Health Insurance

USVI PLAN Membership Guide

Your membership guide & policy conditions

IMPORTANT
You are requested to read this document.
It contains important information about Your Policy.

OPTIMUM GLOBAL
INTERNATIONAL INSURANCE SOLUTIONS

Welcome to Optimum Global

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 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

Contents

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.

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

Accidental Dental Treatment is Treatment necessary to restore or replace natural teeth, damaged or lost in a covered Accident. To be covered under this policy Accidental Dental Treatment must take place within fourteen (14) days of the date of the covered Accident.

Acute Conditions: An acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return You to the state of health You were in immediately before suffering the disease, illness or injury, or which leads You to Your full recovery.

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 dependants 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.

Applied behaviour analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.

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.

Assured, You, Your it means the Insured Person as shown on the Policy Schedule.

Autism services provider means any person, entity or group that provides treatment for autism spectrum disorders.

Autism spectrum disorders means the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

Behavioral therapy means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder, that are:

a. Provided to children younger than twenty-six years of age,

b. Provided or supervised by:
   a. a behavior analyst who is certified by the Behavior Analyst Certification Board,
   b. a licensed physician, or
   c. a licensed psychologist.

For the purposes of this definition "behavioral therapy" supervised by a "behaviour analyst" means supervised by a behavior analyst, licensed physician or licensed psychologist when the supervision entails at least one hour of face-to-face supervision of the autism services provider by such behavior analyst, licensed physician or licensed psychologist for each ten hours of behavioral therapy provided by the supervised provider.

Child Dependant coverage is available for the policyholder's dependant children up to the nineteenth (19th) birthday, if single, or up to their twenty fourth (24th) birthday if single and a 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 dependants continues through the policy's next anniversary date.

Chronic Condition: A chronic condition is a disease, illness or injury which has one or more of the following characteristics:

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests.
- It needs ongoing or long-term control or relief of symptoms.
- It requires Your rehabilitation, or for you to be specifically trained to cope with it.
- It continues indefinitely.
- It has no known cure.
- It comes back or is likely to come back.

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.

Dependant 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 You and any eligible dependants.

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.

Hearing Aid means durable medical equipment that is of a design and circuitry to compensate for impaired human hearing and optimize audibility and listening.

Home Country means the country declared on the Application Form. The Home Country of the Insured Person's Dependants 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.

In-patient 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 Dependant 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.

Material Fact means any fact or piece of information which We have asked for during the initial application process or during the renewal, which You should reasonably be expected to know.

Medical Condition any disease, illness or injury, including psychiatric illness.

Medically necessary means reasonably expected to do the following:
a. Prevent the onset of an illness, condition, injury, or disability;
b. Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or
c. Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

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.

Principal Country of Residence means the country in which the Insured Person usually lives/works for more than six (6) consecutive months as stated in the Application Form or any other country which We are asked to substitute as the Insured Person's new Principal 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 Principal Country of Residence if that Insured Person lives or intends to live in the other country for more than six (6) consecutive months.

Providers: Facilities and/or Physicians

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 is certified by a Specialist and Company Medical Adviser.

Third Party Administrator (TPA) means a company or organisation that We may contract with to provide local administration and claims handling services.

USA means United States of America, which is defined as there being fifty (50) states and Washington D.C.

Washington D.C. is a federal district under the authority of Congress. Local government is run by a mayor and 13 member city council.

