Group Plan

MediCare INTERNATIONAL

E & G Insurance Co Ltd
Grosvenor Court
Tower Street
Ramsey
Isle of Man

Group Plan Rules

Introduction

The cover provided shall be determined by reading the Rules defined herein together with the Certificate of Insurance (the Certificate) issued to each Insured Person. Any benefit not shown in the Certificate is not provided. Premiums will be paid in Pounds Sterling, US-Dollars or Euros. The base currency for the policy is Pounds Sterling.

The Insurance is effective only after the applicant has been accepted by the Insurer and becomes and remains insured in accordance with the terms, provisions and conditions set out in the Certificate and Rules.

The legal representative of the Insured Person shall have the right to act for an Insured Person who is incapacitated or deceased. Benefits are payable to the Insured Person or to the licensed providers of medical and dental care who provide the medically necessary insured treatments and services to the Insured Person.

Benefits are limited to the usual customary and reasonable charges in the area where treatment is provided.

Benefit payments are processed by claims administrators, appointed by the Insurer, who specialise in medical claims administration.

Definitions

The following definitions apply to the Plan:

Accident is any sudden and unforeseen event occurring during the policy period, resulting in bodily injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control.

Accident and Emergency Room Services are services performed in a Hospital casualty ward or emergency room immediately following an Accident.

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

Childhood Vaccinations cover will be provided for insured children aged up to 16, up to the limit shown on the Certificate of Insurance for childhood vaccinations defined as Diptheria, Tetanus, Whooping Cough (pertussis), Polio, Mumps, Rubella (German Measles), Meningitis C, Pneumococcal, vaccination against the bacteria Streptococcus pneumonia, Hib and Human Papillomavirus (HPV).

Claim is defined as a course of treatment to treat a diagnosed medical condition.

Complementary Therapies are treatments provided by registered and properly qualified Osteopaths, Chiropractors, Homeopaths and Acupuncturists and must be recommended and ordered by a Physician.

Complicated Pregnancy is pregnancy and childbirth where a Physician has certified that a surgical procedure, or treatment requiring a period of inpatient hospital confinement is required during the pregnancy, and where a normal delivery would endanger the life of the mother and or child(ren). All costs, wherever possible, must be approved in advance by the 24 hour Assistance Company, or in the event of an emergency situation as soon as reasonably practical.

Compulsory Plan is where all eligible persons will be included.

Country of Residence is the country declared on the Application Form/Certificate of Insurance as the Country of Residence.

Daycare Surgery is any surgical procedure performed on an outpatient basis but where a period of recovery in a Hospital is required.

Dental Treatment Following Accident is emergency treatment necessary to restore or replace sound natural teeth lost or damaged in an Accident.

Dependant is the spouse (or common-law partner) of the Insured Person (but excluding those legally separated), and/or unmarried children, step-children, foster children and legally adopted children, who are dependent on the Insured Person for support, provided always that such children are not more than 18 years old at the date of enrolment or renewal of the Plan (or 24 if proof is provided that the child is continuing in full-time education).

Emergency Medical Evacuation means the medically necessary expense of emergency evacuation and medical care en-route to move an Insured Person who has a critical medical condition to the nearest Hospital where appropriate care and facilities are available, and not necessarily to the Insured Person's Home Country. In the event of such an emergency the 24 hour Assistance Company should be contacted immediately to approve all Emergency Medical Evacuations.

In dire emergencies in remote or primitive areas where the Assistance Company cannot be contacted in advance, the Emergency Medical Evacuation must be reported as soon as possible.

The Insurer retains the right to decide the place to which the Insured Person shall be transported. The Insurer will pay reasonable transportation costs only of one other Insured Person accompanying the patient on an Emergency Medical Evacuation when this is deemed necessary.

Where the medical condition does not warrant an air ambulance, the cost of a return economy air fare ticket is covered by the Plan.

Employee is an Insured Person who is in Active Service on a full time basis with the Employer or on Contract Employment. It does not mean a person in casual employment. Definition may include a sole proprietor or partner or director of the Employer.

