the insured and his or her dependents are used by the Insurer to determine acceptance of the risk. This includes any medical history, questionnaire and other documents provided to or requested by the Insurer prior to the issuance of the policy.

Approved Hospital means a Hospital approved by the Company to provide treatment for which a benefit may be payable under the Policy.

Area of Cover means the countries in which the Insured Person will be covered.

Child Dependent coverage is available for the policyholder's dependent children up to the nineteenth (19th) birthday, if single, or up to their twenty fourth (24th) birthday if single and full time (minimum twelve (12) hours per week) student of an accredited college or university at the time a claim is incurred. Coverage for such dependents continues through the policy's next anniversary date.

Congenital Condition means any anomalies, including but not limited to inherited conditions, genetic defects and birth defects of the Insured Person that are existing prior to or from the time of birth regardless of the time of discovery and/or the time of physical manifestation of such anomalies or defects.

Dependent means the Insured Person's legal spouse or co-habitant and/or biological or legally adopted children.

Due Date means the date of commencement or renewal of cover as shown on the Schedule or the date on which any subsequent, annual payment of premium falls due.

Effective Date The date on which coverage under this policy begins and which is stated in the Policy schedule, after the policy is approved by the company.

Eligible Person means; in the case of a corporate policy, Your full-time and permanent employees at the Policy Commencement Date or at any Renewal Date and whom We have agreed in writing to be eligible to participate in the insurance plan under this Policy. In the case of an individual/family policy it means You and any eligible dependents.

Emergency Medical Complaint means a medical condition resulting from an Accident, or any sudden beginning or worsening of a severe illness that:

- a. presents an immediate and serious threat to the Insured Person's health and
- b. requires immediate medical attention by a Physician.

Home Country means the country declared on the Application Form. This is the country to which the Insured Person will return if he or she wishes to make a claim for repatriation. The Home Country of the Insured Person's Dependents will be deemed to be the same Home Country as declared for that Insured Person in the Application Form.

Home Country Cover means insurance cover provided by the Policy in the Insured Person's Home Country.

Hospital means an institution which is legally licensed as a medical or surgical hospital in the country in which it is located. It must be under the constant supervision of a Physician. This does not include any entity which is primarily a place for alcoholics or drug addicts, a nursing, rest or convalescent home or a home for the aged or any other similar establishment.

Illness means a physical condition marked by pathological deviation from the normal healthy state.

Injury means unforeseeable damage inflicted to the body caused solely and directly by an Accident.

Inpatient means a person admitted to a Hospital for treatment and for which the Hospital makes a daily room and board charge. It also includes admission of any duration for the purpose of surgery and any preparation and procedure in connection with the surgery without incurring any room and board charge.

Insured Person means any Eligible Person or Eligible Dependent who is covered under this Policy. For the avoidance of doubt, it is an individual for whom an application has been completed, the premium paid and for whom coverage has been approved by the Insurer and commenced.

Physician or Doctor means a person who is legally qualified in medical practice following attendance at a recognised medical school, to provide medical treatment and licensed by the competent medical authorities of the country in which treatment is provided but who should not be the Insured Person or the relative, sibling, spouse, child or parent of the Insured Person.

Policy Year means a period of 12 months starting from original inception (start) date for this Policy and each consecutive 12-month period for which this Policy is renewed.

Pre-Existing Conditions means any injury, illness, condition or symptom:

- a. for which treatment, or medication, or advice, or diagnosis has been sought or received or was foreseeable by You or the Insured Person prior to the commencement of the Policy for the Insured Person concerned, or
- b. which originated or was known to exist by You or the Insured Person prior to the commencement of the Policy whether or not treatment, or medication, or advice, or diagnosis was sought or received.

Reasonable and Customary Charges means charges for medical care which We or Our medical advisers consider to be Reasonable and Customary if they are within a general level of charges being made by other care providers of similar standing in the locality where the charges are incurred when giving like or comparable treatment, services or supplies to individuals of the same gender and of comparable age for a similar disease or injury.

Schedule means The Schedule to this Policy headed "Policy Schedule" which sets out key terms such as the name of the Assured, the Insured Persons, the Benefits and the Policy Limits.

Serious Medical Condition means, for the purpose of interpreting Emergency Medical Evacuation cover, a condition which, in the opinion of the Company or its authorised representatives, constitutes a serious or life threatening medical emergency requiring immediate evacuation to obtain urgent remedial treatment in order to avoid death or serious impairment to an Insured Person's immediate or long-term health prospects. Unless agreed otherwise by the Company it does not mean any circumstances in which the Insured Person is capable of travelling without a medical escort. The seriousness of the medical condition will be judged within the context of the Insured Person's geographical location and the local availability of appropriate medical care or facilities.

Specialist means a qualified and licensed Physician, possessing the necessary additional qualifications and expertise to practice as a recognised specialist of diagnostic techniques, treatment and prevention, in a particular field of medicine such as psychiatry, neurology, paediatrics, endocrinology, obstetrics, gynaecology and dermatology.

Terminal Illness means an advanced or rapidly progressing incurable illness that is expected to result in the death of the Insured Person within 12 months and this conclusive diagnosis of the illness must be certified by the Specialist and Company Medical Adviser.

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

- a. We are informed in writing of any such permanent change* in the country where the Insured Person usually lives and
- b. We confirm Our agreement to continue insuring the Insured Person under this Policy on such terms as We think are appropriate.

* The Insured Person is deemed to make a permanent change in his or her Usual Country of Residence if that Insured Person lives or intends to live in the other country for more than three (3) consecutive months.