The 50 other states are:
Alabama (AL), Alaska (AK), Arizona (AZ), Arkansas (AR), California (CA), Colorado (CO), Connecticut (CT), Delaware (DE), Florida (FL), Georgia (GA), Hawaii (HI), Idaho (ID), Illinois (IL), Indiana (IN), Iowa (IA), Kansas (KS), Kentucky (KY), Louisiana (LA), Maine (ME), Maryland (MD), Massachusetts (MA), Michigan (MI), Minnesota (MN), Mississippi (MS), Missouri (MO), Montana (MT), Nebraska (NE), Nevada (NV), New Hampshire (NH), New Jersey (NJ), New Mexico (NM), New York (NY), North Carolina (NC), North Dakota (ND), Ohio (OH), Oklahoma (OK), Oregon (OR), Pennsylvania (PA), Rhode Island (RI), South Carolina (SC), South Dakota (SD), Tennessee (TN), Texas (TX), Utah (UT), Vermont (VT), Virginia (VA), Washington (WA), West Virginia (WV), Wisconsin (WI) and Wyoming (WY)

For sake of clarity, the definition of USA for the purposes of scope of coverage hereon does not include the US Virgin Islands, Puerto Rico, Guam, American Samoa or the Northern Mariana Islands.

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. divulge matters which the Insured Person knows or ought to know as defined by Us
c. upon Our request sign any document to empower The Company to obtain relevant information, at the Insurer'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 or business 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 Dependant is in Hospital confinement on the date which insurance coverage is to be effective, coverage will not become effective until the Dependant is discharged. In the event of a newborn child, coverage will be incepted with effect from the birth day 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 or Family, 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, Principal 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, 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 Principal 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.

7. 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.

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

The Company can terminate the policy for reasons of nondisclosure, fraud or attempted fraud, on the following basis:

Non disclosure:

- Where the non-disclosure is deliberate and reckless, We will be entitled to void the policy and return any premiums paid, less any amounts that have been paid for claims under the policy.
- Where the non-disclosure is neither deliberate nor reckless, We may void the contract, refuse all claims and return the premiums previously paid if We would not have entered into the contract had all material facts been disclosed to Us.
- If We would have offered different terms had all material facts been disclosed to Us, the contract will be treated as if it had been entered into from inception on those different terms. If these different terms would have included a higher premium We reserve the right to collect the additional premium due, or reduce claim settlement proportionately.

Fraud or attempted 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 Dependant or anyone acting on their behalf to obtain benefit under this Policy;

- Where You commit any fraud in relation to a claim We will have no liability to pay the claim and We will be entitled to recover from You any claim settlements We have previously made on any claim which is later found to be fraudulent.
- We may give You notice that Your contract has been terminated with effect from the time of the fraudulent act. Upon termination We will have no liability for any claim that occurs after the fraudulent act.
- We will be entitled to void the policy and return any premiums paid, less any amounts that have been paid for claims under the policy.

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 when the following events first occurs:

a. the entire Policy is terminated as provided in Clause 8 of this section;

b. where the Insured Person is a Dependant and he or she is no longer qualified as a Dependant of the Eligible Person or when the Eligible Person is no longer insured under this Policy;

c. upon request for cancellation by You;

d. non-payment of premium after the premium Due Date as provided in Clause 12 of this section providing at least 15 days written notice is given to the insured or to their representative in charge of the subject of insurance, by either actual delivery or certified mail.

e. non-disclosure of Material facts as defined in Your Application Form, providing at least 15 days written notice is given to the insured or to their representative in charge of the subject of insurance, by either actual delivery or certified mail.

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 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 in full 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, premium must be received in full by the Policy commencement date. In the event an invoice is issued after the Policy commencement date, premium must be received in full within 14 days of the invoice date.

b. Where the premium is payable other than on an annual basis:

i. Premium must be received in full by the Policy commencement date for the first premium of the Policy period. In the event an invoice is issued after the Policy commencement date, premium must be received in full within 14 days of the invoice date.

ii. Premium must be received in full by Us by the agreed premium Due Dates for subsequent premiums.

c. Failure to comply with these premium payment guidelines may result in the termination of Your policy. Any reinstatement of Your policy is at Our discretion and may be liable to underwriting conditions.

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 time-frame after it has been issued, reinstated or renewed, We will refund any unearned premium. If We cancel, any unearned premium will be refunded on a pro rata basis. If an Insured cancels, any unearned premium refund may be less than 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 amend and change the applicants premium or cancel the Policy and refund all premiums paid (less any claims already paid).