Employer The Employer of the Insured Person or, in the case of a non-employee Group accepted by the Insurer, the sponsoring organisation through which the Plan is offered, effected or administered and to whom the Master Policy is issued.

Excess/Co-insurance shall mean the portion of costs for which the Insured Person is liable. The excess/co-insurance will be applied as specified on the Certificate.

Geographical Area shall mean the Geographical Area selected by the Insured Person and for which the appropriate premium has been paid and is stated on the Certificate.

Area One is worldwide excluding the USA,Canada and Caribbean. The Caribbean is deemedto include Anguilla, Antigua, Aruba, Bahamas, Barbados, Bermuda, Cayman Islands, Cuba, Curaçao, Dominica, Dominican Republic, Grenada, Guadalupe, Haiti, Jamaica, Martinique, Puerto Rico, St Kitts-Nevis, St Lucia, St Vincent, Trinidad & Tobago and Virgin Islands.

Area Two is worldwide.

Group means membership of a Group Plan accepted by the Insurer and which includes at least three employees. It comprises a group of employees employed by one employer or members of a Trade Union or any Association or other institution and their dependants accepted by the Insurer and considered to be a Group for the purpose of this contract.

Home Country is the country of which the Insured Person holds a passport. Where the Insured Person holds more than one passport the Home Country will be taken to mean the nationality which the Insured Person has declared on the Application Form. Dependants will be deemed to have the same Home Country as the Applicant.

Hospital is any institution which is legally licensed as a medical or surgical hospital in the country in which it is located and whose main activities are not those of a spa, hydroclinic, sanatorium, nursing home, or home for the aged. It must be under the constant supervision of a resident Physician.

Hospital Cash Benefit is an alternative cash benefit which may be paid where treatment is provided in a government Hospital where no charge is made. The maximum payable is 30 days in any one Certificate period.

Hospital Services include all medical treatment, excluding Organ Transplantation, provided to the Insured Person only when appropriate diagnostic procedures and/or treatments are not available as Outpatient Services and when admitted as a registered inpatient to a Hospital for a period of not less than 24 hours. Pre-authorisation (as defined) is required for all Hospital Services claims. Hospital Services include reasonable and customary charges, in the area where treatment is provided, for Hospital accommodation up to the cost of a single-bedded room, meal charges, all Hospital medical facilities, and all medical treatment and medical services ordered by a Physician. Where intensive care unit accommodation as well as radiotherapy, chemotherapy and computerised tomography is medically required the reasonable and customary charges will be met. Hospital Services excludes any costs relating to pregnancy, except ectopic pregnancy.

Insured Person is an individual who has currently completed or whose name is included on an Application Form for the Plan and for whom commencement of cover has been confirmed, or who has been issued with a Certificate.

Insurer The Insurer of the plan is Brit Insurance Limited.

Local Ambulance Services include the necessary medical transportation to a local Hospital for emergency or inpatient care.

MRI and CT scans means the cost of magnetic resonance imaging (MRI) and computerised tomography (CT) ordered by a treating Physician.

Master Policy is the contract of insurance which is issued to the Employer or the sponsoring organisation as defined.

Maternity Care means pre-natal, childbirth and post-natal treatment for the Insured Person with respect to both Normal and Complicated Pregnancy up to the limits shown on the

MediCare INTERNATIONAL

Certificate per pregnancy. Where this benefit is included in the Certificate, it will apply only to pregnancies whose expected date of delivery is at least 10 months after the commencement date for Maternity Care benefit of the Insured Person. This benefit does not include the costs of any medical treatment provided to the newborn.

Newborn Care is treatment received by a newborn child from the date of birth until 30 days following discharge from Hospital, provided that an Application form has been completed for the child within 14 days of birth and a Certificate of Insurance has been issued for the newborn. No other benefits are available to newborns until 30 days following discharge from Hospital when the selected Plan benefits and Rules will apply.

Normal Pregnancy is pregnancy and childbirth, including pre and post natal care, of the mother only, where no special obstetric procedure is required.