Waiting Period(s) means the period(s) of time (specified in the Schedule) from the original inception (start) date of the Policy during which this Policy does not cover any treatment made necessary by any cause.



GENERAL CONDITIONS

It is an important part of Our contract that You observe the following General Conditions:

1. Geographical Scope This Policy covers the Insured Persons in the Area of Cover as stated in the Policy Schedule on a twenty-four (24) hour basis.

The Insured Person shall, wherever possible, seek treatment in the specified Area of Cover except for any treatment of an Emergency Medical Complaint occurring while outside the specified Area of Cover for not more than forty-five (45) days per trip.

2. Co-ordination of Benefits The Policy will only provide compensation on a proportionate basis if the Insured Person has any other insurance in force or is entitled to indemnity from any other source in respect of the same Accident, Illness, death or expense. We have full rights where permitted by law to take proceedings in Your or the Insured Person's name, but at Our expense, to recover for Our benefit, the amount of any payment We have made under the Policy.

3. Co-operation We will have no liability under this Policy unless You or the Insured Person do all of the following:

- a. co-operate fully with Us and Our medical advisers and
- b. fully and faithfully disclose all material facts and matters which the Insured Person knows or ought to know and
- c. upon Our request sign any document to empower the Company to obtain relevant information, at the Insured Person's expense, from any doctor or Hospital or other sources.

4. Material Changes We must be informed immediately in writing of any material change in information or circumstances whether relating to occupation, business or sporting activity affecting You or any Insured Person. We reserve the right either to continue cover for the Insured Person on terms and conditions We consider appropriate because of the material change in information or circumstances or to decline to continue cover under this Policy.

5. Commencement of Coverage All Eligible Persons on the Policy commencement date, will be covered under the Policy on such date, unless notified otherwise by Us. If a Dependent is in Hospital confinement on the date which insurance coverage is to be effective, coverage will not become effective until the Dependent is discharged. With the exception of a newborn child, coverage will be incepted on the first day of birth provided that notification in writing has been made within thirty (30) days of birth and approved by Us. A copy of the birth certificate must accompany the application.

6. Data Required If this Policy is administered on the named basis for either individual/family or corporate applications, You are required to furnish Us full particulars showing the Insured Person's name, sex, occupation, identity card number or passport number, date of birth, medical plan, Home Country, Usual Country of Residence, effective date, the date of termination of insurance coverage and change in benefits. You are required to notify Us in writing within thirty (30) days of any addition of new or deletion of Insured Persons under this Policy. We shall charge or refund proportionate premium as may be appropriate.

If this Policy is administered on the headcount basis (experience rated groups), You are required to furnish Us full particulars showing the Insured Person's name, sex, occupation, identity card number or passport number, date of birth, medical plan, Home Country and Usual Country of Residence and effective date of insurance coverage by each renewal date.

You are required to furnish Us all information and documents which We may reasonably require with regard to any matters pertaining to this Policy. We will not be liable for any errors or omissions arising directly or indirectly from any errors or omissions in any information or documents so furnished. Your records, as may in Our opinion have a bearing on the insurance coverage provided under this Policy, will be available for inspection by Us at any reasonable time at Your cost.

You are required to give Us immediate notice of any change in the nature of Your business and pay any additional premium that may be required by Us.

7a. Renewal for Individual/Family Policies. Your coverage is automatically renewed for the next insurance year by payment of the renewal premium before the Due Date provided the existing plan You have selected for this policy is still available. On the renewal date, We may vary the benefits, cover and/or premium by giving thirty (30) days advance notice in writing to You.

7b. Renewal for Corporate Policies. The Policy is automatically renewed for a further term of 1 (one) Policy Period on each Renewal Date. At each yearly renewal of the Policy, We have the right to vary the terms and conditions of the Policy by giving thirty (30) days advance notice in writing to You.

8. Termination The Policy may be terminated with effect from any renewal date by either party by giving thirty (30) days notice in writing of its intention not to renew the Policy.

The Company can terminate the policy for reasons of non-disclosure, fraud or attempted fraud, as determined by the Company.

With respect to corporate Policies, if there are three (3) or less employees insured as the Insured Persons under this Policy on any Renewal Date, We will reserve the right to terminate this group Policy and offer individual membership.

In the event of war (declared or undeclared) or act of war (whether or not there has been a declaration of war), We reserve the right to terminate this Policy by notifying You, the date of termination being at Our sole discretion.

9. Termination of Insured Person's Coverage An Insured Person's cover under this Policy shall terminate automatically on the date any one of the following events first occurs:

- a. the entire Policy is terminated as provided in Clause 8 of this section;
- b. with respect to corporate applications, on the date the Insured Person resigns, retires or terminates his employment with You;
- c. where the Insured Person is a Dependent and he or she is no longer qualified as a Dependent of the Eligible Person or when the Eligible Person is no longer insured under this Policy;
- d. upon request for cancellation by You;
- e. non-payment of premium after the premium Due Date as provided in Clause 12 of this section;
- f. Non-disclosure of material facts as defined in your application form.

10. Cancellation You may cancel the Policy with effect from any renewal date by giving thirty (30) days notice in writing of your intention not to renew the Policy. The cover on all Insured Persons will cease on the renewal date. We can suspend or cancel the product with three (3) months' notice before the anniversary of the policy offering another similar policy.

11. Premium mode All policies are deemed annual policies and premiums are to be annual, unless We authorise another mode of payment.

