



APG Health Care Plan
Membership guide
Valid from December 2010 • USD



APG Health Care Plan

Being abroad can present you with all kinds of challenges. Standards of health care, and even medical practice patterns, vary from country to country. While many countries today have high medical standards and low medical risk, some parts of the world still have higher medical risks due to disease, suspect water supplies or public hygiene.

ihi Bupa puts your health first by offering insurance plans suitable for customers requiring international health coverage and advise on health and wellbeing.

We want to make sure that customers with special needs are not excluded in any way. We offer the choice of Braille, large print or audio for your letters and literature. Please let us know should you require one of these.

ihi Bupa - a company you can trust

We have built up a global network of business partners and well-respected medical consultants. We are authorized and regulated by the Financial Services Authority (the UK

insurance authority). ihi Bupa is a part of the worldwide health insurance

organization Bupa International, which has over 35 years' expertise in caring for the healthcare needs of expats, local nationals and their families around the globe.

Covering almost 800,000 people in 190 countries, Bupa International is the world's largest international health insurer for expatriates, providing quality individual and group medical coverage to people living in their home country or abroad.

In order to provide APG members with high quality worldwide medical coverage, ihi Bupa has prepared this special APG Health Care Plan. It provides coverage for hospitalization, outpatient treatment, medicine, and medical evacuation.

Key benefits

Worldwide coverage

You are covered anywhere in the world and there is no limit on the time you can spend abroad, whether you are travelling on business or on holiday or if you have homes in several countries.

Free choice

Because our plans are truly international, you can choose to have treatment anywhere in the world. You are in charge when it comes to choosing a hospital, clinic or any qualified doctor or specialist you wish to consult. We do not limit your choice through networks, but we can give you advice on appropriate places of treatment for specific illnesses or the names of generally recommended hospitals and specialists.

Occupations and activities

Whatever your work involves or wherever it may take you, you will be covered. There are no restrictions on hobbies or sports of any kind, even if conducted on a professional level.

Accidents

You are covered for health care benefits arising as a result of an accident (whether work-related or not).

Insurance sums

In each policy year there is a maximum overall coverage per person, which is renewed every policy year regardless of the number of claims you have presented. There is no lifetime maximum coverage.

The annual maximum cover under APG Health Care Plan is USD 1,000,000 per person, per policy year, which offers you peace of mind.

Deductible

There is only one deductible per person per policy year and this applies to all services.

In case of an accident involving 3 or more insured family members, only the highest deductible will apply.

Co-insurance

Co-insurance is the part of the medical bills you must pay on each hospitalisation that takes place in the U.S. and Canada. This means that once the deductible and the specific limits have been applied, the Company will reimburse 80% of the first USD 5,000 and 100% of the remaining balance.

Application procedures

Coverage under the Plan

In order to be covered under the APG Health Care Plan, you must complete one Application Form A per family.

Once completed, the form should be returned to your APG contact in Kingston.

Contacts at APG

In case you have questions, please call your local contact.

Name: Sandra Spalding

E-mail: apghealth@gmail.com

Phone: 876 978 5854
876 978 4083
954 281 8592

Office hours: Monday - Friday 8:30am to 4:30pm

Eligible family members

APG will define the eligible persons who may be enrolled under this plan.

Under this group scheme, we have incorporated coverage for dependents.

The dependents of the APG members who meet the following criteria are eligible for medical coverage under this plan:

- **Spouse:** including common law as defined by legislation in the employee's home country, unless legally separated.
- **Children:** unmarried, natural or legally adopted children of your spouse or yourself.

A child whose parent is eligible for maternity coverage, is automatically enrolled in the parent's policy regardless of the child's state of health. Even congenital and hereditary conditions will be covered. Upon the birth of the child, you must notify your APG contact in Kingston.

Upon becoming 19 years old, the child automatically continues the insurance paying a student premium (if full time student), or an adult premium with the same conditions without having to undergo new medical underwriting.

