Policy Terms & Conditions GBP £

KEY FACTS & STATEMENT OF DEMANDS AND NEEDS

The Financial Services Authority (FSA)
The FSA is the independent watchdog that regulates financial services in the United Kingdom. One of their primary aims is to protect you, the consumer.

Who Regulates Us
Worldwide "Teacher Care" and "Expatriate Care" is the trading style of Journeyman Services Ltd; who are authorised and regulated by the Financial Services Authority.

Our FSA Firm Reference Number is: - 312035

Journeyman Services Ltd is authorised to carry on Regulated Activities in accordance with the permissions granted by the FSA under Part IV of the Financial Services and Markets Act 2000. You can check this on the FSA's Register by visiting the FSA's website www.fsa.gov.uk/register or by contacting the FSA on +44 (0) 845-606-1234. We believe that all our customers, regardless of where the policy was bought, or where the customer is in the world, should be entitled to the same regulatory benefits and protection as those purchasing cover in a FSA regulated territory. Accordingly, wherever possible, we shall extend these benefits to all of our customers.

Fees & Charges
We do not separate premiums, fees or charges for our insurance. If your insurance has been arranged via an insurance broker or intermediary, we will pay them a commission. You should not be charged a separate amount by them if their sole consideration is the advice and provision of the Worldwide Teacher Care / Expatriate Care Policy.

Significant Features and Benefits
Please refer to the Benefit Schedule contained in the Worldwide Teacher Care / Expatriate Care brochure.

Right to Cancel
If for any reason you are not satisfied with the Policy provided you may cancel your cover within 30 days of the Effective Date or any subsequent Renewal Date, and so long as you have not made a claim in that period, your premium for the new Period of Cover will be refunded in full. If you do not exercise this cancellation right, the insurance policy will be binding on you.

What to do if you have a Complaint
We aim to give you the highest standards of services, however if you have a complaint about how your policy was sold or administered, or about the settlement of a claim, please contact:-
The Managing Director
Journeyman Services Ltd
The Laurels, Parkend Walk
Sling, Coleford,
Gloucestershire
GL16 8JJ United Kingdom

Telephone: - + 44 (0) 1594 839333

Fax : - +44 (0) 1594 839444
Email : - tony@jsl.uk.com

For Sales and Administration

The Sales Manager
Journeyman Services Ltd
The Laurels, Parkend Walk
Sling, Coleford,
Gloucestershire
GL16 8JJ United Kingdom
Telephone: - +44 (0) 1594 839333
Fax: - +44 (0) 1594 839444
Email: - info@journeyman-services.com

If you cannot settle your complaint directly you are entitled to refer it to the
Financial Ombudsman Service,
South Quay Plaza,
183 Marsh Wall
London
E14 9SR

Statement of Demands and Needs
This insurance meets with the demands and needs of those persons who wish to ensure that their private medical insurance requirements are met whilst they are living or working away from their country of nationality, subject to the terms and conditions of the policy. Where we provide you with personal recommendation as to whether this policy is suitable for your specific needs, we would recommend that you seek additional impartial advice from a professionally qualified and registered insurance intermediary. This statement does not form part of the Policy summary or the terms and conditions of cover.

Disclosure Statement
This policy is underwritten by Hauteville Insurance Company who are rated A+ 'Superior' by A.M Best and AA 'Strong' by Standard and Poors.

GENERAL PROVISIONS
INSURING AGREEMENT
In consideration of the payment of the Premium, the Insurer, (Hauteville Insurance Company) agrees with the Policyholder to reimburse up to the limits detailed in the Insured Person's Confirmation of Insurance for costs incurred during the Policy Term subject to all of the exceptions, limitations and provisions of this Policy.

***Notice to the Insured Person:* If you are hospitalised, do not assume that someone has contacted the insurer on your behalf. It remains your responsibility to ensure that the insurer or its authorised representatives have been contacted prior to admission or as soon as reasonably possible, failure to do so could affect settlement of your claim.**

Any word explained in the Definitions section herein will have the same meaning throughout this document.
A Confirmation of Insurance will be issued only when an Insured Person has completed an application form that has been accepted by the Insurer and the required Premium has been paid.
The currency of this Policy is expressed in Great British Pounds (GBP/£).

BENEFIT SCHEDULE	SILVER	GOLD PLUS	PLATINUM PLUS
Annual Maximum	£500,000	£1,000,000	£1,500,000
Percentage Payable	100%	100%	100%
Deductible - Standard	£65 per Annum	£65 per Annum	£65 per Annum
Alternative Deductible Options Available on Request			
INPATIENT TREATMENT			
Hospital Fees Includes Accommodation, Nursing Fees, Physicians Fees, Prescribed Medicines, Reconstructive Surgery following an accident, artificial body parts surgically implanted to form permanent parts of an insured's body. X-rays, Laboratory tests, Post hospitalisation treatment, MRI, CT & PET Scans	100%	100%	100%
Oncology Tests, drugs, consultant fees and cover for chemotherapy and radiotherapy, MRI, PET & CT Scans, Surgical Services	100%	100%	100%
Physiotherapy When referred by a Medical Practitioner	100%	100%	100%
Parent Accommodation When an insured child under the age of 18 is hospitalised	Maximum £90 per night 30 days payment	Maximum £90 per night 30 days payment	Maximum £120 per night 45 days payment
OUTPATIENT TREATMENT			
Primary Consultations and Treatment by a Licensed Physician	Not Covered	100% to maximum of £3,000 per policy year	100% to maximum of £6,000 per policy year
Medications Prescribed medications to treat non-chronic conditions	Not Covered	100%	100%
X-Rays, Laboratory Services	Not Covered	100%	100%
Physiotherapy When referred by a medical practitioner. Osteopathic, Chiropractic, Homeopathic and Acupuncture when referred by a licensed Physician	Not Covered	100% to maximum of £300 per policy year	100% to maximum of £450 per policy year
Oncology Tests, drugs, consultant fees and cover for chemotherapy and radiotherapy, MRI, PET & CT Scans, Outpatient Surgical Services	Not Covered	100%	100%
Medical Supplies & Services Including casts, crutches, canes, slings, trusses, braces and short term rental of a wheelchair. Requires a Physician recommendation	Not Covered	Not Covered	100% to maximum of £150 per policy year
Repair and Replacement of Eyeglasses When damaged as a result of an accident	Not Covered	Not Covered	100% up to £120 every 24 months
Home Nursing Following a course of inpatient hospital treatment	Not Covered	Not Covered	100% maximum £35 per day and limited to 30 days per policy year
Accidental Damage to Natural Teeth	Not Covered	100% to maximum of £750 per accident	100% to maximum of £1,200 per accident
Emergency Dental Treatment For the relief of acute dental pain	Not Covered	100% to maximum of £750 per policy year	100% to maximum of £1,200 per policy year
Routine Annual Physical Examinations	Not Covered	Not Covered	100% to maximum of £300 per policy year
CHRONIC MEDICAL CONDITIONS			
Acute exacerbations/episodes of chronic conditions	Not Covered	Subject to the Overall maximum policy limit	Subject to the Overall maximum policy limit
Consultations, Diagnostic Testing & Ongoing Care relating to stable Chronic Conditions	Not Covered	Maximum £3,000 per Policy Year	Maximum £3,000 per Policy Year
Medications Prescribed medications for the treatment of chronic conditions	Not Covered	100% to maximum of £3,000 per policy year	100% to maximum of £6,000 per policy year