12. Premium Payment Any premium due must be paid by You and actually be received in full by Us within the time frame stipulated below:

- a. Where the premium is payable on an annual basis, either thirty (30) days from the Policy commencement date or renewal date; or 30 days from the date of the premium invoice issued by Us, whichever is later.
- b. Where the premium is payable other than on an annual basis:
 - i. Either 30 days from the Policy commencement date or renewal date; or 30 days from the date of the premium invoice issued by Us, whichever is later, for the first premium of each Policy period.
 - ii. On the agreed premium payment due dates for subsequent premiums.

With respect to corporate Policies, where You have confirmed to renew this Policy but have not provided us with the complete data necessary for the renewal of this Policy by the renewal date, We shall issue a premium invoice stating the estimated renewal premium shall be made within the period stated. In the event any premium due is not paid to Us within the premium payment period stated, We reserve the right to terminate this Policy and We will be discharged from all liabilities.

For the avoidance of doubt, if a premium has not been received by the company, claims will not be paid (or agreed to be paid).

13. Refunds If an Insured or the Company cancels the policy within the agreed timeframe after it has been issued, reinstated or renewed, We may refund the premium on a pro rata basis.

14. Age For the purpose of determining premiums payable, an Insured Person's age shall be based on his/her age last birthday. If the age of any Insured Person has been misstated, We reserve the right to cancel the Policy and refund all premiums paid (less any claims already paid).

15. Fraud If any claim shall in any respect be false or fraudulent or if fraudulent means or devices are used by the Insured Person or any Dependent or anyone acting on their behalf to obtain benefit under this Policy, the Policy will be cancelled immediately and all benefit and premium forfeited.

16. Assignment You or the Insured Person will have no rights to assign this Policy or any insurance coverage effected under this Policy.

17. Applicable Law The terms and conditions of this Policy will be governed by and construed, determined and enforced in accordance with the laws of the Island of Guernsey.

18. The Insurer Windward Insurance PCC Limited of PO Box 484, Second Floor, St Andrews House, Le Bordage, St Peter Port, Guernsey, GY1 1BR in respect of Optimum Global Cell. Windward Insurance PCC Limited is a protected cell company within the meaning of the Companies (Guernsey) Law 2008 as amended ("the Law"), registered in Guernsey under registration no. 38989 and regulated by the Guernsey Financial Services Commission under The Insurance Business (Bailiwick of Guernsey) Law 2002. Under these regulations there is no policy holder protection scheme in place. Optimum Global Cell is a Cell within Windward Insurance PCC Limited. The liability of Windward Insurance PCC Limited to You in respect of this insurance is solely limited to the extent of the cellular assets (within the meaning of the Law) for the time being of Optimum Global Cell and You have or shall have no claim against the Company's non-cellular assets.

19. Currency Payment Payment of all claims and benefits will be made in the currency in which this Policy is effected. Charges incurred in any other currency shall be payable in the currency of the Policy on the basis of the exchange rate used by Us on the date the claims were processed.



INSURANCE COVER

This document, together with your insurance schedule and benefit table, forms your insurance policy. Your policy is issued by Windward Insurance PCC Limited – Optimum Global Cell, a Guernsey registered insurer licensed by Guernsey Financial Services Commission. Guernsey is a world-class financial centre renowned for clear regulation. Windward Insurance PCC Limited – Optimum Global Cell is provided with reinsurance security for the Optimum Global Health plans by AVIVA Ltd, a subsidiary company of AVIVA plc. AVIVA plc is the world's fifth largest insurance group, serving 50 million customers across Europe, North America and Asia Pacific. AVIVA's main business activities are long-term savings, fund management and general insurance, with worldwide total sales of S\$133.64 billion and funds under management of S\$789.20 billion at 31 December 2008. AVIVA plc is the largest insurance services provider in the UK and one of the leading providers of life and pension products in Europe with a Standard & Poors 'AA-' rating. In addition, it has an 'Aa3' rating by Moody's and an 'A' rating from AM Best.

EXTENT OF COVER

The Policy will pay up to the limits and sub-limits stated in the Benefit Table for medical or other covered expenses as defined and required as a direct result of the Insured Person suffering an Accident, Illness, death or any other covered event.

We will pay any benefits due under this Policy either to the Insured Person or where a guarantee of payment has been placed to the providers of covered medical, transportation or other services whose official receipt to pay that benefit will discharge Us from the liability We have under the Policy. Only the usual Reasonable and Customary Charges in the geographical area where covered treatment or services are provided will be paid. Satisfactory proof of claim must be submitted in all cases, and We may appoint independent administrators to settle claims on Our behalf.

LIMITS OF LIABILITY

The Company's liability is limited in amount to the sub-limits which the Benefit Table says applies to each item or type of cover provided. The annual limit per Insured Person stated in the Benefit Table is the maximum amount recoverable under the Policy as a whole in respect of any one Insured Person during any one Policy Year. If benefits are properly claimable after the date of termination or non-renewal of the Policy, the amounts payable shall be calculated as if the expenses had been incurred wholly during the preceding Policy Year.

DEDUCTIBLE & CO-INSURANCE

A Deductible is the amount of a claim which has to be borne by the Insured Person before the relevant benefits are payable under this Policy.

An Annual Aggregate Deductible is the accumulative total amount of medical expenses incurred by an Insured Person during any one Policy Year in excess of which the Policy will indemnify or compensate the Insured Person for medical expenses covered by the Policy. In order to claim for any expense in excess of the Deductible, the Insured Person must be able to substantiate that incurred expense said to fall within the Deductible would have been covered by the Policy if the Deductible were not applied.