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

16. 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 U.S. Virgin Islands.

17. The Insurer – Optimum Global Insurance Company Registered Office: PO Box 549, Town Mills, Rue du Pre, St Peter Port, Guernsey, GY1 6HS in respect of Optimum Global Insurance Company Limited.

18. Currency Payment Payment of all claims will be made in the currency You request on Your claim form unless this is a restricted currency, in which case payment will be made in the currency in which this policy is effected. Claim settlements are calculated on the basis of the exchange rate used by Us on the date the claims were assessed.

19. Limitation and Exclusion Clause No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom, Bailiwick of Guernsey or United States of America.

20. Entire contract; changes: This policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

21. Time limit on certain defenses:

(a) After three years from the date of issue of this policy, no misstatements except fraudulent misstatements made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three-year period.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of this policy.

22. Grace period: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force subject to the right of the insurer to cancel in accordance with cancellation provision hereof.

23. Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: Provided, however, That if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and the insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

24. Notice of claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (Caribbean Risk Group, Foothills Professional Building, 9151 Estate Thomas Suite 201, St. Thomas, VI 00802), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

25. Claim forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, the character and the extent of the loss for which claim is made.

26. Proofs of loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

27. Time of payment of claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

28. Payment of claims: The benefits provided under this policy will be payable to the insured, a network provider, or at the insurer's option, a non-network provider rendering services that would be covered under the policy.

29. Physical examinations and autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

30. Legal actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Insurance Cover

This document, together with Your insurance Schedule and benefit table, forms Your insurance policy. Your policy is issued by Optimum Global Insurance Company Limited, a Guernsey registered insurer licensed by Guernsey Financial Services Commission. Guernsey is a world-class financial centre renowned for clear regulation. Optimum Global Insurance Company Limited is provided with reinsurance security for the Optimum Global Health plans by AXA PPP healthcare Limited. AXA PPP healthcare Limited is part of the AXA Group, a global insurance company with a long experience in the insurance market of more than 70 years providing exclusive insurance services to more than 105 million clients in more than 54 countries around the world.

The AXA Group provide a wide range of products and services that meet the insurance, protection, savings, retirement and financial planning needs of millions of customers throughout the UK and the rest of the world.

*source axahealth.co.uk & axa.com

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 & Co-Payment

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 the 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 eligible medical expenses which are covered under the insurance.

Co-payment means the proportion of eligible medical expenses which are not covered under the insurance and must be borne by the Insured Person.

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 You need to do before You have treatment

You must contact Us when planning In-patient or daycare treatment (This is treatment for which You are admitted to hospital or clinic even if only for a few hours)

If the treatment is given as an emergency then You may not be able to contact Us beforehand. Do, however, ask someone to contact Us as soon as possible (ideally within 24 hours of admission) and make sure that, when you are admitted to hospital, the hospital is given Your membership details and proof of identity so that they can contact Us straight away in order that a Guarantee of Payment may be placed.

Please note that failure to obtain pre-authorisation for scheduled surgery may result in a higher than expected charge for Your treatment which We may not be able to settle in full. In such case You will have to pay the difference.

Contact Our 24 hour support line on 1 (833) 568 8286 24 hours a day 7 days a week.

Or contact Optimum Global on claims@optimumglobal.com (Monday – Friday 9am – 5pm, UK time)

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/Benefit table to determine the cover actually provided to the Insured Person concerned.

1. 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 in-patient to a hospital.

Cover includes:

- Pre-admission preparation and procedures in connection with the surgery without incurring any room and board charge.
- 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 fees,
- Operating theatre charges,
- Intensive care unit charges,
- Specialist consultations or visits
- All drugs, dressings or medications prescribed by the treating Physician for in-hospital use.
- Prescribed Post Hospital Treatment following an eligible In-hospital admission (up to max 30 days following discharge)

We do not pay for the costs of non-medically necessary goods or services including (but not limited to) items such as telephone, television, newspapers, and meals or accommodations of guests.