HIV, AIDS AND ARC (Excluded if Pre-Existing)			
Urgent or Emergency Injuries or Sicknesses	Annual Maximum £50,000	Annual Maximum £50,000	Annual Maximum £50,000
MENTAL & NERVOUS			
Inpatient	£3,000 per policy year	£3,000 per policy year	£4,500 per policy year
Outpatient (12 Month Wait Period Applicable to Individual Family Policies only)	Not Covered	£1,500 per policy year	£1,800 per policy year
ORGAN TRANSPLANTS			
Cost of Surgical procedure for transplant of Kidney, Liver, Heart, Lung (cost for recipient only)	£150,000 per Transplant	£240,000 per Transplant	£300,000 per Transplant
MATERNITY CARE			
Complicated Maternity Includes Newborn Accommodation & Neonatal Intensive Care. Emergency maternity not subject to wait period	100% to maximum of £6,000	100% to maximum of £6,000	100% to maximum of £9,000
Routine Maternity Includes Newborn Accommodation (12 Month Wait Period Applicable to Individual Family Policies only)	Not Covered	Not Covered	100% to maximum of £6,000
CONGENITAL CONDTIONS			
Congenital Conditions	100% Inpatient Only	100%	100%
EMERGENCY MEDICAL EVACUATION, REPATRIATION, COMPASSIONATE EMERGENCY VISIT & AMBULANCE			
Ambulance Road ambulance only to nearest hospital where adequate treatment can be rendered	100%	100%	100%
Frontier MEDEX Plus Includes the following: Evacuation, Repatriation, Ancillary Benefit	100%	100%	100%
Repatriation of Mortal Remains	100%	100%	100%
Compassionate Emergency Visit Limited to economy airfare to visit Parent, Child or Spouse up to age 75, family member must be on a critical list or due to death, limited to one trip per plan year	Maximum £1,500	Maximum £1,500	Maximum £1,500
War & Terrorism (Subject to Limitations)	100%	100%	100%

Geographical Area of Coverage

Zone 1 – Worldwide
Zone 2 – Worldwide **Excluding** North America and Canada

EFFECTIVE DATE AND POLICY TERM

This Policy takes effect at 12:01a.m., on the date stated in the application for coverage or the date coverage is approved by the insurer and from which date all insurance months shall be calculated. It continues in force for the period for which premium had been paid. Coverage may be renewed subject to approval by the Insurer for further consecutive terms, not exceeding 12 months, on payment of premium at the rate and in the amount determined at the time of renewal by the Insurer.

ELIGIBILITY

For the purposes of this Policy, Insured Persons shall be considered as those persons who:

1. are working outside of their Home Country or pre-approved local national
2. are eligible dependants residing outside of their Home Country or pre-approved local national
3. are under age sixty five (65) for Individual / Family policies and under age seventy five (75) for Group policies, and
4. have completed and signed the application form in acceptance of the Policy terms and conditions and received underwriter's acceptance.
5. have paid the required premium or had such premium paid on their behalf by the Policy holder.

DEFINITIONS

Accident wherever used in the Policy means any sudden and unforeseen event occurring during the Policy term, 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.

Benefits wherever used in the Policy means any covered expenses / services that the Insurer will pay under the Benefit Plan wording of the Policy.

Chronic Condition wherever used in the Policy means any Injury or Sickness which requires medical attention, monitoring or treatment for a period exceeding 12 months. The 12 months commences as of date of diagnosis or the effective date of coverage if diagnosed prior to this policy's effective date.

Day Patient wherever used in the Policy means a Patient who occupies a Hospital bed or is charged for a Hospital bed.

Deductible wherever used in this Policy, means the dollar amount for which the Insured Person is liable, as stated on his / her Confirmation of Insurance before any remaining eligible expenses are reimbursed under this Policy.

Dependant wherever used in the Policy means:

a) The spouse of an Insured Person (but excluding those legally separated), and under the age of 70 for Individual / Family policies, and under the age of 75 for Group policies.
b) Unmarried children, step-children, foster children and legally adopted children, who are dependant on the Insured Person for support, provided that such children are not less than 15 days old (unless birth of newborn is an insured event under this policy in which case newborn is insured from date of discharge from hospital) and not more than 18 years old at the date the Policy was purchased (or 24 years old provided it can be proved that the child is continuing in full-time education).

Diagnostic Services wherever used in the Policy means laboratory tests and x-ray services, radiographs and nuclear medication procedures used to diagnose and treat medical conditions.

Effective Date wherever used in the Policy means the date on which the coverage under this Policy begins, as specified on the Confirmation of Insurance.

Emergency wherever used in the Policy means a sudden and unexpected turn of events or change of condition which requires immediate Medical Treatment and which first manifests itself while this Policy is in force as to the Insured Person.

Expatriate wherever used in the Policy means a person who leaves his / her Home Country to reside in a foreign country for which he / she does not hold a valid passport.

Geographical Area of Coverage wherever used in this policy means the area for which premiums have been paid for Emergency and Routine Care as provided under the Terms and Conditions of the policy purchased.

Home Country wherever used in the Policy means the country for 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 country that the Insured Person has declared on the Application Form. Where a family is to be covered by the Policy there will be deemed to be one Home Country for that family, which will be the Home Country declared on the Application Form.

Hospital wherever used in the Policy means any medical or surgical institution which is legally licensed in the country in which it is located and whose main activities are not those of a rehabilitation centre, spa, hydro clinic, sanatorium, nursing home or home for the aged. It must be under the constant supervision of a resident Physician.

Hospital Services wherever used in the Policy means costs for accommodation, nursing, operating theatres, drugs, dressings, diagnostic procedures or any other necessary costs made by the Hospital for Medical Treatment.

Host Country whenever used in this Policy refers to the Country where the insured person is living and working.

Immediate Family Member wherever used in the Policy refers to spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother of the Insured Person.

Injury wherever used in the Policy means an unexpected and unforeseen harm to the body caused by an Accident occurring while the Policy is in force and resulting, directly and independently of all other causes, in the Insured Person incurring Medical Expenses.

In-Patient wherever used in the Policy means a patient who occupies a Hospital bed for more than 24 hours for Medical Treatment and for which admission was recommended by a Physician or Surgeon.