Nursing at Home includes medical services, excluding home help, provided by a government licensed nurse in the Insured Person's home when prescribed by a Physician and related directly to an illness or injury for which the Insured Person has received and is receiving treatment covered under the terms and conditions of the Plan. Cover will be limited to 26 weeks in any one Certificate period.

Oncology, Chemotherapy and Radiotherapy includes hospital charges for tests and drugs that are related specifically to the treatment of malignant disease (cancer).

Organ Transplantation Surgery is the costs incurred in respect of kidney, heart, heart-lung and liver transplants up to a maximum limit per transplant as shown in the Certificate. No other organ transplantation is covered. The cost of acquisition of the organ and any costs incurred by the donor are not covered.

Out of Area Cover is short-term cover available when travelling outside the Geographical Area selected by the Insured Person. Cover is only available outside the selected Geographical Area for a maximum aggregate period of 30 days in any one Certificate period, provided always that the trip was not specifically made for the purpose of, or with the intention of, obtaining medical treatment. This cover only applies to emergency medical conditions and acute episodes of existing covered conditions.

Outpatient Services are medical treatments provided to the Insured Person when the Insured Person is not a registered inpatient in a Hospital, or any other facility for medical care. Outpatient Services include services provided by or ordered by a Physician who is licensed as a General Practitioner, Specialist or Consultant, laboratory testing, radiographic and nuclear medicine procedures used to diagnose and treat medical conditions. Outpatient Services also includes Complementary Therapies, Physiotherapy and Prescription Drugs as separately defined.

Outpatient Psychiatric Care cover is provided in respect of professional fees for a Consultant Psychiatrist, for the treatment of any psychological or psychiatric disorder, the treatment of anxiety, stress, clinical depression and phobic states. Cover will also include therapy performed by a behavioural or clinical psychologist, provided the therapy is ordered by a Consultant Psychiatrist. All covered treatment under this benefit is limited to the amount shown in the Certificate of Insurance.

All treatment must be pre-authorised in advance by the 24-hour Assistance Company. Where this benefit is included in the certificate, it will apply only to treatment received after a period of 12 months' continuous cover.

Overall Limits are the total aggregate benefits that may be claimed in any one Certificate period by an Insured Person, and are shown on the Certificate.

Parental Accommodation is hospital accommodation costs for one parent accompanying a Hospital-confined child aged 17 years and under.

Physician/Therapist is a legally licensed medical practitioner/therapist recognised by the law of the country where treatment is provided and who, in rendering such treatment, is practising within the scope of his/her licensing and training.

Physiotherapy must be provided by a licensed Physiotherapist and ordered by a Physician.

Pre-Existing Conditions:

A pre-existing is any known medical condition (or related condition) that has, within a two year period immediately prior to the commencement of the policy one or more of the following characteristics;

It has been diagnosed.
It has needed medical treatment (including drugs, special diets, injections or other procedures or investigations).
Medical advice has been sought including routine medical examinations.
Medical advice should have been sought if recognised clinical advice had been followed.
It has undiagnosed symptoms, whether recognised or not.

After two years of continuous cover, pre-existing conditions will become eligible for cover (unless the condition or benefit is specifically excluded) if, at the first time of receiving treatment the insured person has not:

- Suffered any symptoms.
- Consulted any medical practitioner for check ups, follow up examinations, medical treatment or advice.
- Been prescribed or taken medicine including over the counter drugs, special diets, injections, physiotherapy for that medical condition or any related condition for a continuous two years.

Prescription Drugs include medications whose sale and use are legally restricted to the order of a Physician, and do not include items that may be purchased without a Physician's prescription.

Rehabilitation Care means inpatient medical treatment or other care where the purpose is to restore health and mobility after injury or illness to a state in which the insured person can be self sufficient. This benefit is subject to a lifetime maximum limit of £100,000.

Repatriation or Local Burial is the expense of preparation and air transportation of the mortal remains of the Insured Person from the place of death to the Home Country, or the preparation and Local Burial or cremation of the mortal remains of an Insured Person who dies outside his Home Country. Such arrangements must be made by the 24-hour Assistance Company. This benefit is not available to persons joining the Plan at 65 or over.