Lifetime Guarantee

For people living in a foreign country, private medical insurance is a vital factor. ihi Bupa offers a guarantee that your coverage can stay with us as long you need it. This benefit is available, on an individual basis, transferring to a similar ihi Bupa plan.

The transfer possibility and the lifetime guarantee for individual coverage (post APG) is optional and requires medical information at the time of registration in the new plan by filling out a medical questionnaire that can be required by your local contact, Sandra Spalding.

The key points about the Lifetime Guarantee benefit are:

- At the appropriate time, you can have a smooth transition from the APG Plan to a similar ihi Bupa plan, on an individual basis.
- Your medical insurance premium for your post-APG situation will be based on your health condition when you joined the Plan.
- ihi Bupa will contact you with the result of the evaluation of your medical questionnaire. Once you are

accepted for the Lifetime Guarantee, any subsequent medical condition while working at APG will not negatively impact your later coverage.

- You are not obliged to take out the Lifetime Guarantee. However, it is essential that you submit your medical questionnaire to ihi Bupa immediately if you wish to avoid problems and retain medical coverage when you leave APG, or when a dependent ceases to be eligible.
- If you would like to continue coverage with an individual policy, it is important that you inform your administrator for further information no later than the date your policy will be cancelled.

Enrolment in the Lifetime Guarantee

The medical information that you send to ihi Bupa will continue to be valid, and your future coverage will be based on this information.

ihi Bupa will assess your state of health and confirm in writing to you under what conditions we will be prepared to cover you (i.e. totally, with an exclusion, or a premium loading) the day you leave APG.

In some situations we may need to receive further medical information in order to assess your state of health and provide confirmation that you will be covered after leaving APG. Failure to request our assessment of your health in good time could result in a situation where ihi Bupa cannot offer individual coverage when you leave APG. In very rare cases, a previous medical history may mean that we reject your application.

When does coverage start

As a general rule, there is a waiting period of 4 weeks from the policy commencement date before coverage is be effective. However, there are certain exceptions to this rule:

In the event of injury or serious acute illness, you are covered immediately. Expenses related to pregnancy and childbirth are covered when the insurance has been in effect for 10 months.

USA Medical Services

One of the advantages of being a customer at ihi Bupa is our medical center: USA Medical Services. Our professional, careful and service minded staff are ready to assist you 24 hours a day, 365 days a year, and several of our own medical consultants are always on duty.

Our medical center gives you:

- Assistance in case of illness and emergency, including arrangement of medical evacuations
- Assistance in practical matters related to a hospitalization.
- Guidance when finding the right place of treatment. You only need to send us medical information together with the diagnosis, and we will provide you with information on relevant and appropriate places of treatment in the countries of your choice.
- Access to medically qualified representatives with extensive experience in the industry to help you avoid or reduce unnecessary medical expenses and overcharges

- Advice when planning journeys abroad
- Access to national and international networks of doctors, clinics, ambulance companies, hospitals, etc.

The purpose of our team of medical consultants is to give advice should you become ill and ensure that immediate and correct treatment is arranged. The team is carefully put together and includes several medical consultants.

We are often in contact with nurses and doctors at the hospitals before, during and after the course of treatment, and we get many questions in connection with routine treatments, hospitalizations and evacuations that can be answered immediately due to the experience and



knowledge of our doctors, nurses, and medical coordinators.

USA Medical Services has access to our policy and service systems and cooperates closely with your service team, so the solution is tailored to your specific needs. We have in-depth knowledge about the specific different insurance products to make the correct decisions - fast and efficiently. USA Medical Services is your direct line to medical expertise.

24-Hour Service

Our office in Miami is open from 9:00 am to 5:00 pm EST, Monday to Friday.

However, through our 24-hour emergency service-USA Medical Services-you can always reach us wherever you are and at any time of the day or night you require our assistance.

On the back of the insurance card you will find the telephone number for the 24-hour emergency service together with information about other ways of contacting ihi Bupa.

USA Medical Services

USA Medical Services is serviced by multilingual employees who will assist you in case of an emergency.