Insured Person/You/Your wherever used in the Policy means an eligible person as defined in the ELIGIBILITY section of this Policy.

Insurer wherever used in the Policy means Hauteville Insurance Company who provide this insurance.

Maternity Care wherever used in the Policy refers to the medically necessary expenses associated with pregnancy and childbirth.

Medical Appliances wherever used in the Policy means minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, orthotics and the temporary rental of a wheelchair when prescribed by a Physician or Surgeon.

Medical Expenses wherever used in the Policy means those medical and related expenses for which coverage is provided under the Benefits Section of this Policy which are necessarily incurred as a result of Injury or Sickness while coverage is in force under this Policy as to the Insured Person.

Medical Treatment wherever used in the Policy means surgical or medical procedures the sole purpose of which is the cure or relief of an acute Sickness or Injury. An acute Sickness or Injury is characterised by an occurrence of brief duration, after which the Insured Person returns to his / her normal or previous state and degree of activity.

MSH International wherever used in the Policy means the Third Party Administrator and claims administrator appointed by the insurer.

Newborn Nursery Care wherever used in the Policy means the medically necessary expenses associated with the care and treatment of a newborn child while in hospital immediately following

birth and any medically necessary expenses incurred up to the guaranteed period of coverage provided under the Maternity Care Benefit.

Out-Patient wherever used in the Policy means an Insured Person who receives treatment, including Diagnostic Services at a Hospital, or other medical institution, or at a Physician's office; where the Insured Person is not admitted or confined to a Hospital bed as an In-Patient or Day-Patient.

Overall Maximum Limit: The total aggregate benefits limit per Policy Year that may be claimed by an Insured Person. Such limit is indicated in the Benefit Plan Booklet.

Physician or Surgeon wherever used in the Policy means a legally licensed medical practitioner 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. A Physician or Surgeon must not be the Insured Person or an Immediate Family Member of an Insured Person.

Provider wherever used in the policy means Frontier MEDEX.

Reasonable and Customary Costs wherever used in the Policy means costs incurred for approved, eligible treatment or supplies that do not exceed the standard cost of other providers of similar standing in the same region, for the same treatment of a similar Sickness or Injury.

Sickness wherever used in the Policy means any unexpected and unforeseen illness or disease manifesting itself while this Policy is in force as to the Insured Person and which causes the Insured Person to incur Medical Expenses.

Well Baby Care wherever used in the policy is the customary medical program recommended for all newborns, including checkups and immunisations.

OTHER INSURANCE

If, at the time of loss, the Insured Person has insurance from another source for benefits provided under this Policy; the policy with the earliest effective date will be deemed to be first payer. Any benefits payable by the following shall not be considered as a covered cost under this policy:

1. Any group or individual Hospital or Medical Plan.
2. Any government Hospital or Medical Plan.
3. Any Worker's Compensation Act
4. Any public or tax-supported agency.

TERMINATION DATE OF INSURANCE

The insurance of an Insured Person shall terminate on the earliest of the following:

1. The date this Policy is terminated;
2. The date that any premium required or due on the part of the Insured Person remains unpaid;
3. The date that the Insured Person reached age seventy (70) for Individual / Family policies, and seventy five (75) for Group policies;
4. The date the foreign assignment or employment terminates.
5. The date the insured Dependant ceases to be an eligible Dependant as defined in this Policy.
6. When medical advice has been received that the Insured Person cannot continue foreign assignment due to a disability, then all benefits are extended for a maximum period of 90 days from the first day of disability.

Termination of the insurance of any Insured Person either because of termination of employment or termination of this Policy will not prejudice consideration of any claim that may have occurred prior to such termination.

REFUNDS

A full refund of the premium paid, less administration fees, will be made provided the Insurer receives a written request to terminate within 30 days of an Insured becoming ineligible and subject to no claims having been paid since original date of inception.

The premium may be partially refunded on a pro rata basis (a minimum of three months premium is retained) should the Insured Person's situation change during the Policy Term. Once the insurer has received satisfactory evidence that the Insured Person is eligible for a refund, it will be calculated from the return date to their Home Country, will be based on the postmarked date of the Insured Person's written request.

GENERAL EXCLUSIONS

This Policy does not cover expenses caused or contributed to directly or indirectly by:

1. air travel, other than as a passenger in a certified commercial aircraft that provides passenger services and compiles with government regulations concerning pilot licensing and current certificates of airworthiness;
2. active participation in war or any act of war, or while participating in any armed forces training exercises or manoeuvre; radioactive contamination or committing or attempting to commit any criminal act;
3. intentionally self-inflicted injury, suicide or self destruction or any attempt (while sane or insane);
4. termination of pregnancy or expenses relating thereto;
5. mountaineering, scuba diving, rock or precipice climbing, hang gliding, paragliding, sport parachuting, sky diving, athletic or sports activities for remuneration or prize money, or while riding or driving in or on any motorised vehicle or device in any race of speed contests;
6. injuries received, if operating a vehicle when the Insured Person's blood contains more than 80 milligrams of alcohol per 100 millilitres of blood;
7. misuse of medication, use of intoxicants or illegal drugs, or treatment therefore, or accidents related thereto;
8. examinations by, or the services of, a physician if required solely for the use of a third party;
9. any claim arising from a trip or assignment undertaken outside the host country for the purpose of securing treatment (or therapy) unless pre-approved by the Insurer.
10. persons age seventy (70) or over for Individual / Family policies, and seventy five (75)for Group policies;
11. any costs incurred during any period for which the appropriate premium has not been paid or while the Policy is not in force as to the Insured Person;

LIMITED WAR EXCLUSION CLAUSE

(Personal Accident or Illness Insurances)

Notwithstanding anything to the contrary contained herein, this Insurance does not cover loss consequent on;

a) war, whether declared or not, between any of the following countries, namely China, France, the United Kingdom, the Russian Federation and the United States of America,

or

b) war in Europe, whether declared or not, other than
   i) civil war,
   ii) any enforcement action by or on behalf of the United Nations,

in which any of the countries stated in (a) above or any armed forces thereof are engaged.

NUCLEAR, CHEMICAL, BIOLOGICAL TERRORISM EXCLUSION

Notwithstanding any provision to the contrary within this insurance or any endorsement thereto it is agreed that this insurance excludes any losses, directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with any act of nuclear, chemical, biological terrorism (as defined below) regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

For the purpose of this endorsement:

"Nuclear, chemical, biological terrorism" shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public or any section of the public, in fear.

"Chemical" agent shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on

people, animals, plants or material property.

"Biological" agent shall mean any pathogenic (disease producing) micro-organisms(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesised toxins) which cause illness and/or death in humans, animals or plants.

If the Underwriters allege that by reason of this exclusion any loss is not covered by this insurance the burden of proving the contrary shall be upon the Insured.