Routine Dental Treatment is all routine dental care such as dental inspection, preservation and relief of pain including simple fillings, X-Rays, treatment of gums, operative and gnathological procedures, and dentures. Dentures include restoration of the function of dental prostheses and the installation of new prostheses, crowns, bridges and pivot teeth. Orthodontic treatment is available for insured persons up to age 16 years.

Cover is only available to Insured Persons who have attended for dental inspection and concluded all necessary treatment in the twelve month period immediately prior to enrolment in the Plan, or immediately prior to claiming Routine Dental Treatment benefit under the Plan, whichever is the later. The benefit is limited to the amounts shown on the Certificate.

Voluntary Plan is where enrolment by an employee/member is voluntary.

Wellness Benefit shall mean one full medical examination every second policy year, up to a maximum limit shown on the Certificate, per adult member only. A full medical examination would be deemed to include a general physical examination and various diagnostic tests forming part of a full medical screening. This benefit is only available to members who have maintained two years of continuous cover under the Plan. This benefit does not provide cover for stand-alone routine diagnostic tests or procedures.

Administration

Due Date is the date of commencement or renewal of cover as shown on the Certificate.

Co-ordination of benefits The Plan will not provide compensation other than 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 bodily injury, sickness, disease, death or expense. The Insurer has full rights of subrogation.

Pre-Authorisation: ***All inpatient costs and any other claim likely to exceed £2,500 in any one Certificate period must be authorised and agreed by the 24 hour Assistance Company before being incurred. In the case of an emergency admission, the Assistance Company must be notified within 72 hours. Failure to comply will affect settlement of your claim. If pre-authorisation is not obtained, the Insured Person shall be responsible for the first £1,000 of any claim.***

Notice and proof of claim: The Insured Person must provide written notice of a claim, no later than 90 days from the start of treatment, to the Insurer or to the appointed claims administrator. A separate claim form must be submitted for each medical condition.

Such notice must be provided even where the original supporting documentation is not yet available. Written notice must be followed, when available, by a fully completed Insurers' claim form signed by the treating Physician and original supporting documentation, invoices and receipts as soon as reasonably practicable and in any event within 90 days of treatment. Photocopies are not acceptable. Any invoices/receipts received by the Insurer or appointed claims administrator that are more than 180 days old will not be paid.

The burden of proof is on the Insured Person.

When an Insured Person undergoes medical treatment for illness, he/she can claim from the start of the course of treatment until the time when it is

medically confirmed that treatment is no longer necessary or until the expiry of the Certificate period, or the termination of this insurance, whichever is the earlier event. Where compensation is claimed for medical treatment received and the Insured Person subsequently claims for a new course of treatment, which is not in any way connected with the former treatment, the subsequent Claim will be regarded as a new Claim.

Upon receipt of proof of claim the Insurer will pay up to the limits shown in the Certificate for expenses necessarily incurred as a direct result of the Insured Person suffering bodily injury, sickness, disease (or being pregnant, where Maternity Care benefit is included in the Certificate) during the valid Certificate period.

Change of Cover Level/Geographical Area: A change of cover level can only be made at a renewal date. Where the insured person upgrades cover at renewal any benefit waiting period will be applied from the date cover is upgraded. Only one change of Geographical Area can be made in any one Certificate Period and only if the Insured Person is relocating to a country within the new Geographical Area selected.

Examinations: The Insurer shall have the right and opportunity through their medical representative to examine any Insured Person whenever and so often as may be reasonably required within the duration of any Claim. In addition the Insurer shall have the right to require an autopsy in the case of death, where this is not forbidden by law.

Legal proceedings: No action at law or equity shall be brought to recover under the Plan prior to the expiration of sixty days after the proof of claim has been furnished in accordance with the requirements of the Rules. Nor shall any such action be brought at all unless commenced within six years from the date of the Claim.

English Law shall govern and control in the event of any conflict or dispute between the parties with regard to the Plan and that the parties submit themselves to the exclusive venue and jurisdiction of the Courts of England for the resolution of any such conflict or dispute.