Rehabilitation

We do cover in-patient rehabilitation for a short period, but there are some limits to Our cover.
We will cover in-patient rehabilitation for up to 28 days, so long as:

- it is a part of treatment that is covered by Your policy
- it takes place in a hospital or unit that specialises in rehabilitation
- a medical practitioner who specialises in rehabilitation is overseeing Your treatment
- We have agreed the costs before You start rehabilitation
- the treatment could not be carried out on an out-patient basis.

If you have severe central nervous system damage following external trauma or Accident, We will extend this cover to up to 180 days of in-patient rehabilitation.
If you need rehabilitation, please contact Us so We can tell you if you are covered.

ii. Cancer Treatment Cover includes charges for the investigation and active treatment of cancer. This includes surgery, radiotherapy or chemotherapy, alone or in combination, oncology related tests, drugs and Specialist fees for treatment received as an in-patient or out-patient during a course of oncology treatment.

By course We mean a course of six cycles of chemotherapy or six weeks of radiotherapy. A 'cycle' of chemotherapy is determined by the number of sessions for which the drug is licensed. This will be determined by reference to AXA PPP healthcare's clinical panel in the United Kingdom on a case by case basis.

iii. Kidney Dialysis Treatment

Charges for treatment of an Insured Person for kidney dialysis, this includes treatment received as a registered in-patient or as an out-patient at a legally registered dialysis centre.

iv. Physiotherapy Treatment

If this benefit is listed on you benefit table, We will pay charges for physiotherapy treatment of an Insured Person which is received as a registered in-patient at a Hospital. After 10 sessions of physiotherapy, We will require a medical report to enable us to determine eligibility before We will pay for any further sessions.

v. Day Surgery

The cover provided by the Hospital Treatment & Services benefit extends to include Day Surgery and Surgery performed in an outpatient setting. This benefit 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. (This is subject to pre-authorisation see page 12).

vi. Psychiatric Treatment

We will pay for the costs of psychiatric treatment received as an in-patient 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.

vii. Hospital Accommodation for Accompanying Parent of Insured Child

If this benefit is listed on you benefit table, We will pay 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 in-patient for a period and the treating Physician has advised in writing that a parent should remain with the Insured child. This is paid from the insured child's policy.

viii. 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 Emergency 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.

ix. 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.

x. Home Nursing following Hospitalisation

Following discharge from Hospital, cost of the 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 twenty six (26) weeks in any one Policy Year and in total for any one claim or event.

xi. Hospital Cash Benefit

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 for each night the member is hospitalised, up to the sub-limits stated in the benefit Schedule and for a maximum of thirty (30) days per disability.

xii. Accidental Dental Treatment

If this benefit is stated on the Benefit Table, We will pay Dental Treatment required to restore or replace sound natural teeth lost or damaged in an Accident and for which treatment was received following the Accident and as an in-patient admission.

xiii. Chronic Medical Conditions

If this benefit is stated on the Benefit Table, We will pay as per i. Hospital Treatment & Services listed above to the amount detailed on Your table of Benefit Table for Your selected plan. If this benefit is not listed as a separate benefit on Your Benefit Table it will be paid as part of 1. Hospital & Related Services (and the sub benefits within) to the associated benefit amount of Your plan.

xiv. Congenital Conditions

If this benefit is stated on the Benefit Table, We will pay as per i. Hospital Treatment & Services listed above to the amount detailed on Your table of Benefit Table for Your selected plan.