GENERAL PROVISIONS AND LIMITATIONS

Arbitration: Any differences with respect to medical opinion will be settled between two medical experts appointed by the two parties. This dispute resolution will be in writing. Any difference of opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing at the outset by the two medical experts.

Legal Proceedings: No legal proceedings shall be commenced until 60 days after a claim had been correctly submitted and no such action shall be brought unless commenced within 3 years from the first date of treatment.
This policy is governed by the Laws of Canada and the province of Alberta and any dispute arising out of this Policy shall be settled in the courts of Alberta.

Misrepresentation and Fraud: All benefits under this Policy shall be voidable if the Insurer determines, whether before of after the loss, the Insured Person has concealed or misrepresented any material fact or circumstance concerning this Policy or his/her interest therein, or in the case of fraud or false swearing by you or if you refuse to disclose information or permit the use of such information, pertaining to any of the insured persons under this policy.
The completed and signed Application Form is the basis of and forms part of this Policy and any erroneous responses therefore constitute material misrepresentation.
Any claim to which any concealed or misrepresented material fact or circumstance pertain shall not be payable under this Policy and You shall be solely responsible for all expenses relating to your claim, including Part F - Emergency Medical Evacuation Costs.

Payment of Benefits: The claims administrator will, on behalf of the Insurer, make payment to the Insured Person or legal representative or directly to the provider of treatment or services. Payment will made in GBP currency.

Pre-Authorisation: All In-Patient and Day-Patient Hospitalisation and special Out-Patient Services must be pre-authorised and arranged in advance by MSH International, or the medical assistance provider.

Subrogation: If an Insured Person suffers a loss covered under this Policy, the Insurer is granted the right from the Insured Person to take action to enforce all the rights, powers, privileges and remedies of the Insured Person, to the extent of Benefits paid under this Policy against any person or organisation which caused such loss. Additionally, if No Fault benefits or other collateral sources of payment of expenses are available to the Insured Person, regardless of fault, the Insurer is granted the right to make a demand for, and recover those benefits. If the Insurer institutes an action, the Insurer may do so at its own expense, in the Insured Person's name, and the Insured Person will attend at the place of loss to assist in the action. If the Insured Person institutes a demand or action for a covered loss he or she shall immediately notify the Insurer so that it may safeguard its rights. The Insured Person shall take no action after a loss that will impair the rights of the Insurer.

Statutory Conditions
The Application, the Policy, any document attached to the Policy when issued, and any amendment to the contract greed upon in writing after the Policy is issued, constitute the entire contract. Any provision of the Policy which, on its effective date, is in conflict with the statutes of the jurisdiction in which the Policy was issued is hereby amended to conform to the minimum requirements of such statutes.

PRIVACY GUIDELINES

MSH International recognize and respect every individual's right to privacy.
When you apply for coverage or submit a claim, we establish a confidential file of personal information.
We use the information to administer the individual benefit plan under which you are covered. This includes many tasks, such as:

- Determining your eligibility for coverage under the plan
- Enrolling you for coverage
- Assessing your claims and providing you with payment
- Managing your claims
- Verifying and auditing eligibility and claims
- Underwriting activities, such as determining the cost of the plan, and analysing the design options of the plan
- Preparing regulatory reports, such as tax slips

We limit access to information in your file to MSH International staff or persons authorised by MSH International who require it to perform their duties, to persons to whom you have granted access, and to persons authorised by law. MSH International, your health care provider, other insurance and reinsurance companies, and your plan administrator may also exchange information when the information is needed to administer the group benefit plan.

MAJOR MEDICAL BENEFITS
MAXIMUM LIMIT

Notwithstanding the limits stated in the separate sections of this Policy, the Overall Maximum Limit for Medical Expenses per Policy Year shall not exceed:

SILVER	£500,000
GOLD	£1,000,000
PLATINUM	£1,500,000

100% Reimbursement of eligible expenses with a £65 deductible per Annum.

Part A- Hospital Benefits:
When, by reason of Injury or Sickness, an Insured Person is confined to a Hospital the Insurer will pay the Reasonable and Customary costs for room and board charges (up to semi-private room accommodation), including the costs relating to Physicians, Surgeons, nursing, operating room, prescription drugs, Physiotherapy, dressings, diagnostic services, Post hospitalisation treatment, medical appliances, and any other necessary cost made by the Hospital for In-Patient Hospital Services, Day-Patient Hospital Services, as well as costs incurred in an Intensive Care Unit. When deemed medically necessary the Insurer will pay Reasonable and Customary costs for artificial body parts surgically implanted to form a permanent part of an Insured's body.

Part B- Medical, Surgical and Diagnostic Services:
When by reason of Injury or Sickness, an Insured Person incurs expense for any of the following while under the regular care and attendance of a Physician or Surgeon, the Insurer will pay the reasonable and customary costs incurred for the following:

1. Diagnostic, X-Ray, and Laboratory Services. X-Ray, Laboratory examinations, MRI, CT and PET scans, Oncology tests, consultants' fees, cover for chemotherapy and radiotherapy and Out-Patient surgical services. All services must be on the recommendation of a Physician or Surgeon for Diagnostic Services. Laboratory and x-ray services must be provided by or ordered by a Physician.

2. Paramedical Services. The services of a chiropractor, physiotherapist, osteopath, homeopath, or acupuncturist up to a maximum of

Not covered	Silver
£ 300	Gold
£ 450	Platinum

per profession per policy year per insured

3. **Ambulance Charges**. Charges for licensed ground ambulance transportation to the nearest Hospital or from one Hospital to another or from a Hospital to the Insured Person's residence.

4. Routine Maternity Care Coverage. Insured to a maximum of

Not covered	Silver
Not covered	Gold
£ 6,000	Platinum

per pregnancy for prenatal care, cost of delivery services, and New Born Nursery Care

This benefit is available when the expected date of delivery is a minimum period of 12 months from the original effective date of coverage for Individual / Family policies, and from inception for Group policies. Pregnancy and newborn care reimbursed at 100% within the Host Country. No coverage for expenses incurred outside of the Host Country is provided unless pre-approved by MSH International. The Newborn is insured under this Maternity Benefit until discharged from Hospital. Application must be made and underwriter's acceptance received for continuation of coverage for the newborn under the Major Medical Benefit and subject to applicable premium being paid.

5. Complications Relating to Maternity Care. Complications are defined as any medical condition relating to pregnancy that if not immediately treated will threaten the life of the mother or unborn child. Insured to a maximum of

£ 6,000	Silver
£ 6,000	Gold
£ 9,000	Platinum

per pregnancy
for pre-natal care, cost of delivery services, and New Born Nursery Care.

Pregnancy and Newborn care reimbursed at 100% within the Host Country. No coverage for expenses incurred outside of the Host country is provided unless pre-approved by MSH International. The New Born is insured under this Maternity Benefit until discharged from Hospital. Application must be made and underwriter's acceptance received for continuation of coverage for the newborn under the Major Medical Benefit and subject to applicable premium being paid. Once a pregnancy has complications the balance of that pregnancy and any previously incurred expenses will be adjudicated under the Complications Relating to Maternity Care benefit.