You can e-mail or call our 24-hour emergency service free of charge at:

Tel: +1 305 275 1500

Fax: +1 305 275 1518

Toll free: +1 (800) 726-1203

E-mail: usamed@usamedicalservices.com

The insurance card

Each insured person will receive a personal identification card. You should always carry your card with you, as it serves as proof to the hospital of your health insurance and can prevent any issues about payment.

List of Reimbursements

Valid from December 1, 2010

Please review the glossary at the end of this insurance guide where certain words are defined or explained further.

All amounts are in USD

Maximum Coverage	Worldwide	US Network
Maximum coverage, per person, per policy year	1,000,000	1,000,000

Hospitalization		
Private or semi-private room, per day Max. 240 consecutive days	1,000	100%
Intensive care room, per day Max. 180 consecutive days	2,200	100%
Room and board at the hospital for a relative accompanying an insured person under 18, per day	300	100%
Surgery	100%	100%
Anesthesia	100%	100%
Medical treatment, laboratory tests , X-rays	100%	100%
Medicine treatment during hospital stay	100%	100%
Chemotherapy and radiation for treatment of Cancer	100%	100%
Dialysis for treatment of kidney failure	100%	100%
Prostheses, corrective devices, and medical appliances which are medically and surgically required	100%	100%
Organ transplant Max. per diagnosis and course of treatment, all inclusive <i>Only human organs. The procurement of the organ must be pre-approved by the Company.</i>	300,000	100%

Childbirth		
Normal and complicated delivery, all inclusive max.	10,000	100%
Elective caesarean delivery, all inclusive max.	10,000	100%

The maternity benefit is subject to the deductible but no co-insurance.

Pre-natal and post-natal care is reimbursed according to the rates for non-hospitalization treatment.

Day Case Treatment		
Ambulatory surgery in hospital/clinic	100%	100%
One day pre-surgical analysis preparing for anesthesia in connection with a scheduled surgery	100%	100%
Emergency room treatment in connection with acute illness or accident	100%	100%
Chemotherapy, radiation, and dialysis	100%	100%
Emergency dental treatment due to serious accident	100%	100%
Prescribed Rehabilitation Following Hospitalization	Worldwide	US Network
Medically prescribed rehabilitation at an authorized rehabilitation center following hospitalization due to serious accident or injury, max. per day, all inclusive For max. 30 days per incident	525	525
<i>Rehabilitation must be pre-approved by the Company</i>		

Home Nursing (30 days per incident)		
Medically prescribed home nursing by a registered nurse following hospitalization due to serious accident or injury, max. per day, all inclusive For max. 30 days per incident	200	100%
<i>Home Nursing must be pre-approved by the Company</i>		

Outpatient Benefits		
Doctors, max per consultation	100	100%
Specialists, max. per consultation	100	100%
Surgical intervention in consultation, up to max.	500	100%
Psychiatrists, per consultation	100	100%
<i>Max. 30 consultations with doctors, specialists, or psychiatrists, per policy year.</i>		
Health check-up, max. per policy year, all inclusive (not subject to deductible)	200	200
Prescribed dietetic guidance by an authorized dietician, 4 consultations per policy year, max. per consultation	70	100%
Chiropractor, max. per consultation	60	100%
Physiotherapy, including treatment, max. per consultation	60	100%
<i>Max. 40 consultations with chiropractors or physiotherapists per policy year.</i>		
Echocardiography, ultrasound, etc., max. per exam all included	600	100%

MRI scan, max per scan, all included	600	100%
CAT scan, max per scan, all included	600	100%
Endoscopy, gastroscopy, colonoscopy, cystoscopy, max per exam, all included	600	100%
X-rays, max. per exam, all included	300	100%
Laboratory tests, max. per exam, all included	250	100%
Prescribed medicine, max per policy year	1,500	1,500
Vaccinations for children up to 17 years old, up to USD100 each membership year.		

Outpatient Dental & Optical Coverage

Max. per policy year	2,000	2,000
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Ground Transportation

Emergency transportation to hospital by local ground ambulance	1,500	1,500
Air ambulance, max per policy year	75,000	75,000

Co-insurance in USA and Canada (hospitalization)	1,000	1,000
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Hereinafter, 80% of the first USD 5,000 and 100% of sums in excess of USD 5,000 up to the relevant reimbursement rates.