2. Pre & Post Hospitilisation

i. Pre Hospitalisation Medical Expenses

If this benefit is stated on the Benefit Table, we will pay for the cost of Pre-admission preparation and procedures in connection with an in-patient surgery without incurring any room and board charge.

ii. Prescribed Post Hospital Treatment

If this benefit is stated on the Benefit Table, we will pay for any prescribed Post Hospital Treatment following an eligible In-hospital admission (up to max 30 days following discharge)

3. Organ Transplantation

All medically necessary costs of an operation for the transplantation of the kidneys, heart, liver, lung or bone marrow where the Insured Person is the recipient. 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 non 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. All eligible costs will be covered under this Organ Transplantation benefit without recourse to other benefit limits insured under this Policy.

4. Emergency Medical Evacuation & Repatriation

This benefit applies while You are travelling:

a. outside the Home Country or Principal Country of Residence on holiday or business, not exceeding forty-five (45) days per trip, and
b. within the Home Country or Principal Country of Residence but excluding war zones, countries where the prevailing conditions render evacuation and repatriation impractical.

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 in-patient 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.

This benefit may include moving You to another hospital which has the necessary medical facilities either in the country where You are taken ill or in another nearby country (evacuation) or bringing you back to Your Principal Country of Residence or Your home country (repatriation). The service includes any necessary treatment administered by the international assistance company appointed by Us whilst they are moving You.

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 Principal 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 Principal 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 Principal 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 Principal 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 Principal 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. This number can be found on the reverse of Your membership card. 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.

5. Out-patient Benefits
If these benefits are stated on the benefit table We will pay for eligible medically necessary treatment provided to an Insured Person who is not a registered in-patient at a Hospital and defined as:

i. Family Doctor Services and Prescribed Drugs
If this benefit is stated on the Benefit Table, We will pay for out-patient 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. We will pay up to a maximum supply of three months medication per prescription for any individual claim made. We will not pay for medication due to be taken after Your cover has ended.

ii. Specialist Services
If this benefit is stated on the benefit table, We will pay for Out-patient 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 up to the maximum limit per year.

iii. Drugs Prescribed by Specialists
If this benefit is stated on the benefit table, We will pay for prescribed drugs up to the maximum limit as stated in the benefit table. We will pay up to a maximum supply of three months medication per prescription for any individual claim made, provided there is more than three months to Your renewal date. We will not pay for medication due to be taken after Your cover has ended.

iv. Prescribed Medical Aids
Medical aids which are ordered by a Physician and are medically necessary such as artificial limbs, prosthesis following cancer treatment, or the rental or purchase of a wheelchair, crutches or walking frame. We will pay up to the maximum limit per year as stated on Your benefit table.

v. Chronic Medical Conditions
If this benefit is stated on the Benefit Table, We will pay as per 5. Out-patient Benefits (and the sub benefits within) listed above to the amount detailed on Your table of Benefit Table for Your selected plan. If this benefit is not listed as a separate benefit on Your Benefit Table it will be paid as part of 5. Out-patient Benefits (and the sub benefits within) to the associated benefit amount of Your plan.

vi. Out-patient 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 as stated on Your benefit table.

vii. Out-patient Psychiatric Treatment
If this benefit is stated on the Benefit Table, We will pay for out-patient Specialist consultations with a registered psychiatrist, or by a psychotherapist or psychologist when under the control of a 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.

viii. Prescribed Physiotherapy, Speech & Oculomotor therapy
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 as stated on Your benefit table.

ix. Accidental Dental Treatment

If this benefit is stated on the Benefit Table, We will pay 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. We will pay up to the maximum limit per year. 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. Prescribed Alternative Medicine

If this benefit is stated on the Benefit Table, We will pay for treatment of a specific medical condition by a qualified chiropractor, homeopath, osteopath, acupuncturist, podiatrist/ chiropodist or Chinese medicine physician. We will pay up to the maximum limit per year. 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.

xi. Emergency Room Accident & Emergency Services

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

xii. Vaccinations

If this benefit is stated on the benefit table, We will reimburse the cost of vaccinations up to the limits stated on Your benefit table. This includes childhood vaccinations and HPV vaccine.

xiii. 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 after the insured Person has been insured under this policy for a continuous period of twelve (12) months.