Co-insurance means the proportion of covered medical expenses claims which the Insured Person must pay.

Deductible amounts and co-insurance and the items of cover to which they apply are stated on the Schedule and Benefit Table. Deductible amounts and co-insurance contributions are annually accumulative for the purpose of this Policy and the order in which they shall be applied to eligible claims is Deductible amounts first and co-insurance amounts second.

WHAT WE COVER

The following benefits are available. Not all of them may apply in respect of Your Policy, so please refer to the Schedule to determine the cover actually provided to the Insured Person concerned.

I. HOSPITAL & RELATED SERVICES i. Hospital Treatment & Services

All medically necessary treatment and services provided by or on the order of a Physician to the Insured Person when admitted as a registered inpatient to a Hospital.

Cover includes Hospital accommodation (up to the cost of a standard private class single-bed air conditioned room, meal charges, general nursing services, diagnostic, laboratory or other medically necessary facilities and services, physician's/surgeon's/anaesthetist's or physiotherapist's fees, operating theatre charges, intensive care unit charges, specialist consultations or visits and all drugs, dressings or medications prescribed by the treating Physician for in-hospital use. We do not pay for the costs of

non-medically necessary goods or services including such items as telephone, television and newspapers.

ii. Cancer Treatment

Charges for treatment of an Insured Person for cancer, this includes treatment received as a registered inpatient or as an outpatient at a registered cancer treatment centre.

iii. Kidney Dialysis Treatment

Charges for treatment of an Insured Person for kidney dialysis this includes treatment received as a registered inpatient or as an outpatient at a legally registered dialysis centre.

iv. Physiotherapy Treatment

Charges for physiotherapy treatment of an Insured Person which is received as a registered inpatient at a Hospital.

v. Psychiatric Treatment

We will pay for the costs of psychiatric treatment received as an inpatient in a psychiatric unit of a Hospital after the Insured Person has been insured under this Policy for a continuous period of 10 months. All treatment must be administered under the direct control of a registered psychiatrist.

vi. Day Surgery

The cover provided by the Hospital Treatment & Services benefit extends to include Day Surgery. Day Surgery means all medically necessary surgical procedures and related treatment provided by or by order of a Physician to the Insured Person at a Hospital which does not involve an overnight stay. We do not pay for non surgical procedures and related treatment.

vii. Casualty Ward Accident & Emergency Services

Services provided to the Insured Person as an outpatient in a Hospital Casualty Ward immediately following an Emergency Medical Complaint or Accident.

viii. Hospital Accommodation for Accompanying Parent of Insured Child

Accommodation charges incurred by one parent sharing the Hospital room of an Insured child under eighteen (18) years old, where the latter is treated for Illness or Injury at a Hospital, as an inpatient for a period and the treating Physician has advised in writing that a parent should remain with the Insured child.

ix. Emergency Local Ambulance Services

The medically necessary transportation of the Insured Person by road ambulance to a local Hospital. Cover extends to include local transportation of the Insured Person between airports and/or home and/or Hospitals by taxi or other suitable modes of transport for the purpose of receiving Hospital treatment covered by the Policy.

For the purpose of this clause, 'local' means within the country in which the Insured Person is in when he requires the service.

x. Emergency Treatment Outside Area of Cover

Charges for an Emergency Medical Complaint occurring during short period business or holiday travel, not exceeding forty-five (45) days per trip, as stated in the Benefit Table. We will not cover any costs for treatment provided in a Hospital unless the hospitalisation begins within twenty-four (24) hours after the Emergency Medical Complaint arose.

xi. Home Nursing following Hospitalisation

Following discharge from Hospital, cost of a full-time or part-time services of a State registered or Government-licensed nurse in the Insured Person's home so long as all of the following apply:

- it is prescribed by a Physician for the continued treatment of the specific medical condition for which the Insured Person was hospitalised, and
- is essential for medical, as distinct from domestic, reasons.

Cover is limited to a maximum period of ten days (10) in any one Policy Year and in total for any one claim or event.

xii. Hospital Cash

If an Insured Person is admitted to Hospital as a nonpaying in patient, where the treatment received is free of charge and covered within the terms under this Policy, We will pay the Insured Person a daily hospital cash benefit up to the sub-limits stated in the benefit schedule and for a maximum of thirty (30) days per disability.

2. ORGAN TRANSPLANTATION

The cost of an operation for the transplantation of the kidneys, heart, liver, lung or bone marrow where the Insured Person is the recipient. We do not pay for the costs of acquiring the organ or expenses incurred by the donor. No other type of benefit insured by the Policy provides cover in connection with Organ Transplant.

We will only pay for the transplant that is deemed necessary due to the consequence of an illness that meets the criteria for transplant. We will not pay for any transplants performed with organic organs or animal organs. We will not pay for any costs associated with acquiring the organ and we will not pay for the medical expenses of the donor.

3. EMERGENCY MEDICAL EVACUATION & REPATRIATION

This benefit applies while You are travelling:

- a. outside the Home Country or Usual Country of Residence on holiday or business, not exceeding forty-five (45) days per trip, and



- b. within the Home Country or Usual Country of Residence but excluding war zones, countries where the prevailing conditions render evacuation impracticable and repatriation.

The Company and its medical advisers reserve the absolute right to decide if the Insured Person's medical condition is sufficiently serious to warrant emergency medical evacuation and/or repatriation. The Company or its medical advisers shall also decide the place to which the Insured Person shall be evacuated and the means by which the evacuation should be carried out, having regard to all the assessed facts and circumstances of which the Company is aware at the relevant time.