Policy Conditions

APG Health Care Plan

Valid from December 1, 2010

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Art 1. Acceptance of coverage

1.1: Bupa Insurance Limited, hereinafter called the Company, shall accept enrolments of all APG members (and their dependents) and affiliates invited to participate in this plan by APG in Kingston, Jamaica. In order for coverage to be accepted and the Company to become your insurer, the enrolment form must be duly signed by the applicant and confirmed by APG, and the necessary premium paid to the Company.

Art. 2 Commencement date

2.1: The insurance shall be valid as of the date on which the application is approved by the Company. The date of commencement is stated in the policy schedule.

Art. 3 Waiting periods in connection with new insurance contracts

3.1: When a new insurance contract is entered into, the right to reimbursement under the new insurance contract shall take effect 4 (four) weeks after the date of commencement of the insurance.

3.1.1: In the event of acute serious illness or serious injury, the right to reimbursement shall, however, take effect concurrently with the

date of commencement of the insurance.

3.1.2: However, for pregnancy and childbirth and consequences thereof, the right to compensation shall only take effect 10 (ten) months after the date of commencement of the insurance.

Art. 4 Who is covered by the insurance?

4.1: The insurance shall cover the insured person(s) named in the policy schedule, including children registered therein.

4.2: Free coverage for children is subject to:

- the child being registered with the Company,
- one of the insured persons having legal custody of the child, and
- the child being registered at the same address as the insured having legal custody of the child.

4.2.1: Children are covered as follows:

- ages 0-18 are covered free of charge
- ages 19-24 must present written proof of being a student

4.3: An application form must be submitted for newborn children.

4.3.1: If the insurance of one of the parents has been valid for a minimum of 10 (ten) months, newborn children can be insured without submitting an application form, cf. however Art. 8.2 h). However, a copy of the birth certificate must be submitted within 3 (three) months after the birth. If the birth certificate is not submitted to the Company within 3 (three) months after the birth, a Medical Questionnaire must be submitted for the child, who has to undergo the standard underwriting procedure according to Art. 1. Registration of the child will take place from the date the Medical Questionnaire has been signed.

4.3.2: In case of adoption, the insured must submit a Medical Questionnaire for the adopted child.

Art. 5 Where is coverage provided?

5.1: The insurance shall provide worldwide coverage unless otherwise stated in the policy schedule.

Art. 6 What is covered by the insurance?

6.1: The insurance shall cover the insured's medical expenses

in accordance with the coverage chosen and the applicable reimbursement rates. The valid reimbursement rates are stated in the List of Reimbursements.

6.2: Reimbursement shall be paid following the Company's approval of the expenses as being covered by the insurance after a fully completed claim form with original, receipted and itemised bills enclosed has been submitted to the Company.

6.3: Once the covered expenses have met the annual deductible, the reimbursable amount will be paid. The deductible shall be reduced with amounts not exceeding the maximum rates specified in the valid List of Reimbursement. The deductible shall apply per person per policy year. Each hospitalization in the U.S.A. and Canada is subject to co-insurance. Once the applicable deductible and specific limits have been met, the Company reimburse 80% of the first USD 5,000 and 100% of sums in excess of USD 5,000 up to the relevant reimbursement rates.

6.3.1: In case of accident where 3 or more family members insured with the Company are involved, only one deductible is applied.

6.4: Physicians, specialists, etc. performing the treatment must have authorization in the country of practice. Furthermore, the method must be approved by the public health authorities in the country where the treatment takes place. Methods of treatment not yet approved by the public health authorities, but under scientific research will only be covered if approved in advance by the Company's medical consultants.

6.5: In no event shall the amount of reimbursement exceed the amount shown on the bill. If the insured receives reimbursement from the Company in excess of the amount to which the insured is entitled, the insured shall be under an obligation to repay the Company for the excess amount immediately. Otherwise, the Company will set off the excess amount in any subsequent payments made to the insured.