- Annual faecal occult blood test
- Blood tests (full blood count, biochemistry, lipid profile, thyroid function test, liver function test, kidney function test)
- Bone densitometry
- BRCA1 and BRCA2 genetic test
- Cancer screening
- Cardiovascular examination (physical examination, electrocardiogram, blood pressure)
- Chest X-ray
- Diabetic Screen
- ECG
- Mammogram
- Neurological examination (physical examination)
- PAP test
- Physical examination
- Urinalysis
- Well child test

6. Other benefits

i. Hearing Aids

If this benefit is stated on the Benefit Table, We will pay the full cost of one hearing aid per hearing impaired ear up to $2,200 per ear, every thirty-six months for medically necessary hearing aids for insured children under the age of 18 or under 21 if still attending high school.

Hearing aid coverage includes; the hearing aid evaluation; hearing aid selection; fitting and dispensing services; programming; repairs and modification; auditory training; and ear molds, as necessary to maintain optimal fit.

ii. Autism Spectrum Disorders

If this benefit is stated on the Benefit Table, cover is provided for the diagnosis of an autism spectrum disorder, and treatment when prescribed and ordered by a licensed physician, psychiatrist, psychologist or clinical social worker.

Cover includes consultations with a psychiatrist or psychologist; behavioral, physical, occupational and speech and language therapy; equipment determined necessary to provide evidence-based treatment; and prescription drugs prescribed by a licensed physician, physician's assistant or advanced practice registered nurse. Prescription drugs are subject to the outpatient drugs and dressings allowance on the policy.

iii. Virtual Doctor

If this benefit is stated on the Benefit Table, You can access a Virtual Doctor service for unlimited video appointments and telephone consultations. To register and use the service please visit: axaglobalhealthcare.com/doctor If the plan has an excess, you do not have to pay the excess if you claim for the Virtual Doctor service.

7. Complications of Maternity and Childbirth

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

- We will pay for additional costs incurred for the treatment of medical conditions as a direct result of pregnancy and childbirth complications. As an illustration We would consider treatment of the following:
  - Charges for surgery and related medical care for caesarean section, which is non-elective and medically necessary, when a Physician has certified in writing that a natural delivery will endanger the life of the Insured Person and/or her Child(ren).
  - ectopic pregnancy (where the foetus is outside the womb)
  - hydatiform mole (abnormal cell growth in the womb)
  - retained placenta (afterbirth retained in the womb)
  - placenta praevia
  - eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
  - diabetes (if you have exclusions because of Your past medical history which relate to diabetes, then you will not be covered for any treatment for diabetes during pregnancy)
- post-partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
- miscarriage requiring immediate surgical treatment
- charges for other necessary care which is provided during hospitalisation for pernicious vomiting in pregnancy

Optional Benefits, subject to additional premium

1. Maternity Benefit

If this benefit is stated on the Policy Schedule, 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.

i. Routine Maternity

- We will pay for in-patient or out-patient antenatal consultations, delivery and post-natal consultations for up to six weeks following birth as detailed in the benefit table, up to the usual amount charged by the medical practitioner for these services.
- We will pay for routine care and accommodation for Your baby for up to five days following the birth.
- Charges for surgery and related medical care for caesarean section which is elective and not medically necessary (i.e. a natural delivery will not endanger the life of the Insured Person and/or her Child(ren)) will be covered up to the customary and reasonable costs of a natural birth at the treating hospital.

ii Newborn Cover

- Any charges for non-routine medically necessary treatments of a newborn for the first thirty days following birth.

We do not cover any treatments for a baby born after taking any prescription or non-prescription drug or other treatment to increase fertility, or as the result of any methods of assisted conception, such as IVF where the baby requires treatment in Special Care Baby unit or requires paediatric intensive care.