Eligibility: Employed or self-employed persons of all nationalities who are less than age 65 years at the date of enrolment are eligible. Dependants are also eligible to join. Newborn children shall be eligible for insurance from birth. The benefits available to newborn children are as defined under Newborn Care and up to the limits shown in the Certificate. Cover is subject to completion of an Addition of Dependant form within fourteen days of birth. Dependants must elect the same Plan as the applicant.

The Plan is not available to USA, Canadian or Caribbean nationals who are resident in their Home Country, nor persons who are subject to exchange controls or local insurance licensing regulations.

Commencement and renewal: Insurance shall commence from the date specified on the Certificate. Premiums are payable on or before the inception date of the Plan. At renewal, premiums are payable prior to the Due Date to avoid termination of cover.

Once registered and subject to continued renewal, cover will automatically cease at the first Due Date following the 65th birthday or on termination of employment/membership, whichever is the earlier. Termination of the insurance of the Insured Employee/member shall also result in termination of cover for his Insured Dependants, unless otherwise agreed by the Insurer.

The Plan is an annual contract which until terminated shall be renewed each year on the anniversary of the Due Date subject to the Rules and premiums in force at the time of each renewal and any variations as may be set out in writing by the Insurers.

Renewal will be effected by the Insured Person/ Employer paying and the Insurer accepting the required renewal premium prior to the Due Date.

The Plan may be terminated with effect from any Due Date by either party. The Insurer, whilst acting as Insurer of MediCare, will not invoke cancellation as a result of an Insured Person's health record whilst insured under the Plan. However, renewal will be subject to premiums and Rules offered by the Insurer.

If the Plan is terminated by the Employer at a date other than the Due Date a pro-rata refund of premium will be made by the Insurer.

All premiums will be payable in advance of the Due Date. If payment is not made on or before the Due Date the agreement will be terminated with effect from the Due Date.

Return to Home Country: Cover can remain in force when an Insured Person returns to his/her Home Country except for USA and Canadian nationals, whose cover will automatically be cancelled following three consecutive months in the Home Country. Cover in the Home Country is only available if the relevant premium has been paid to include that Geographical Area.

Arbitration: Any difference in respect of medical opinion in connection with the results of an accident or illness will be settled between two medical experts appointed 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.

Cancellation: If any claim shall in any respect be false or fraudulent or if fraudulent means or devices are used by the Insured Person or anyone acting on his behalf to obtain benefit hereunder then the Certificate shall be cancelled immediately and all benefit and premium forfeited. The Plan shall be cancelled immediately if any relevant facts were not disclosed or were misrepresented at the time of inception of the Plan.

Exclusions

The following treatment, conditions, activities, items, and their related expenses are excluded from the insurance and the Insurer shall not be liable for:

- Pre-Existing Conditions (as defined earlier) unless this exclusion has been waived on the Certificate.
- Any costs incurred outside the Geographical Area, except as defined in the Rules.
- All transportation costs occurring during trips specifically made for the purpose of obtaining medical treatment if not part of an Emergency Medical Evacuation, except as defined under Local Ambulance Services. For further details see definition of Emergency Medical Evacuation.
- All Emergency Medical Evacuation costs not approved in advance by the appointed Assistance Company, except as provided for in the Rules.
- Services or treatment in any long term care facility, spa, hydroclinic, sanatorium, nursing home or home for the aged that is not a Hospital as defined in this policy.
- Any costs relating to Nursing at Home that is for domestic reasons and not medically necessary.
- Routine medical examinations (including annual routine diagnostic procedures other than when they form part of the Wellness Benefit, as defined earlier, and Wellness Benefit is shown on the Certificate of Insurance, including vaccinations other than Childhood Vaccinations as defined earlier and Childhood Vaccinations is shown on the Certificate of Insurance), the issue of medical certificates and attestations, and examinations as to suitability for employment or travel. Routine eye and ear examinations, including the cost of spectacles, contact lenses and hearing aids.
- Treatment relating to birth defects and congenital illnesses. Birth defects are deemed to include hereditary conditions.
- All dental treatment unless Routine Dental Treatment or Emergency Dental Treatment, as defined, is included in the Certificate.
- All elective dentures.
- The costs of precious metals used in dental treatment.
- Tests and treatment relating to infertility.
- All abortions except where there is an immediate threat to the life of the mother.
- All elective caesarean section deliveries.
- All costs relating to pregnancy and childbirth, other than ectopic pregnancy, unless Maternity Care benefit is included in the Certificate.
- Prostheses, corrective devices and medical appliances, which are not required intra-operatively.
- Treatment of any psychological or psychiatric disorders, and treatment of anxiety, stress, depression and phobic states (except where Outpatient Psychiatric Care is shown on the Certificate of Insurance), other than hospital confinement, subject to 30 days maximum per Certificate period.
- Treatment, diagnostic procedures (including sleep study) and Prescription Drugs for sleep disorders, including but not restricted to sleep apnoea, sleep related breathing problems, snoring or insomnia.
- All elective cosmetic surgery and the consequences thereof. The Insurer will pay for reconstructive surgery which is required to restore appearance/function following an accident or illness which occurred after your Certificate became effective and which is required within twelve months of the accident/illness occurring.
- Costs resulting from self-inflicted injury, suicide, abuse of alcohol, drug addiction or abuse, and treatment of sexually transmitted diseases.
- Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV positive.
- Costs resulting from racing of any form other than on foot, and all professional sports.