6.6: Reimbursements payments shall be limited to the usual, customary and reasonable charges in the area or the country in which the treatment is provided.

6.7: Any discount, which has been negotiated directly between the Company and providers, will be specifically used by the Company for the overall benefit

of the insured persons within the insurance product as a whole.

6.8: Any ex-gratia payments are at the Company's discretion. If the Company makes a payment to which the insured is not entitled under the insurance, this will still count toward the annual maximum cover per person per policy year.

Art. 7 Air ambulance coverage

7.1: The special conditions listed below shall apply for coverage or air ambulance:

7.1.1: The sum insured for air ambulance coverage is stated in the List of Reimbursements.

7.1.2: Reimbursement shall be paid for reasonable expenses incurred by the insured for air ambulance transportation in the event of acute serious illness or serious injury. Transportation shall be to the nearest suitable place of treatment and only if no qualified treatment can be obtained locally.

7.1.3: The expenses for an air ambulance transportation covered under the Insurance, but not arranged by the Company, shall only be reimbursed for an amount equivalent to the expenses the Company would have incurred

had the Company arranged the transportation.

7.1.4: Cover shall be provided subject to the attending physician and the Company's medical consultant agreeing on the necessity of transferring the insured, and agreeing on whether the insured should be transferred to his/her country of residence or to the nearest suitable place of treatment.

7.1.5: The insurance shall cover reasonable and necessary transportation expenses for one person accompanying the insured.

7.1.6: Only one transportation is covered in connection with one course of an illness.

7.1.7: Air ambulance coverage shall only apply if the illness is covered under the insurance.

7.1.8: In the event that the insured is transported for the purpose of receiving treatment, he/she and the accompanying person, if any, shall be reimbursed for the expenses for a return journey to the insured's place of residence. The return journey shall be made at the latest 90 (ninety) days after the treatment has been completed. Coverage shall only be provided for travelling expenses equivalent

to the cost of an airplane ticket on economy class, as a maximum.

7.1.9: In the event that the insured has received treatment covered by the insurance, but now has reached the terminal phase, he/she and the accompanying person, if any, shall be reimbursed for the expenses of the return journey to the insured's place of residence.

7.1.10: The company cannot be held liable for any delays or restrictions in connection with the transportation caused by weather conditions, mechanical problems, restrictions imposed by public authorities or by the pilot, or any other condition beyond the Company's control.

7.2: In the event of the insured's hospitalization abroad, reimbursement shall be paid for expenses incurred by the insured's spouse for emergency air travel to the place of hospitalization.

7.2.1: The covered expenses include one return transportation on economy class. The return journey the insured's spouse must be made at the latest at the time of the return journey of the patient.

7.2.2: The expenses shall only be compensated under the

Air Ambulance supplementary insurance.

Art. 8 Exceptions to reimbursement

8.1: The insurance shall not cover medical expenses incurred for any disease, illness or injury known to the policyholder and/or the insured at the time of application, unless agreed upon with the Company.

8.2: Furthermore the Company shall not be liable to pay reimbursement for expenses which concern, are due to, or are incurred as a result of:

- a) cosmetic surgery and treatment unless medically prescribed and approved by the Company;
- b) obesity surgery, unless approved by the Company;
- c) venereal diseases, AIDS, AIDS-related diseases and diseases relating to HIV antibodies (HIV positive). However, diseases related to AIDS and HIV antibodies (HIV positive) are covered, if proven to be caused by a blood transfusion received after the commencement of the policy. The HIV-virus will also be covered if proven to be contracted as the result of an accident occurring during

the course of the following occupations only: doctors, dentists, nurses, laboratory personnel, ancillary hospital workers, medical and dental assistants, ambulance personnel, midwives, fire brigade personnel, policemen/women, and prison officers. The insured shall notify the Company within 14 (fourteen) days after such accident and at the same time provide a negative HIV antibody test;