2. Dental Benefit

If this benefit is stated on the Policy Schedule, We will pay for dental expenses up to the Sub-Limit stated in the Benefit Table 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 and claims conditions

The pre-authorisation and payment of all claims / treatment costs will be subject to Our clinical protocols and managed care programme. "Managed Care Programme" means a healthcare delivery arrangement designed to monitor and reduce unnecessary utilisation of services, to contain costs and to measure performance while providing accessible, quality and effective healthcare including the most effective and efficient utilisation of benefits available to each insured person.

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 to:

- 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 in-patient (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 as soon as reasonably possible after 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 in-patient treatment. A Claim form may be obtained from Your usual 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 and B and sign it. Bank details must be provided on each claim form submitted.
- the treating Physician or Dentist must complete all questions in Section C, affix his stamp on the Claim form and sign it.
- give Us all supporting medical information (including all relevant documents and bills) as soon as possible after such information is reasonably available, whichever is earlier. We will not accept photocopies of the relevant documents. Scanned copies of the completed claim form and supporting documents should be emailed to **claims@optimumglobal.com**. We reserve the right to request originals if deemed necessary.
- 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. We will pay claims in Your preferred currency, however if there is a restriction on the preferred currency We reserve the right to make payment in the currency Your policy is administered in.

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 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 out-patient 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
Documentation and receipts together with a fully completed Claim form signed by the treating Physician must be submitted to The Company as soon as practically possible. 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. 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.

What we cover

Making A Complaint

If You are dissatisfied 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 CRG in the first instance at:

Tel: 340-774-2323
www.optimumglobal.com

Email: customerservice@optimumglobal.com

A full copy of Our complaints procedure is available to You, please contact Us using 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. The cost of medical reports, completion of claim forms, administration charges or any reports unless confirmed by Us.

2. Pre-Existing Conditions as defined unless otherwise declared on the Application Form and expressly confirmed acceptance by Us. If You have been accepted on an MHD basis this exclusion does not apply.

3. Treatment which is not medically necessary or which may be considered a matter of personal choice.

4. Routine medical examinations or check-ups (except when such benefit is covered under the well being benefit), routine eye examinations, any treatment to correct problems of vision such as but not limited to long/short sightedness and astigmatism, routine ear examinations, 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, hydroclinic, sanatorium or long term care facility even if it is registered as a Hospital.

5. Treatment for developmental delay or behavioural problems in children whether physical or psychological or learning difficulties for more than the first 3 months following diagnosis and only once in the members lifetime except as shown in the Covered Expenses section for treatment of autism.

6. Test or treatment related to infertility, assisted conception, contraception, sterilisation or its reversal, impotence, sexual dysfunction, birth defects, Congenital illnesses unless as part of newborn benefit or listed as a separate benefit on Your benefit table, umbilical blood or stem cell storage or collection, hereditary conditions or any abortion performed due to psychological or social reasons and consequences thereof.

7. Pregnancy or childbirth except when such benefits are shown in the Policy Schedule.

8. 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.

9. Cost of drugs prescribed by family doctor or Specialist except when such benefits are stated in the benefit table.

10. Standard toiletries such as, but not limited to, shampoos, soaps, toothpastes, contraceptives, proprietary headache and cold cures, vitamins (even if prescribed), supplements (even if prescribed), dietary medicines, herbal products, cosmetic creams, weight control medicines, etc. which may be bought over the counter, with or without prescription, at a local pharmacy or similar.

11. Costs incurred for or related to any kind of bariatric surgery, regardless of the reason surgery is needed this includes but is not limited to the fitting of a gastric band or creation of gastric sleeve.

12. The removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons (including but not limited to breast reduction).

13. Any costs relating to orthodontic treatment and related services.

14. Prosthesis, corrective devices and medical appliances which are not surgically required.

15. Aids or devices that assist with nonverbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf, and memory books, except as shown in the Covered Expenses section for treatment of autism.

16. Treatment by a family member.

17. Treatment that is not scientifically recognised by Western European or North American standards except as defined and covered under Prescribed Alternative Medicine.