6. Organ Transplant. 100% reimbursement of cost for recipient only to a maximum of

£ 150,000	SILVER
£ 240,000	GOLD
£ 300,000	PLATINUM

per person per transplant of Kidney, Liver, Heart, or Lung

Part C – Out-Patient Services
When by reason of Injury or Sickness, an Insured Person incurs expenses for any of the following while under the regular care and attendance of a Physician or Surgeon, the Insurer will pay the reasonable and customary costs incurred:
1. Primary Consultations and treatments by a licensed Physician, including Surgeon's to a combined maximum of

Not covered	SILVER
£ 3,000	GOLD
£ 6,000	PLATINUM

per person per policy year
2.100% reimbursement for drugs, medicine, serums and vaccines obtainable only upon a written prescription and dispensed by a pharmacist, a Physician, Chemist or Surgeon, limited to a 90 day supply per reimbursement for Non-Chronic Conditions.
Lifestyle Prescription Medications are excluded

3. blood or blood plasma (includes the administration of blood).

Part D – Chronic Medical Conditions
Silver Medical option only
Does not provide a separate policy provision for Chronic Conditions therefore hospitalisation or inpatient services relating to a Chronic Condition will be included as a part of the overall lifetime maximum and adjudicated based on standard terms and conditions of the policy.

Gold and Platinum option
Stabilisation of acute exacerbations/episodes of Chronic Conditions shall be subject to the overall maximum of the policy and adjudicated based on standard terms and condition of the policy.

Not covered	SILVER
Policy limit	GOLD
Policy limit	PLATINUM

Consultations, Diagnostic Testing and ongoing care required after the stabilisation of the chronic medical condition insured up to a maximum of

Not covered	SILVER
£ 1,500	GOLD
£ 3,000	PLATINUM

per policy year

Outpatient prescription medications required in the treatment of Chronic Conditions

Not covered	SILVER
£ 3,000	GOLD
£ 6,000	PLATINUM

per policy year

Part E – Mental, Nervous, or Emotional Disorders
100% reimbursement of Hospital In-Patient services to a maximum of

£ 3,000	SILVER
£ 3,000	GOLD
£ 4,500	PLATINUM

per policy year

100% reimbursement of Out-Patient services to a maximum of

Not covered	SILVER
£ 1,500	GOLD
£ 1,800	PLATINUM

per policy year after 12 month waiting period.

Part F – Emergency Dental Treatment
When an accidental blow to the mouth or face results in Injury to an Insured Person, the Insurer will pay for the emergency dental treatment necessary to restore or replace permanently attached artificial teeth or sound natural teeth lost or damaged in an Accident, and for which dental treatment is initiated within 30 days following an Accident and completed within the Policy Term. Detailed medical documentation from a Physician or dentist must be provided to support an Insured Person's claim. All indemnity payable under this Part F is reimbursed at 100% GOLD / 100% PLATINUM subject to a maximum amount of

Not covered	SILVER
£ 750	GOLD
£ 1,800	PLATINUM

per Insured person per Injury.

Routine dental treatment for the relief of acute dental pain will be reimbursed at 100% GOLD / 100% PLATINUM to a maximum of

Not covered	SILVER
£ 750	GOLD
£ 1,200	PLATINUM

per policy year.

Part G – Medical Extension Upon Permanent Return to Home Country:
Your emergency medical care and maternity benefit, if applicable, can be extended for up to a maximum of 90 days with premium based on geographical area of Home Country. During this time, application must be made for coverage under any Government Hospital or Medical plan for which you and your Dependants are eligible. This extended protection terminates on the earliest of 90 days or when eligible for the Government Hospital or Medical Plan coverage.

Part H – Parent Accompanying Child
When an Insured Person under 18 years of age is confined to Hospital as an In-Patient, the Insurer will pay the reasonable and customary costs charged by the Hospital for one parent to stay with the child. Further, if an Insured Person who is a single parent is confined to a Hospital as an In-Patient, the Insurer will pay the reasonable and customary costs for a Dependant child under 18 years to stay with such Insured Person.
Overall maximum payable under this section is

£ 90	SILVER
£ 90	GOLD
£ 120	PLATINUM

per night

and to a maximum of

30 nights	SILVER
30 nights	GOLD
45 nights	PLATINUM

per hospitalisation.

Part I – Compassionate Emergency Visit
Limited to economy airfare to visit Spouse, Dependant Child, or parent up to age 75 in the event of a critical illness (the family member must be on the critical list) or in the event of the passing of a Spouse, Dependant Child, or Parent up to age 75. Maximum is one round trip per year to a maximum of £1,500.00.

PLATINUM COVER ONLY
Part J - Home Nursing Care Services of a Registered Nurse, Licensed Practical Nurse or Registered Nursing Assistant, following a period of hospitalisation lasting at least 2 days and upon the recommendation of a physician. Reimbursement is limited to £35 per day for a maximum of 30 days in the aggregate per policy year.

Part K – Medical Supplies and Services
The following list of medical supplies and services will be reimbursed under the policy subject to the following limitations.

- Annual routine physical examination, maximum £300 per policy year.
- Repair or replacement of eyeglasses when damaged as a result of an accident, limited to £120 in any 24 month period.
- When recommended by a physician the purchase of casts, crutches, canes, slings, trusses, braces, and short term rental of a wheelchair (1 month maximum wheelchair rental). The combined maximum reimbursement for all services listed is £150 per policy year.

MEDICAL EXCLUSIONS

1. Prostheses, corrective devices and medical appliances unless specifically stated as covered under the policy. Glasses, contact lenses, hearing aids, dentures or dental appliances;
2. Elective and/or cosmetic surgery, whether or not for psychological reasons unless required as the result of Injury incurred while this Policy is in force;
3. Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex Syndrome (ARCS) and all diseases caused by/and/or related to the HIV virus or any other sexual transmitted disease, except as provided for under the Blood Borne Diseases Endorsement;
4. Fertility Treatment and/or drugs related to such treatment;
5. Any Medical Expense incurred while covered under the plan but submitted 365 days following the date the expense was incurred or 90 days after the coverage terminated.
6. non-emergency treatment out-side location of Host Country except as provided under Part H Elective Treatment in Home Country
7. Lifestyle Prescription Medications
8. Routine Annual Check-up (Covered on PLATINUM Level)
9. the rental (or purchase) of crutches, casts, splints, canes, slings, trusses, support stocking, braces, orthotics and the temporary rental of a wheelchair, hospital type bed, iron lung, or other approved durable equipment for temporary therapeutic use.