- d) abuse of alcohol, illegal drugs, and/or medicines;
- e) intentional self-inflicted bodily injury;
- f) contraception, including sterilization;
- g) induced abortion unless medically prescribed;
- h) any kind of fertility test and/or treatment, including hormone treatment, insemination, or examinations and any procedures related hereto, including expenses for pregnancy, pre-natal and post-natal treatments of the newborn child/children. An application form must therefore be submitted for children born as a result of fertility treatment and/or born by a surrogate mother. The applicant will undergo

- the standard underwriting procedure, according to Art. 1;
- i) treatment of sexual dysfunction;
 - j) any kind of care which is not part of a medical or surgical treatment, including stays in long-term care establishments, health resorts, convalescent homes and similar institutions;
 - k) treatment by naturopaths or homeopaths and naturopathic or homeopathic medications and other alternative methods of treatment;
 - l) routine medical examinations, unless specified in the reimbursement list, vaccinations, injections, the issue of medical certificates and attestations and examinations as to suitability for employment or travel;
 - m) treatment of diseases during military service;
 - n) treatment for sickness or injuries directly or indirectly caused while actively engaging in:
 - war, invasion, acts of a foreign enemy, hostilities (whether war has been declared or not), civil war, terrorist acts, rebellion, revolution, insurrection, civil commotion, military or usurped
 - power, martial law, riots or the acts of any lawfully constituted authority, or army, naval or air services operations, whether war has been declared or not;
 - o) nuclear reactions or radioactive fallout;
 - p) treatment performed by the insured, his/her spouse, parents, or children, or any enterprise owned by one of the aforesaid persons;
 - q) epidemics which have been placed under the direction of public authorities;
 - r) treatment by psychologists;
 - s) medicines, unless specified in the reimbursement list, medical articles and auxiliary appliances which have not been administered during hospitalization;
 - t) Hospitalization if the sole purpose is the administration of medicine, treatment by a therapist or complementary medical practitioner, or any other treatment when this could take place as outpatient treatment.

Art. 9 How to report a claim

9.1: A fully completed Claim Form must be submitted to the Company for each claim. The Claim Form must be completed and signed by the attending

physician and accompanied by the official, original and itemized bills and receipts for the treatment received. Photocopies shall not be regarded as acceptable documentation.

9.2: Written proof of claim must be submitted to the Company immediately and at the latest within 90 (ninety) days of the insured event for which the claim is brought.

9.2.1: Complaints regarding the Company's claims handling shall be filed not later than 30 (thirty) days after receipt of the amount of reimbursement.

9.3: The Company shall be notified immediately of any stays in hospital, and such notification must include the physician's diagnosis. All notifications should be made by telephone, fax or mail; the Company shall defray all expenses incurred in this connection.

9.3.1: All treatment within the UHC provider network must be pre-approved by the Company. If the Company is not contacted for pre-approval, the expenses will be reimbursed according to the out-of-network limits stated in the valid List of Reimbursements. If due to an emergency, the insured is not reasonably able to contact

the Company for pre-approval, the insured must let the Company know of any admission to a hospital with 72 (seventy-two) hours.

9.3.2: If during the approval phase, it becomes evident that the Company's network of providers cannot offer the treatment in question, the Company will reimburse the expenses as if they had taken place within the network of providers.

Art. 10 Coverage by third parties

10.1: Whenever there is coverage by another insurance policy or healthcare plan, this must be disclosed to the Company when claiming reimbursement.

10.2: Under these circumstances the Company will co-ordinate payments with other insurance companies, and the Company will not be liable for more than its ratable proportion.

10.3: If the claim has been covered in whole or in part by any scheme, program, or similar, or funded by any government, the Company shall not be liable for the amount covered.

10.4: The policyholder and any insured person undertakes to cooperate with the Company

and to notify the Company immediately of any claim or right of action against third parties.

10.5: Furthermore, the policyholder and any insured person will keep the Company fully informed and will take any reasonable step in making a claim upon another party and to safeguard the interests of the Company.

10.6: In any event, the Company shall have the full right of subrogation.