- Treatment by a family member and any autotherapy including Prescription Drugs.
- Treatment that is deemed by the relevant professional body to establish medical practice and/or established medical opinion as not scientifically recognised, unproven or experimental.
- Claims for treatment and/or disabilities, costs and expenses resulting from participation in war, riots, strikes, lockouts, civil commotion, rebellion, revolution, insurrection, terrorism, military or usurped power or any illegal act, including resultant imprisonment.
- Claims resulting from the release of weapon(s) of mass destruction (nuclear, chemical or biological) whether such involve(s) an explosive sequence(s) or not.
- Injury or illness while serving as a member of a police or military force or unit.
- All costs directly or indirectly caused by or contributed to or arising from:
  - ionising radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
  - the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
- Claims and costs for treatment in respect of medical expenses incurred after the expiry date of the Certificate.
- Costs for acquisition and implantation of artificial heart and mono or bi-ventricular devices.
- All expenses of cryopreservation.
- All expenses of introduction or re-introduction of living cells or living tissue, whether autologous or provided by a donor. However, the Insurer will pay 80% of all covered expenses associated with and necessitated by both autologous and donor provided bone marrow transplants. Expenses relating to the acquisition of transplant materials and donor's expenses are not covered.
- All Organ Transplantation costs (unless this benefit is included in the Certificate and then only heart, heart-lung, kidney and liver transplants).
- Costs in respect of Hormone Replacement Therapy.
- Treatment for learning difficulties, hyperactivity, attention deficit disorder, speech therapy and developmental, social or behavioural problems.
- Contraception, sterilisation or any treatment of sexual problems (including impotence, whatever the cause).
- All expenses relating to vitamins, minerals and other supplements, including homeopathic remedies, irrespective of whether these have been prescribed or not.

Complaints Procedure

Our objective is to provide our clients with a high level of service at all times. With the best of intentions we have to accept that there may be an occasion when you, our customer, feel that objective has not been met. Should you have any reason to complain, in the first instance contact the Senior Executive Director at MediCare quoting your certificate number. In the

event that you remain dissatisfied and wish to file a complaint with the insurer of MediCare, please contact:

The Customer Relations Manager,
Brit Insurance Ltd,
55 Bishopsgate,
London, EC2N 3AS.

Telephone: +44 (0)20 7098 6509
Fax: +44 (0)20 7984 8473

Email: customer.relations@britinsurance.com

In the event that you still remain dissatisfied, you may be able to take your complaint further by contacting The Financial Ombudsman Service, whose details are as follows:

The Financial Ombudsman Service
South Quay Plaza, 183 Marsh Wall,
London, E14 9S

Helpline: +44 (0) 845 080 1800
Switchboard: +44 (0)20 7964 1000

Website: www.financial-ombudsman.org.uk

This complaints procedure is without prejudice to your right to take legal action.