ADDITIONAL EXCLUSIONS ON SILVER

10. Patient Prescription Medications, serums and vaccines
11. Routine Annual Checkups
12. the rental (or purchase) of crutches, casts, splints, case, slings, trusses, support stockings, braces, othotics and the temporary rental of a wheelchair, hospital type bed, iron lung or other approved durable equipment for temporary therapeutic use.
13. Out-Patient diagnostic, X-Ray, and Laboratory Services X-Ray, Laboratory examinations, MRI, CT and PET scans.
14. Out-Patient Oncology tests, consultants' fees, cover for chemotherapy and radiotherapy, and Out-Patient surgical services.
15. Paramedical Services. The services or a chiropractor, physiotherapist, osteopath, homeopath, or acupuncturist.
16. Routine Maternity Care Coverage. Pre and Post natal care, cost of delivery services, and Newborn Nursery Care. Application must be made and underwriter's acceptance received for coverage for the newborn under the Major Medical Benefit and subject to applicable premium being paid.
17. Out-Patient Services
    a) Consultations and treatments by a licensed Physician, including Surgeons
    b) Blood or blood plasma (includes the administration of blood).
18. Out-Patient and In-Patient services and medications relating to Chronic Medical Conditions
19. Out-Patient services for mental, nervous, or emotional disorders.
20. Emergency Dental Treatment due to an accidental blow to the mouth or face.
21. Routine Dental Treatment except as provided under the Optional Dental if elected.

Please refer to each benefit description for additional exclusions.

BLOOD BORNE DISEASE ENDORSEMENT WORDING

The Blood Borne Disease Policy Endorsement is in three parts:
Part 1 of this endorsement sets out the general information that applies to this insurance:

- Scope of cover and definitions

Part 2 of this endorsement tells specifically what will and will not be payable, and includes the Compensation Table.
Part 3 of this endorsement details the conditions that apply to the cover.

Part 1

Scope of cover

The cover provided by this policy only applies to Blood borne disease arising out of or in the course of activities or during the time limits or subject to any other limitations specified in the Scope of Cover in the Certificate of Insurance.

Definitions

Whenever used in this benefit the following words have the special meaning given to them:

Accident means a sudden, unexpected, unusual, specific event that occurs at an identifiable time and place.

Act of Terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or similar purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

Blood Borne Disease means the following diseases:- Hepatitis B, Hepatitis C, Hepatitis D, HIV, Syphilis, and Human T-cell Lymphoma Virus (HTLV-1)

Positive Diagnosis means the detection of the blood borne disease following testing of a sample of the Insured Persons blood by approved specialist laboratories within 6 months of an identifiable accident giving rise to the blood borne disease

Pre-existing Condition means any condition of which the Insured Person was aware or for which the Insured Person had sought medical treatment or advice in the twelve months immediately preceding the inception date of the insurance.

Schedule of Compensation means the Schedule of Compensation included in the Certificate of Insurance that details the compensation amounts referred to in the Compensation Table. Compensation is only payable for the Items that have an amount inserted against them in the Schedule of Compensation.

Scope of Cover is the Scope of Cover detailed in the Certificate of Insurance. The cover provided by this policy only applies to Bodily Injury or Blood borne disease arising out of or in the course of activities or during the time limits or subject to any other limitations specified in the Scope of Cover. The maximum payable under this Blood Borne Disease Endorsement shall not exceed £50,000 per Insured Person per Policy Year.

Specific event is one or several of the following incidents:

(1) an accidental bodily injury by a medical instrument, or
(2) accidental exposure to blood or bloodstained bodily fluid, or
(3) bodily injury from sharp body tissues or body parts in body cavities or in poorly visualised or confined body sites from a person infected with a blood borne disease.
(4) bodily injury caused by a physical and bodily assault by another person on the Insured Person during the period of insurance
(5) the administering of medical treatment provided by a registered and legally qualified medical practitioner or registered nurse of an insured person during the period of insurance

Part 2

What will be payable:

If an Insured Person has a positive diagnosis of a blood borne disease within 6 months of a specified event, Hauteville will pay to the Insured, his Executors or Administrators, Compensation according to the Compensation Table, within a reasonable time after the total claim is substantiated under this insurance.
But

(a) Compensation is only payable if the Blood borne disease arises out of, is sustained or occurs in the course of activities or during the time limits specified in the Scope of Cover and is subject to any other limitations specified in the Scope of Cover.
(b) The total sum payable under this insurance for any one or more claims by any one Insured Person will not exceed in all in any one Period of Insurance the largest compensation amount applicable to that Insured Person under any one of the Items in the Compensation Table.

What will not be payable

This insurance does not cover blood borne disease –

(a) consequent on war, invasion or civil war unless an Insured Person is travelling on a scheduled flight en route to a principal destination as shown on the flight ticket where no state of war, invasion or civil war exists.
(b) resulting from suicide or intentional self injury or from an Insured Person's own criminal act, or sustained whilst an Insured Person is in a state of insanity, or resulting from stress or anxiety related conditions.
(c) resulting from any Pre-Existing Condition
(d) resulting directly from any specified event which occurs outside the period of insurance
(e) where within 48 hours of a specified event the insured person has not submitted a blood sample to be specifically tested for a blood borne disease carried out by an approved infectious disease specialist laboratory
(f) directly or indirectly consequent upon the Insured Person operating any machinery or driving a vehicle of any kind whilst under the influence of intoxicating liquor or drugs.
(g) directly or indirectly resulting from intravenous or subcutaneous drug use other than in the course of medical treatment legally prescribed by and under the supervision of a registered medical practitioner
(h) directly or indirectly resulting from sexual transmission or sharing of needles
(i) that does not arise from an accidental specific event
(j) that occurs as a result of the use, existence or escape of nuclear weapons material or ionising radiation from or contamination by radioactivity from any nuclear fuel or nuclear waste from the combustion of nuclear fuel;

Compensation Table

Item and Amount Payable

100% reimbursement subject to the maximum payable under this Blood Borne Disease Endorsement which shall not exceed £50,000 per Insured Person per Policy Year.

1. **Accidental contraction of HIV**
2. **Accidental contraction of Hepatitis C**
3. **Accidental contraction of Hepatitis B**
4. **Accidental contraction of Hepatitis D**
5. **Accidental contraction of Human T-cell Lymphoma**
6. **Accidental contraction of Syphilis**

Part 3

Conditions

(a) Immediate notice must be given to Hauteville of any Accident or specified event happening to the insured person which could give rise to the possibility of that Insured Person contracting a blood borne disease. Following any specified event the Insured Person must as early as possible place himself under the care of a medically qualified practitioner and within 48 hours of the incident arrange for testing for the presence of any blood borne disease.

(b) If in the event of changes in clinical practice or immunisation and vaccination developments, Hauteville will rely on prevailing expert medical opinion when interpreting the Insured Person's antigen and antibody status in order to confirm evidence of infection

(c) In no case will Hauteville be liable to pay Compensation to the Insured or his representatives unless the medical adviser or advisers appointed by Hauteville for the purpose are allowed as often as Hauteville believe is necessary to make an examination of the Insured Person.