Art. 11. Payment of Premium

11.1: APG is responsible for payments of the total premium to the Company. Contribution made by Plan members towards the total premium will be deducted from salary on a monthly basis.

11.2: Premiums are determined by the Company and shall be payable in advance. The Company' adjusts the premiums once a year as from the anniversary date on the basis of the loss experience in the group during the previous year.

11.3: The policyholder shall be responsible for punctual payment to the Company and, if a premium is not received by the Company within the 10 (ten) days grace

period at any premium due date, the Company's liability shall lapse.

11.4: Depending on your country of residency and type of policy purchased, you may be subject to applicable taxes or other charges which may be collected and included as part of your total invoiced premium.

Art. 12 Information necessary to the Company

12.1: The policyholder and/ or the insured shall be under an obligation to notify the Company in writing of any changes of name or address and changes in health insurance cover with another company, including a consolidated company. The Company must also be notified in the event of death. The Company shall not be liable for the consequences if the policyholder and/or the insured fails to notify the company of such events.

12.2: The insured shall also be under an obligation to provide the Company with all obtainable information required for the Company's handling of the insured's reasonable claims against the Company.

12.3: In addition, the Company is entitled to seek information about the insured's state of health and

to contact any hospital, physician, etc. who is treating or has been treating the insured for physical or mental illnesses or disorders. Furthermore, the Company is entitled to obtain any medical records or other written reports and statements concerning the insured's state of health.

Art. 13 Assignment, cancellation and expiration

13.1: Cancellation of the insurance takes place automatically upon leaving APG. Should a Plan member wish to continue health care coverage on a private basis, the policyholder must contact ihi Bupa directly.

Art. 14 Complaints

14.1: Making a Complaint: We are pleased to hear about any aspect of your insurance coverage that you have particularly appreciated. We work hard to provide you with the best quality service. However, if we have not met your expectations, we have a simple procedure

to ensure your concerns are dealt with as quickly and effectively as possible. If you have any comments or complaints, you can call the ihi Bupa Customer Service at +1 305 270 3944.

Alternatively you can e-mail at premier1@bupalatinamerica.com, or write to us at

USA Medical Services
7001 SW 97th Avenue
Miami, Florida 33173, USA

14.2 Taking it further: If we have not been able to resolve the problem and you wish to take your complaint further, please contact the Complaints Manager at +1 305 270 3944 or by mail at

Complaints Manager
USA Medical Services
7001 SW 97th Avenue
Miami, Florida 33173, USA

It is very rare that we cannot settle a complaint, but if this does happen, you may be entitled to refer your complaint to an independent organization for review. The organization will depend on the nature of the complaint and the location of the ihi Bupa office where the cause of the complaint occurred. We will provide you with that information when needed. In most cases this will either be the Danish Insurance Complaints Board or the UK Financial Ombudsman Service. If you would like further information about the Danish Insurance Complaints Board you can

- Write to them at Anker Heegaards Gade 2, DK-1572 Copenhagen V, Denmark
- Call them at Tel. +45 (0) 33 15 89 00
- Find details on their website at www.ankeforsikring.dk

If you would like further information about the UK Financial Ombudsman Service you can

- Write to them at: South Quay Plaza, 183 Marsh Wall, London E14 9JR, UK
- Call them at: Tel: 0845 080 1800 or +44 (0) 20 7964 1000
- Find details on their website: www.financial-ombudsman.org.uk

Please let us know if you want a full copy of our complaints procedure. (None of these procedures affect your legal rights).

Art. 15 Confidentiality

15.1 The confidentiality of patients and customer information is of paramount concern to the companies in the Bupa Group. To this end, ihi Bupa fully complies with the Data Protection Legislation and Medical Confidentiality Guidelines. ihi Bupa sometimes uses third parties to process data on our behalf. Such processing, which may be undertaken outside the European

Economic Area (EEA), is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Art. 16 Applicable law

16.1 Your insurance policy is governed by Danish law. Any dispute that cannot otherwise be resolved will be dealt with by courts in Denmark. If any dispute arises as to the Interpretation of this document, the English version of this document shall be deemed to be conclusive and taking precedence over any other language version of this document. You can obtain a copy at any time by contacting our Customer Service at +1 305 270 3944.

