IHI Premier 1

Valid from 2007 • USD

"I feel better knowing our health insurance covers all our needs"

A member of the BUPA group

International Health Insurance danmark a/s

Your insurance guide

We put your health above all

Have you ever thought about what would happen to your family, career and financial situation if you were struck by an unexpected illness? Our experience shows that long-term illness may have serious financial and social consequences.

International Health Insurance danmark a/s (IHI) guarantees to put your health above all, offering you the best suited insurance plan and advising you on health and wellbeing.

IHI - a company you can trust

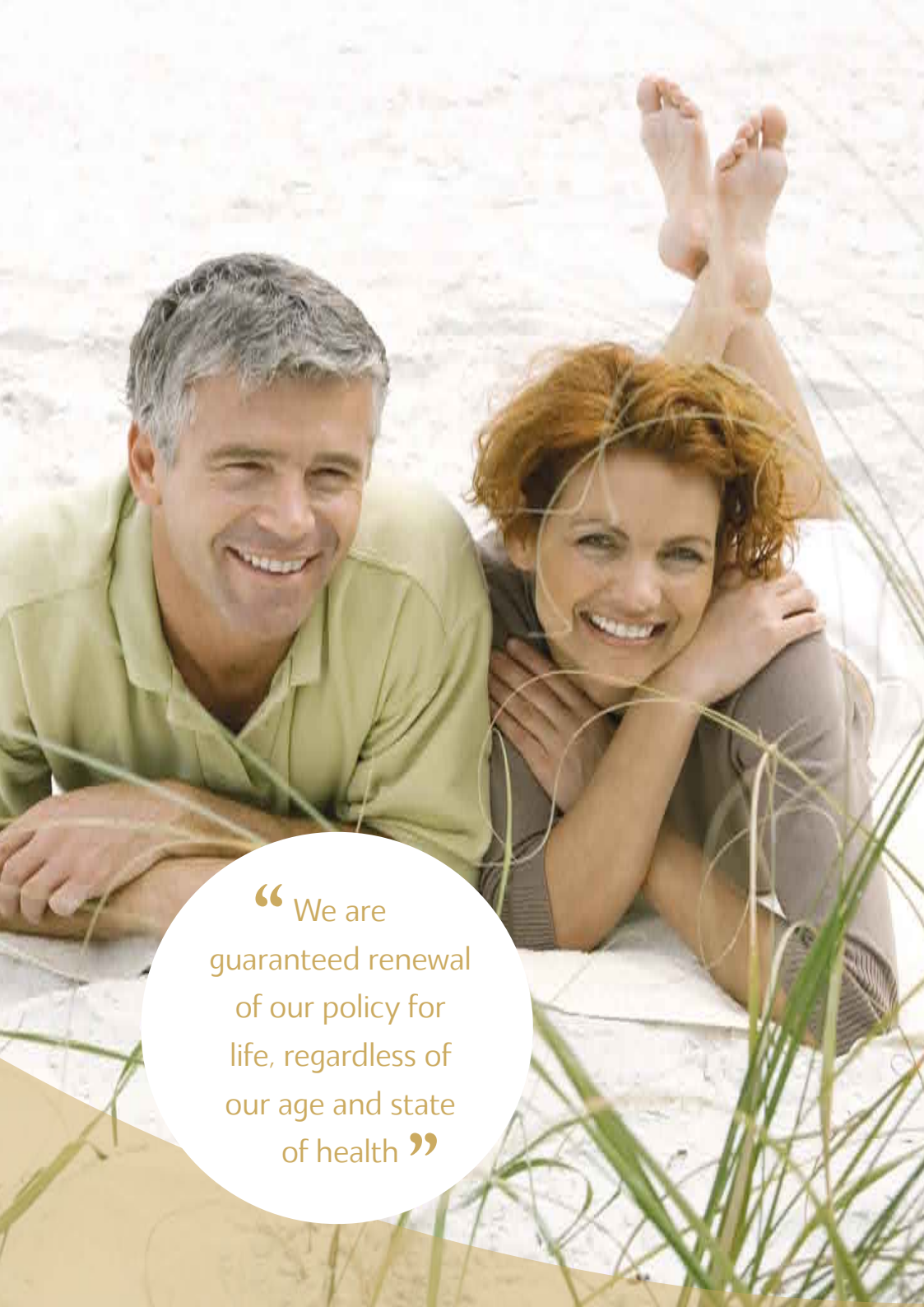
250,000 private and corporate clients in over 190 countries rely on IHI for their health and travel insurance. For more than 30 years, we have built up a global network of business partners, local offices and well-respected medical consultants.