CLAIMS PROCEDURES APPLIABLE TO MEDICAL, MATERNITY AND DENTAL BENEFITS

The Insurer will pay Benefits provided that:

1. The Insured Person has contacted and received Pre-Authorisation of any costs to be incurred as either a Day-Patient or an In-Patient. In an emergency when the claims administrator cannot be contacted in advance, then the admission to Hospital must be reported as soon as reasonably possible.
2. Written details of all claims have been sent to the claims administrator as soon as possible and in any event not later than 365 days from the beginning of the Medical Treatment or received by MSH International within 90 days of termination, and
3. All documentation relating to the claim including the claim form and accounts are originals and not copies; and
4. The required premiums have been paid relative to the Insured Person making the claim.

It is understood that:

1. The insurer can ask for medical information from any Physician or Surgeon as often as required and if necessary examine the Insured Person; and
2. The insurer shall be notified of any circumstances that may lead to a claim against a third party or any other insurance; and
3. In the case of a claim in the Insured Person's Home Country, proof of the Insured Person's entry date into their Home Country is provided.

All pertinent information shall be sent to:

Individual Policys and North and South America

MSH International (Canada)
300, 999-8th Street S.W.
Calgary, AB
T2R 1N7
Canada

Asia

MSH International (China)
East Unit, 5th Floor
North Tower, Building 9
Lujiazul Software Park
No. 20, Lane 91
E Shan Road, Pudong
Shanghai P.R.China 200127

Middle East & Africa

MSH International (Dubai)
DIFC, Liberty House
PO Box 506537
Dubai
UNITED ARAB EMIRATES

Europe

MSH International (France)
82 rue Villeneuve
92587 Clichy Cedex
FRANCE

Pre-approval of Medical Treatment please email
precertification@americas.msh-intl.com
Or
Fax to the Attention of Precertification Department
(Canada) 001-403-265-9425

For Claim Inquiries
claims@americas.msh-intl.com
Or
Fax to the Attention of Claims Department
(Canada) 001-403-265-9425

For Client Services please email
clientservice@americas.msh-intl.com
or Fax to the Attention of Client Services
(Canada) 001-403-265-9425

IN A MEDICAL EMERGENCY CONTACT

Frontier MEDEX

24-Hour Emergency Number

Identification No. 31511

CALL COLLECT
001 (410) 453-6330

In order to assist you in an emergency situation, Frontier MEDEX will require the following information when you contact them.

- Name of caller, telephone number and relationship to the patient.
- Name of the patient, age, sex and location and their certificate number
- Name of organisation
- Frontier MEDEX Identification number (31511), Policy 011765/000
- Nature of medical problem
- Telephone numbers of medical personnel involved
- How and when the next communication will take place

In the event of a medical emergency, you must contact Frontier MEDEX immediately. They will take the appropriate action to assist you and monitor your care until the situation is resolved -24 hours a day, 7 days a week, 365 days a year.

INTERNATIONAL TOLL FREE TELEPHONE ACCESS NUMBERS
Listed below are the telephone numbers for the worldwide Frontier MEDEX Assistance Network. If you have a medical or travel problem, call Frontier MEDEX. Printed on your ID card are the telephone numbers for the worldwide Frontier MEDEX network. Call the toll-free number for the country you are in if one is available. If you are in a country that is not listed or the call will not go through, please call the Baltimore, Maryland coordination centre collect. Be prepared to give Frontier MEDEX your name, identification number, organisation's name and brief description of your problem.
Full list of Toll free Telephone access numbers will be provided with policy documentation.

Australia and Tasmania	1-800-127-907
Austria	0-800-29-5810
Belgium	0800-1-7759
Brazil	0800-891-2734
China	10811-800-527-0218
Egypt * inside Cairo	510-0200-1-877-569-4151
Egypt * outside of Cairo	02-510-0200-1-877-569-4151
Finland	0800-114402
France and Monaco	0800-90-8505
Germany	0800 1 811401
Greece	00-800-4412-8821
Hong Kong	800-96-4421
Indonesia	001-803-1471-0621
Israel	1-800-941-0172
Italy, Vatican City and San Marino	800-877-204
Japan	00531-11-4065
Mexico	001-800-101-0061
Netherlands	0800-022-8662
New Zealand	0800-44-4053
Philippines	1-800-1-111-0503
Portugal	800-84-4266
Republic of Ireland (Eire)	1-800-409-529
Republic of South Africa	0800-9-92379
Singapore	800-1100-452
South Korea	00798-1-1-004-7101
Spain and Majorca	900-98-4467
Switzerland and Liechtenstein	0800-55-6029
Thailand	001-800-11-471-0661
Turkey	00-800-4491-4834
UK & N. Ireland, Isle of Jersey and Isle of Man	0800-252-074
United States, Canada, Puerto Rico, US Virgin Islands, Bermuda	1-800-527-0218

Frontier MEDEX Assistance Coordination Centers
(call collect)
United States
Baltimore, Maryland [1]-410-453-6330

NOTES

When a toll free number is not available, travellers are encouraged to call Frontier MEDEX collect. The toll free numbers listed are only available when physically calling from within the country. We strongly encourage you to note this in your printed material to avoid confusion.
The toll free ISRAEL line is not available from payphones and there is a local access charge.
The toll free ITALY, VATICAN CITY AND SAN MARINO number has a local charge for access.
The toll free JAPAN line is only available from touchtone phones (including payphones) equipped for International dialling.

Standard Dental – Option 1

Benefit Schedule

After 3 months of continuous coverage - Preventative and Basic services 75% to a combined maximum of £315 each per insured per policy year.
Reimbursement is based on reasonable and customary charges in the area that the expense was incurred.

Basic Services

The following diagnostic services are covered:

1. one complete oral examination once every 12 months;
2. specific and emergency examinations.

Preventative services

1. polishing once every 12 months for dependant children and adults;
2. scaling and root planning – 3 time units a year.

A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval.

Each incident of services is considered 1 time unit, regardless of its duration.

No Benefit will be paid for:

1. custom fluoride appliances;
2. audio-visual oral hygiene instruction; or,
3. nutritional counselling.

Minor restorative services

1. amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 3 years old or the existing filling was not covered under this plan;
2. extraction of teeth.

No Benefits will be paid for:

1. surgical movement of teeth;
2. services performed to remodel or recontour oral tissues, other than those listed above. Services for remodelling and recontouring oral tissues are covered under major coverage; or,
3. alveoplasty or gingivoplasty performed in conjunction with extractions;
4. hypnosis or acupuncture.