A. Emergency Medical Evacuation & Assistance

The cover under this Benefit Clause 3A is defined as:

i. Emergency Medical Evacuation

We will only pay for evacuation or repatriation arrangements if it is prior approved and authorised by Our 24-hour Emergency Assistance Centre. We will pay in full the Insured Person's reasonable transportation costs for him or her to be evacuated for inpatient treatment if the treatment he or she needs is covered under the Policy and is recommended by his or her doctor for medical reasons and is not available locally. This must be approved in advance by the 24-hour Emergency Assistance Centre. The Insured must provide Us with any information or proof that We may reasonably ask him or her to support his or her request.

We will only pay for the evacuation of the person requiring the treatment to the nearest place where the treatment is available. This could be another part of the country which he or she is in if this is appropriate. Please note that the nearest country may not be the Insured Person's Home Country.

ii. Compassionate Travel

We will pay the expense of the cost of one economy class return airfare and all ancillary charges (accommodation, food and transport only) up to the limit as stated in the Benefit Table, for a family member to join an Insured Person who becomes seriously ill while travelling alone outside the Home Country or Usual Country of Residence and so long as:

- The Insured Person has been or will be hospitalised in a Hospital for a period that is more than seven (7) days and with Our prior approval
- We or Our medical advisers consider it necessary on medical grounds and/or to avoid the need for medical evacuation.

iii. Return of Minor Children

The expense, up to the cost of economy class one way airfares and usual ancillary charges, to return children who are left unattended to the Home Country or Usual Country of Residence as a result of the accompanying adult Insured Person's Accident, Illness, death, hospitalisation or medical evacuation covered by the Policy.

iv. Dispatch of Medicines

The expense incurred by or on the order of the Company or its medical advisers to replace essential medical commodities for an Insured Person travelling outside the Home Country or Usual Country of Residence in circumstances where such commodities have been lost or stolen and no suitable replacements or substitutes are available locally.

B. Repatriation

The cover under this Benefit Clause 3B is defined as:

i. Repatriation, Travel or Accommodation Expenses

We will pay the expense necessarily and unavoidably incurred in returning the Insured Person to the nearer of the Home Country or Usual Country of Residence following Emergency Medical Evacuation provided that such additional costs are medically necessary and approved in advance by Us or Our medical advisers. This will not be applicable if an Emergency Medical Evacuation is carried out within the Home Country or Usual Country of Residence. We will also pay reasonable transportation costs for one other person to travel or remain with the Insured Person during evacuation when this is considered necessary for medical reasons. We only pay for one repatriation per illness or injury.

ii. Repatriation or Local Burial of Mortal Remains

We will pay the expense of preparation and air transportation of the mortal remains of an Insured Person from the place of death to the Home Country, or the preparation and local burial of the mortal remains of an Insured Person who dies outside the Home Country. Within the stipulated Policy limit for this benefit, cover includes the cost of a single, economy class airfare for one family member accompanying the body back to the Home Country.

For the purpose of this clause 'local' means within the country where the Insured Person died.

C. Emergency Medical Advice & Assistance

In emergencies, the Insured Person may call Our 24 hour Emergency Assistance Centre any time for medical advice, and evaluation from the attending co-ordinator doctor in order to locate suitable medical services anywhere in the world or to provide referral to Physicians or Hospitals for personal assessment and/or treatment as medically appropriate.

You understand and agree for yourself and for each Insured Person that such telephone conversations cannot establish a diagnosis and must be considered as advice only.

The Emergency Assistance Centre will as far as it is reasonably possible facilitate necessary Hospital admissions by confirming the extent of insurance cover, monitoring claims procedures and issuing appropriate guarantees in accordance with the payment guarantee condition of this Policy.

D. International Travel Assistance Services

While the Insured Person is travelling, the 24-hour Emergency Assistance Centre can provide the following administrative assistance and services:

- i. visa, immunisation, vaccination, special medication and weather information services prior to departure
- ii. retrieval and redirection of lost luggage
- iii. replacement and delivery of essential lost travel documents such as passport, travel tickets and credit cards
- iv. emergency message transmission and interpreting service.

You and the Insured Person understand and agree that any third party fees or charges reasonably and properly incurred by the Company in the delivery of these services must be borne entirely by the Insured Person or You.

4. OUTPATIENT BENEFITS

If these benefits are stated on the benefit table We will pay for medically necessary treatment provided to an Insured Person who is not a registered inpatient at a Hospital and defined as:

i. General Practitioner Services and Prescribed Drugs

If this benefit is stated on the Benefit Table, We will pay for outpatient services provided by a Physician in his or her capacity as a general practitioner including the cost of prescribed drugs which are medically necessary up to the maximum limit per year.

ii. Specialist Services

If this benefit is stated on the benefit table, We will pay for Outpatient Services provided by or on the order of a Physician who is licensed and practices as a Specialist or Consultant in respect of the services rendered including the cost of prescribed drugs.

iii. Drugs Prescribed by Specialists

If this benefit is stated on the benefit table, We will pay for prescribed drugs up to the maximum sublimit as stated in the benefit table.

iv. Outpatient Psychiatric Treatment

We pay for outpatient specialist consultations with a registered psychiatrist up to the sub-limits stated in the Schedule when the Insured Person has been referred by a Physician. This benefit is available after the Insured Person has been insured under this Policy for a continuous period of ten (10) months.

v. Outpatient Laboratory, X-ray and Diagnostic Services

Laboratory, testing, radiographic and medicine procedures, CT, PET and MRI scans used to diagnose or treat medical conditions. Such services must be provided by or ordered by a Physician. We will pay up to the maximum limit per year.

vi. Prescribed Outpatient Therapies

We pay for treatment by a legally qualified physiotherapist, speech therapist or oculomotor therapist provided the Insured Person has been referred for such treatment by a Physician. We will pay up to the maximum limit per year.

vii. Prescribed Medical Aids

Medical aids which are ordered by a Physician and are medically necessary such as artificial limbs, hearing aids, or the rental or purchase of a wheelchair. We will pay up to the maximum limit per year.

viii. Prescribed Alternative Medicine

We pay for treatment by a qualified chiropractor, homeopath, osteopath, acupuncturist, Chinese medicine physician and kinesiologist.