As a Danish company, we are regulated by the strict standards set by the Danish Insurance Contracts Act and the European supervisory authorities.

IHI is a member of the worldwide health and care organisation BUPA which has been trading since 1947, and now looks after nearly 8.2 million members of 115 nationalities worldwide.

As a provident association BUPA has no shareholders to pay, which means that all surpluses and profits are continuously reinvested back into providing better health and care services for our members. BUPA has considerable financial resources and in 2005 group income totalled over USD 6.8 billion with group reserves of USD 4.793 million. BUPA Insurance Limited has been rated by Moody's and Fitch*.

** The rating from Moody's is A3. The ratings from Fitch are Long Term A, Insurer Financial Strength A+*


“ We are guaranteed renewal of our policy for life, regardless of our age and state of health ”

Your cover

IHI Premier 1 is a flexible plan with two cover options that can be supplemented with our IHI Travel plan.

Whichever cover option you choose, you will have excellent benefits and be covered both in and out of IHI's provider network, giving you complete freedom of choice when deciding which hospital, clinic or specialist to use.

Cover options

IHI Premier 1 - Diamond: This plan offers you comprehensive services, top benefits and worldwide cover for both inpatient and outpatient benefits. The yearly insurance sum is USD 2 million, giving you complete peace of mind.

IHI Premier 1 - Gold: This plan offers you comprehensive services and generous benefits for both inpatient and outpatient benefits. It also provides the possibility of choosing between cover in Latin America* only or worldwide cover. There is a yearly insurance sum of USD 1.5 million.

Supplementary option

IHI Travel: With an IHI Premier 1 plan your medical expenses are of course covered on travels outside your country of residence** but by taking out an IHI Travel plan you get extra travel benefits; eg next of kin accompaniment and repatriation if relatives at home get seriously, acutely ill. Furthermore, there is no deductible on IHI Travel - your travel claims count towards the annual deductible on IHI Premier 1. If you take out IHI Travel in addition to IHI Premier 1 you will receive a discounted rate on the travel plan.

The Policy Conditions for IHI Travel are described in a separate brochure.

** Please see Glossary for definition of Latin America*
*** With a Gold - Latin America you are covered on travels in Latin America*: with a travel insurance you are covered worldwide*

Choice of deductible

We offer a range of annual deductible options to help you reduce the price you pay for your cover - the higher the deductible, the lower the premium. You can choose between the following deductibles:

Deductible (USD)					
250	500	1,000	2,000	5,000	10,000

There is only one deductible per person per policy year and this applies to all services. However, to help you reduce your costs, as a family you will only have to pay the sum of the two highest deductibles on your policy.

Co-insurance

Co-insurance is the part of the medical bills that you must pay for each hospitalisation that takes place in the U.S.A. Once the deductible and the specific reimbursement rates have been applied, IHI will reimburse 80% of the first USD 5,000 and 100% of the remaining balance. This means that the maximum co-insurance you would have to pay for each hospitalisation in the U.S.A. is USD 1,000. There will be no co-insurance in connection with medical bills for maternity and serious accidents.

Children

When a parent is eligible for maternity cover, a newborn child is automatically enrolled in the parent's policy irrespective of the child's state of health at birth*. An important feature of IHI Premier 1 is that two children under the age of ten are insured free of charge.

Lifetime cover

You can be insured regardless of most conditions that you may have suffered from before taking out the insurance. IHI's medical consultants will conduct an assessment of your condition and decide the terms of your insurance policy. There may be an additional premium or exclusion for a given condition.