Glossary

The Glossary is guidance to your understanding of some of the terminology:

Acute serious illness: an “acute serious illness” shall be determined to exist only after review and agreement by both the attending physician and the Company’s medical consultant.

Anniversary date: 12 (twelve) months from the commencement date and the same date in each year thereafter.

Applicant: a person named on the application form and the medical questionnaire as an applicant for insurance.

Application: the application form and medical questionnaire.

Claim: the economical demand covered in whole or in part by the insurance. In the Company’s evaluation/determination of the claim, the time of treatment is decisive, not the time of the occurrence of the injury/illness.

Co-insurance: that part of the medical expenses the insured must pay if hospitalized in the U.S.A or Canada.

Commencement date: the date indicated in the policy schedule on which the insurance commences, unless otherwise stated in the policy conditions.

Company: Bupa Insurance Limited a company registered in England No. 3956433. Our address is 15-19 Bloomsbury Way, London WC1A 2BA, UK.

Day case treatment: treatment which, for medical reasons, normally requires a patient to occupy a bed in hospital or clinic for less than 24 (twenty-four) hours.

Deductible: the amount of money noted in the policy schedule which each insured agrees to pay

each policy year before being compensated by the Company.

Documents: any written information related to the insurance including original bills, policy schedules, etc.

Due date: date on which a premium notice is due to be paid.

Hospitalization: surgery or medical treatment in a hospital or clinic as an inpatient when it is medically necessary to occupy a bed overnight.

ihl Bupa: A trading name of Bupa Insurance Limited.

Insurance: the policy conditions and policy schedule representing the insurance contract with the Company and setting out the scope terms of the insurance, the premium payable, deductible and reimbursement rates.

Insured: the policyholder and/or all other insured persons as listed in the valid policy schedule.

Policy conditions: the terms and conditions of the insurance purchased.

Policyholder: the person identified as the policyholder on the application form and/or in the policy schedule.

Policy schedule: policy details showing the type of insurance purchased, premium, deductible and any special terms.

Pre-existing condition: the medical history, including the illnesses and conditions listed in the medical questionnaire, which may affect our decision to insure or not to insure or to impose special terms.

Rehabilitation: Medically prescribed rehabilitation at an authorized rehabilitation center following hospitalization.

Reimbursement rates: the maximum amount of money which will be paid by way of reimbursement of medical expenses in one year from the commencement date or from

each anniversary date, as further detailed in the policy conditions.

Renewal: the automatic renewal of the insurance as per the anniversary date.

Serious injury: a "serious injury" shall be determined to exist only after review and agreement by both the attending physician and the Company's medical consultant.

Special terms: restrictions, limitations or conditions applied to our standard terms as detailed in the policy schedule.

Standard terms: the Company's standard insurance terms with no special restrictions, limitations or conditions.

Subrogation: the insurer's right to enforce a remedy which the insured has against a third party and the insurer's right to require the insured to repay the insurer if the insurer has paid expenses recouped by the insured from a third party.

Terminal phase: when the advent of death is highly probable and medical opinion has rejected active therapy in favour of relief of symptoms and support of both patient and family. This decision must be confirmed by the Company's medical consultant.

Waiting period: a period of time from the commencement date where the insurance provides no coverage unless as per specification in Art. 3.

We/us/our: Bupa Insurance Limited or USA Medical Services acting on Bupa Insurance Limited's behalf.

Valid from December 1, 2010



European addresses:

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The world of Bupa

- Health assessment • Medical coverage • Travel coverage
- Financial health protection • International medical coverage • Home healthcare
- Care homes • Childcare • Health and care assistance

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ihi Bupa

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Calls will be recorded and may be monitored.

www.bupalatinamerica.com • www.ihl.com



ihi Bupa is a trading name of Bupa Insurance Limited.
Registered in England No 3956433.

Registered Office: Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA, UK.

Bupa Insurance Limited is authorized and regulated
by the Financial Services Authority (UK).