For the purpose of this clause, 'qualified' means the person is fully trained, legally qualified, registered and licensed to practice in the country in which the treatment is provided but who should not be the Insured Person or the relative, sibling, spouse, child or parent of the Insured Person.

ix. Accidental Dental Treatment

Dental treatment required to restore or replace sound natural teeth lost or damaged in an Accident and for which treatment was received within fourteen (14) days following the Accident.

Sound natural teeth means teeth that are free of decay, fillings, gum disease, root canal treatment and dental implants and which could function normally in chewing and speech. The Insured Person will be required to furnish proof of sound natural teeth issued and certified by a registered Dental Practitioner and such benefit is not applicable to dental implants, crowns or dentures.

x. Vaccinations

If this benefit is stated on the Policy Schedule, We will reimburse the cost of vaccinations up to the stated sub-limits.

xi. Well Being benefit

If this benefit is stated on the Benefit Table, We will reimburse the cost of the following tests to the stated sub-limits at the end of every two continuous years of insuring under this Policy:

- Radiology
 - Chest X-ray
 - ECG (12 leads)
- Laboratory tests
 - Haematology Screen
 - Diabetic Screen
 - Renal Function Screen
 - Lipid Screen
 - Liver and Biliary Screen
 - Urinalysis



5. MATERNITY BENEFIT

If this benefit is stated on the Benefit Table, We will pay for medical expenses up to the limit stated for each pregnancy that the Insured Person incurs after having been covered under the Plan for the whole of the ten (10) months before incurring the medical expenses.

Medical expenses include ante-natal care such as ultrasound scans, hospital charges, obstetricians' and midwives' fees for childbirth, post-natal care required by the Insured Person immediately following childbirth, secondary conditions brought about by pregnancy such as backache, high blood pressure, vaginal bleeding, nausea, and vomiting.

For the purpose of this clause, covered 'Complications' comprise:

- a. charges for surgery and related medical care for Caesarean section which is non-elective and when a Physician has certified in writing that a natural delivery will endanger the life of the Insured Person and/or her child(ren)
- b. charges for surgery and related medical care for the treatment of extra-uterine pregnancy or complications requiring intra-abdominal surgery after necessary termination of pregnancy for medical reasons
- c. charges for other necessary care which is provided during hospitalisation for pernicious vomiting in pregnancy, toxæmia with convulsions or spontaneous abortion
- d. miscarriage, ectopic pregnancy and stillbirth.

No other type of Benefit insured by the Policy (except for Emergency Medical Evacuation services) provides any cover for expenses incurred in connection with maternity or childbirth.

6. DENTAL BENEFIT

If this benefit is stated on the Benefit Table, We will pay for dental expenses up to the Sub-Limit stated in the Schedule for routine and restorative dental treatment that you incur.

- a. Routine dental treatments including scaling, polishing, x-rays, compound fillings, tooth extractions, gum treatments, surgery for wisdom tooth extractions but only up to the Sub-limit per person per Policy Year as stated in the Benefit Table and subject to the Co-insurance as stated.
- b. Restorative dental treatments and prosthesis including surgery for removal of impacted tooth, removal of roots, crowning, root canal treatment, bridging, new or repair of upper or lower dentures and implants but only up to the Sub-limit per person per Policy Year as stated in the Benefit Table and subject to the Co-insurance as stated.

HOW TO MAKE A CLAIM & CLAIMS CONDITIONS

We will act in good faith in all Our dealings with You and the Insured Persons. You and the Insured Persons, in turn, must ensure that the following are observed:

1. Notification of Circumstances that may give rise to a Claim

If there are circumstances which will or may give rise to a claim on this Policy, You or the Insured Person must ensure that the following are adhered:

- The 24-hour Emergency Medical Assistance Centre we have appointed must be informed immediately if the Insured Person may require emergency medical evacuation or repatriation of mortal remains.
- Before an Insured Person begins treatment as a Hospital inpatient (except in cases of Accident or acute medical emergency), the Insured Person must notify the 24-hour Emergency Medical Assistance Centre immediately in writing of the intention to seek such treatment, with full details of the proposed treatment and the names and addresses of the Physician and Hospital concerned.
- In cases of Accident or acute medical emergency, written notification together with reasonably available supporting medical information must be submitted to Us within forty-eight (48) hours of the event.

2. Making a Claim

If the Insured Person has not telephoned the 24-hour Emergency Medical Assistance Centre and intends to make a claim, he/she must:

- complete Our Claim form and submit it to Us before or as soon as possible after an Insured Person seeks covered Hospital inpatient treatment. A Claim form may be obtained from your usual financial adviser/intermediary or from our website www.optimumglobal.com
In respect of Our Claim form:
- the Insured Person or the Insured Person's legal personal representative must complete all the details in Section A, B and C and sign it

- the treating Physician must complete all questions in Section D, affix his stamp on the Claim form and sign it
- give Us all supporting medical information (including originals of all relevant documents and bills) within ninety (90) days after the treatment begins or as soon as possible after such information is reasonably available, whichever is earlier. We will not accept photocopies of the relevant documents.
- use a new Claim form for each separate claim or course of treatment.