18. 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).

19. Treatment of self-inflicted injury, suicide or attempted suicide, or affray; in respect of affray We will only consider claims where there is clear evidence in a official police report that the member was not the aggressor, abuse of alcohol, drug addiction or substance abuse (whether or not related to psychiatric disorders) and sexually transmitted diseases such as but not limited to Chlamydia, genital herpes, HPV, syphilis, gonorrhoea or any consequences thereof.

20. Treatment related to sexual or gender reassignment or which arises from or is directly or indirectly made necessary by sexual or gender reassignment.

21. Any treatment or test in connection with Human Immunodefiency Virus (HIV) 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.

22. Treatment which the Insured Person has elected to receive outside the Area of Cover except when it is for an Emergency Medical Complaint.

23. Treatment which has not been established as being effective or which is experimental. However We will pay if, before treatment begins, it is established that the treatment is recognised as appropriate by an authoritative medical body and We have agreed with the medical practitioner what the fees will be. What constitutes experimental treatment will be determined by AXA PPP healthcare's Clinical Panel in the United Kingdom. The panel will base its decision on the recommendations of the National Insititute for Clinical Excellence (N.I.C.E) of the United Kingdom and with reference to other authoritative bodies around the world. The decision of the Clinical Panel will be binding in all cases. It is recommended that You contact Us before undergoing any treatment which may fall into this category to ensure that it will be covered by Your plan.

24. We do not pay for genetic screening tests to check whether you have a medical condition when you have no symptoms or if you have a genetic risk of developing a medical condition in the future; or to find out if there is a genetic risk of you passing on a medical condition; or where the result of the test wouldn't change the course of treatment. This might be because the course of treatment for your symptoms will be the same regardless of the result of the test or what medical condition has caused them; or that themselves are unproven or where they are used to direct treatment that is not established as being effective or is unproven.

25. 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.

26. 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.

27. 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.

28. 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.

29. Out-patient services except as defined under the Out-patient Benefits.

30. Hospital in-patient treatment if the Insured Person could have been properly treated for the condition as an out-patient. This includes rehabilitation.

31. We will only cover hormone replacement therapy (HRT) that is required following a medical intervention. We will pay for the medical practitioner's consultations and the cost of HRT implants, patches or tablets for a maximum of 18 months following the intervention. Patches and tablets are subject to Your out-patient drugs and dressings limit.

32. We do not cover investigations (including diagnosing hair loss type), management or advice for, or treatment for hair loss. We will only provide cover for the investigation and treatment of an underlying medical condition.

33. 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.

34. Hotel or non-Hospital accommodation costs except as provided for in the Policy.

35. We do not cover treatment of injuries that are as a result of training for or taking part in any sport for which You:

- are paid
- receive a grant or sponsorship (We do not count travel costs in this), or
- are competing for prize money.

We do not cover treatment of injuries that are sustained when taking part in the following sports and activities:

- base jumping
- cliff diving
- flying in an unlicensed aircraft
- free climbing
- scuba diving to a depth of more than 10 metres, or to a depth of more than 30 metres if You hold an appropriate diving qualification or You are being instructed by an appropriately qualified diving instructor, for example an instructor recognised by PADI (Professional Association of Diving Instructors)
- any activity at a height of over 5,000 metres above sea level
- canyoning
- skiing off piste, or any other winter sports activity carried out off piste without an instructor with the appropriate qualifications.

36. 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.

37. Costs or benefits payable under any legislation or corresponding insurance cover relating to occupational death, Injury, Illness or disease.

38. 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.

39. 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.

40. 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.

41. 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 unless incurred as an innocent bystander and relevant benefits detailed on the Table of Benefits.

a. war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war is declared or not), active involvement in criminal activity, 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.

OPTIMUM GLOBAL

INTERNATIONAL INSURANCE SOLUTIONS

www.optimumglobal.com

107498 UNI / 032023