Major services (NOT INSURED UNDER THIS OPTION)

EXCLUSIONS

Benefits will not be paid for:

1. expenses that private Insurers are not permitted to cover by law;
2. services or supplies the insured person is entitled to without charge by law or for which a charge is made only because the insured person has insurance coverage;
3. services or supplies that do not represent reasonable treatment;
4. services or suppliers associated with;

a) treatment performed for cosmetic purposes only;
b) congenital defects or developmental malformations in people 19 years of age or over;
c) temporomandibular joint disorders
d) myofacial pain; or,

5. any Medical Expense incurred while covered under the plan but submitted 365 days following the date the expense was incurred or 90 days after coverage terminate;
6. implantology or dental implants.

Orthodontic Services (NOT INSURED UNDER THIS OPTION)

Dental Plus – Option 2

Benefit Schedule

After 3 months of continuous coverage - Preventative and Basic services 75%, to a maximum of £950 each per insured per policy year.

Reimbursement is based on reasonable and customary charges in the area that the expense was incurred.

Basic Services

The following diagnostic services are covered:

1. one complete oral examination every 3 years;
2. oral pathology, periodontal, surgical, prosthodontic, and endodontic examinations;
3. limited oral examinations once every 9 months except that only one limited oral examinations is covered in any year that a complete oral examination is also performed;
4. bitewing radiographs, once every 9 months;
5. limited periodontal examinations once every 6 months;
6. specific and emergency examinations;
7. complete series of intra-oral radiographs, once every 36 months;
8. panoramic radiographs once every 24 months. Services provided in the same year as a complete series are not covered;
9. sialography;
10. extra-oral radiographs other than panoramic and sialography;
11. radiopaque dyes used to demonstrate lesions;
12. interpretation of radiographs or models from another source;
13. microbiological, histological, cytological, and pulp vitality tests; and,
14. laboratory reports.

Preventative Services

1. polishing once every 6 months for dependant children and once every 9 months for adults;
2. scaling and root planning – 6 time units a year;
3. topical application of fluoride once every 6 months for dependant children and once every 9 months for adults;
4. oral hygiene instruction once in an insured person's lifetime;
5. pit and fissure sealant on bicuspids and permanent molars, once every 5 years for dependant children only;
6. space maintainers;
7. maintenance of space maintainers;
8. finishing restorations;
9. interproximal disking; and,
10. recontouring of teeth.

A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval.

Each incident of services is considered 1 time unit, regardless of its duration.

No Benefit will be paid for:

1. custom fluoride appliances;
2. audio-visual oral hygiene instruction; or,
3. nutritional counselling.

Minor Restorative Services

1. caries, trauma, and pain control;
2. amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 3 years old or the existing filling was not covered under this plan;
3. retentive pins and prefabricated posts for fillings; and,
4. prefabricated crowns for primary teeth;
5. periodontics;
6. endodnotics.

Oral Surgery

1. removal of teeth;
2. surgical exposure of teeth;
3. the following procedures for remodelling and recontouring

oral tissues;
4. minor alveoplasty;
5. gingivoplasty and stomatoplasty;
6. surgical incisions;
7. surgical excisions of tumours, cysts and granulomas;
8. treatment of fractures, including related bone grafts to the jaw; and,
9. treatment of maxillofacial deformities, including related bone grafts to the jaw and cheiloplasty.

Palatal obturators, although not listed with oral surgery in the Canadian Dental Association Uniform System of Coding and List of Services, are also covered under this provision. Cleft palate obturators are not covered.

No Benefits will be paid for:

1. surgical movement of teeth;
2. services performed to remodel or recontour oral tissues, other than those listed above. Services for remodelling and recontouring oral tissues are covered under major coverage; or,
3. alveoplasty or gingivoplasty performed in conjunction with extractions.

Adjunctive Services

1. minor remedies for relief of dental pain when provided on an emergency basis;
2. therapeutic injections; and,
3. anaesthesia required in relation to covered services. The provision of general anaesthetic facilities, equipment, and supplies is covered only when a separate anaesthetist is required.

No benefits will be paid for hypnosis or acupuncture.

Major Services (NOT INSURED UNDER THIS OPTION)

Crowns and onlays are covered when a tooth has extensive structural loss or a fracture than cannot be adequately restored using other procedures. The following crowns and related items are covered:

1. metal, plastic, porcelain, and ceramic crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns;
2. onlays. Coverage for tooth-coloured onlays on molars is limited to the cost of metal onlays;
3. posts, cores, and pins related to covered crowns;
4. copings related to covered crowns;
5. repairs to covered tooth-coloured materials; and,
6. removal and recementation of crowns and onlays.

Replacement crowns and onlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable.

No Benefits will be paid for:

1. veneers;
2. recontouring existing crowns;
3. staining porcelain; or,
4. inlays, except as provided under alternative Benefits.

If a crown or onlay is provided when a tooth could have been adequately restored using other procedures, alternative Benefits will be provided based on coverage for fillings.

Dentures and bridgework, including overdentures and implant-retained appliances, are covered when required to replace one or more teeth extracted while the person was insured for major coverage.

Replacement appliances are also covered when:

1. the existing appliance is temporary; or,
2. the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is insured for major coverage as a result of;

a) the placement of an initial opposing appliance; or,
b) the extraction of additional teeth. If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.

The following denture-related surgical services for remodelling and recontouring oral tissues are covered:

1. remodelling, excision, removal, reduction, or augmentation of the alveolar bone;
2. remodelling of the floor of the mouth;
3. vestibuloplasty;
4. reconstruction of the alveolar ridge;
5. extensions of mucous folds; and,
6. related surgical grafts.

The following services are covered after the 6-month post-insertion care period has elapsed:

1. denture remakes, once every 3 years;
2. denture adjustments, once a year; and,
3. denture repairs and additions, tissue conditioning and resetting of denture teeth.
4. repairs to bridgework; and,
5. removal and recementation of bridgework;
6. removal of implant-retained prostheses for repair; and,
7. reinsertion of implant-retained prostheses.

EXCLUSIONS

Benefits will not be paid for:

7. expenses that private Insurers are not permitted to cover by law;
8. services or supplies the insured person is entitled to without charge by law or for which a charge is made only because the insured person has insurance coverage;
9. services or supplies that do not represent reasonable treatment;
10. services or suppliers associated with;

a) treatment performed for cosmetic purposes only,
b) congenital defects or developmental malformations in people 19 years of age or over,
c) temporomandibular joint disorders
d) myofacial pain; or,

11. any Medical Expense incurred while covered under the plan but submitted 365 days following the date the expense was incurred or 90 days after coverage terminate.
12. implantology or dental implants.

Orthodontic Services (NOT INSURED UNDER THIS OPTION)

Orthodontic expenses must be incurred by a covered dependant child between the ages of 6-18 years, for the treatment of malocclusion. Laboratory procedures are also included. No benefit will be paid for the replacement or repair of Orthodontic appliances that are lost, broken or stolen.

Additional exclusions are included in the general exclusions section of this policy.

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