Failure to observe these claim conditions, without any reasonable explanation, may invalidate a claim.

3. Payment of Claims

All claims will be reimbursed using the currency conversion rate as at date of assessment.

4. Payment Guarantees & Direct Settlements

When We are given adequate advance notice of a claim as provided in Claims Condition 1, We or the 24-hour Emergency Medical Assistance Centre will give the Insured Person a confirmation of the extent of insurance benefits, monitor claims procedures, issue (wherever reasonably possible) appropriate payment guarantees and/or arrange direct settlement of the bills rendered by Hospitals, Physicians or other service providers.

We will not provide payment guarantees or direct settlements if neither We nor the 24-hour Emergency Medical Assistance Centre is contacted reasonably in advance with all relevant details as stated in Claim Condition 1.

Covered outpatient services are not subject to payment guarantees or direct settlement and must be paid by the Insured Person and reimbursed subsequently under the Policy.

If We make any payment under the payment guarantee or direct settlement when payment should have been made by the Insured Person, You shall reimburse the amount(s) paid by Us within thirty (30) days of being notified.

5. Approved Hospitals

The Company has made direct billing arrangements with many leading Hospitals and Physicians. Use of other Hospitals and Physicians will not invalidate a covered claim provided the notification of claim conditions of the Policy have been met and furthermore, that the Company's liability shall not exceed the level of charges that would have been



made at such approved Hospitals for providing similar treatment or services. The Company reserves the right to make appropriate reductions to the benefits payable in respect of treatment obtained from a Physician or Hospital which is not an approved Hospital if the charges incurred are not considered to be Reasonable and Customary.

6. Proof of Claim

Original documentation and receipts together with a fully completed Claim form signed by the treating Physician must be submitted to the Company within the time limits defined previously and before payment guarantees for inpatient treatment can be made. Photocopies are not acceptable. If, on the balance of medical fact or probability, it is appropriate for the Company to decline a claim by virtue of the Pre-Existing Conditions exclusion, the Insured Person shall have the right and obligation to produce such medical evidence as the Company may reasonably require to enable it to reconsider a claim under the Policy.

7. Examinations

The Company shall have the right and opportunity through its medical representatives to examine the Insured Person whenever and as often as it may reasonably require within the duration of any claim.

In addition, the Company shall have the right to require a post mortem examination, where this is not forbidden by law.

8. Legal Proceedings

No action in law or equity shall be brought to recover under the Policy until after the expiration of sixty (60) days from the date proof of claim has been furnished in accordance with the Policy conditions. The parties have agreed that the law of the country in which the Policy has been issued by the Company shall govern and control in the event of any conflict or dispute between the parties with regard to the Policy, and that the parties submit themselves to that exclusive venue and jurisdiction for the resolution of any such conflict or dispute.

9. Arbitration

Any difference of medical opinion in connection with the results of any Accident, illness, death or expense will be settled between two medical experts appointed respectively in writing by the two parties to the dispute.

Any difference of opinion between the two medical experts shall be referred to an umpire, who shall have been appointed in writing by the two medical experts at the outset.

MAKING A COMPLAINT

If you are dis-satisfied with any aspect of your policy, we want to know about it as soon as possible. It is only by receiving feedback that we can improve things if they go wrong.

Please contact Optimum Global in the first instance at:

Tel: +44 (0) 207 917 6247
www.optimumglobal.com

Email: enquiries@optimumglobal.com

A full copy of our complaints procedure is available to you, please contact us at the above details if you would like a copy.

WHAT WE DO NOT COVER

The following treatment items, conditions, activities and their related or consequential expenses are excluded from the Policy and the Company will not be liable for them:

1. Pre-Existing Conditions as defined unless otherwise declared on the application form and expressly confirmed acceptance by Us.
2. Routine medical examinations or check-ups (except when such benefit is covered under the well being benefit), routine eye or ear examinations, vaccinations, medical certificates, examinations for employment or travel, spectacles, contact lenses, cosmetic treatments and plastic surgery, all dental treatment or oral surgery related to teeth (except when such dental benefits are being covered under the policy), rest cures and services or treatment in any home, spa, hydro-clinic, sanatorium or long term care facility that is not a Hospital as defined.
3. Tests or treatment related to infertility, contraception, sterilisation, impotence, sexual dysfunction, birth defects, congenital illnesses, hereditary conditions or any abortion performed due to psychological or social reasons and consequences thereof.
4. Pregnancy or childbirth except when such benefits are shown in the Policy Schedule.
5. Any Emergency Medical Evacuation expense :
 - related to pregnancy or childbirth (except abnormal pregnancy or vital complication of pregnancy occurring within the first six (6) months of pregnancy which endangers the life of the Insured Person and/or any of her unborn children
 - any evacuation expense related to pregnancy or childbirth or miscarriage after the first six (6) months of pregnancy.
6. Cost of drugs prescribed by family doctor or specialist except when such benefits are stated in the benefit table.
7. Any costs relating to orthodontic treatment and related services.
8. Prosthesis, corrective devices and medical appliances which are not surgically required; treatment by a family member; and all treatment that is not scientifically recognised by Western European or North American standards except as defined and covered under Prescribed Alternative Medicine.
9. All costs relating to cornea, muscular, skeletal or human organ or tissue transplant from a donor to a recipient and all expenses directly or indirectly related to organ transplantation (except as defined under the Organ Transplantation Benefit).
10. Treatment of self-inflicted injury, suicide, abuse of alcohol, drug addiction or abuse and sexually transmitted diseases.
11. Any treatment or test in connection with Acquired Immune Deficiency Syndrome (AIDS) or any AIDS related conditions or diseases unless the Insured Member has been continuously insured under this Policy for five (5) consecutive years. If the condition is not pre-existing and has not been contracted within the first five (5) years of the Insured Member's coverage under this Policy, We will reimburse up to US\$1,000 per Policy Year and maximum US\$10,000 per life time.
12. Treatment which the Insured Person has elected to receive outside the Area of Cover except when it is for an Emergency Medical Complaint.
13. Experimental or pioneering medical and surgical techniques not commonly available which the Insured Person chooses to receive elsewhere in the world even though treatment usually and customarily provided for the medical condition concerned is available within the Area of Cover of the Policy.
14. Second opinions in respect of medical conditions which have already been diagnosed and/or treated at the date such second opinions are obtained unless considered by Our medical advisers to be reasonable and necessary having regard to the medical facts and circumstances.
15. Additional fees billed by a referring Physician for treatment given after the date on which an Insured Person has been referred to another Physician or Specialist.
16. Injury or illness while serving as a full-time member of a police or military unit and treatment resulting from participation in war, riot, civil commotion or any illegal act including resultant imprisonment.
17. Injury or illness sustained while the Insured Person has resided outside the pre-defined Area of Cover for more than forty-five (45) consecutive days during the Policy Year.
18. Outpatient services except as defined under the Outpatient Benefits.
19. Hospital inpatient treatment if the Insured Person could have been properly treated for the condition as an outpatient.
20. Travel costs in respect of trips made specifically for the purpose of obtaining medical treatment unless in the



course of an approved Emergency Medical Evacuation, and all Emergency Medical Evacuation costs which are not approved in advance by Us or Our appointed 24-hour Emergency Assistance Centre.

21. Hotel or non-Hospital accommodation costs except as provided for in the Policy.
22. Rock climbing, mountaineering, potholing, skydiving, parachuting, hang-gliding, parasailing, ballooning, all diving (unless the person concerned has been duly qualified and certified as a diver by an internationally recognised diving organisation or unless such person is at the time of the happening of the event giving rise to a claim actually receiving diving instruction from a duly qualified and certified diving instructor), racing of any kind other than on foot and all professional or inherently dangerous sports unless declared to and accepted by Us in writing prior to the event giving rise to a claim.
23. Costs or treatment after a renewal date (Due Date) arising from Accident, Illness or death occurring during the previous Policy Year unless stated otherwise in this Policy or in any written communication from Us to You.
24. Costs or benefits payable under any legislation or corresponding insurance cover relating to occupational death, Injury, Illness or disease.
25. Costs arising under any legislation which increases the cost of medical treatment and services received by the Insured Person above charge levels which would be considered Reasonable and Customary in the absence of such legislation.
26. Any treatment or expense in respect of persons less than fifteen (15) days old or more than eighty (80) years old at the date of the onset of the event giving rise to a claim unless We have, prior to the start of cover for that Insured Person, agreed to cover such treatment.
27. The cost of transporting an Insured Person by means of Your own or leased watercraft or aircraft or the cost of medical treatment given by the following parties unless We agree in writing to meet such costs:
 - Your personnel or at Your medical facilities
 - by a third party under a contract between that third party and You.
28. Costs arising out of any litigation or dispute between the Insured Person and any medical person or establishment from whom treatment has been sought or given, or any other costs not directly and specifically related to the payment of the medical expenses covered by the Policy.
29. Any loss or damage, cost or expense of whatever nature directly or indirectly caused by, resulting from or in connection with any of the following even though some other cause or event may contribute at the same time or in any other sequence to the loss:
 - a. ionising radiation or contamination by radioactivity from any

nuclear fuel or from any nuclear waste from the combustion of nuclear fuel

- b. the radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component
 - c. any weapon of war employing atomic or nuclear fission and/or fusion or other like reaction of radioactive force or matter.
30. Death, disability, loss, damage, destruction, any legal liabilities, cost or expense including consequential loss of every type which is, directly or indirectly caused by, resulting from or in connection with any of the following even though some other cause or event may contribute at the same time or in any other sequence to the loss:
- a. war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war is declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power; or
 - b. any act of terrorism including but not limited to
 - i. the use or threat of force, violence and/or
 - ii. harm or damage to life or to property (or the threat of such harm or damage) including, but not limited to, nuclear radiation and/or contamination by chemical and/or biological agents, by any person(s) or group(s) of persons, committed for political, religious, ideological or similar purposes, express or otherwise, and/or to put the public or any section of the public in fear; or
 - iii. any action taken in controlling, preventing, suppressing or in any way relating to (a) or (b) above.

If We say that because of this exclusion, any loss, damage, cost or expense is not covered by this Policy the burden is on You to prove otherwise.

RENEWAL OF YOUR POLICY

Your Policy will remain in force for a period of 12 months from the commencement date of your Policy, provided that all premiums due have been paid and that the Policy has not been terminated under Clause 10 of the General Conditions.

As the anniversary of your Policy approaches, We will write to you with the terms of the next period of coverage and the premiums due. If it is necessary to make changes to your Policy, they will only apply from your renewal date.