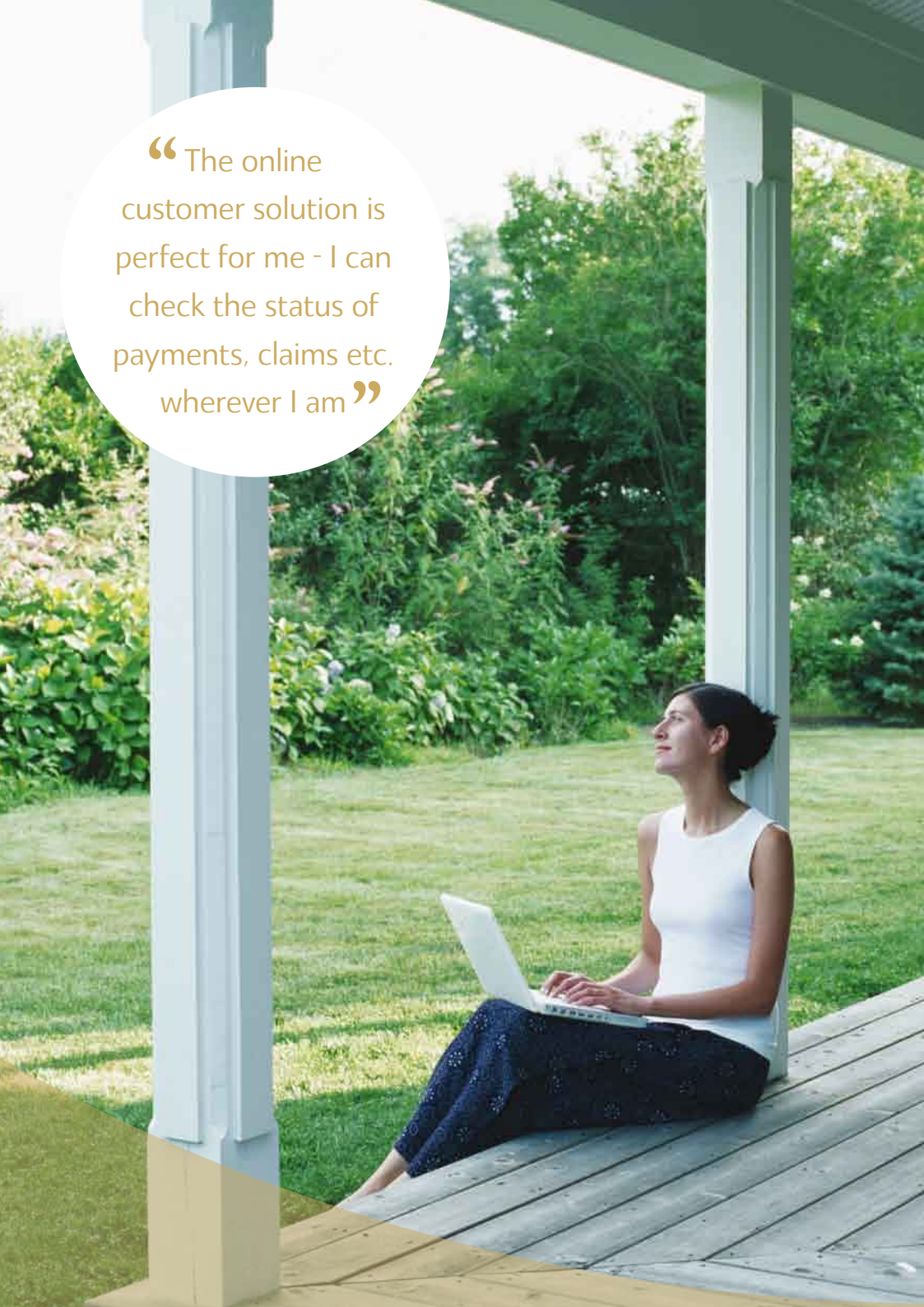
People of all nationalities under the age of 75 years can apply. Once accepted, we guarantee that the policy can be renewed for the rest of your life - regardless of your age and changes in your health. Even if you develop a long-term chronic illness, your cover will remain unchanged.

Occupations and activities

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

Please see the List of Reimbursements and the Policy Conditions for more details.

** See Art. 8.2 h)*


“The online customer solution is perfect for me - I can check the status of payments, claims etc. wherever I am”

Manage your policy online

Online services

As an IHI customer you have access to a range of online services. Visit www.ihi.com and click on "myPage", follow the guide and get access to:

- A complete overview of your policy
- All your documents (policy schedule, renewals, premium notices, receipts, reimbursement letters, etc.)
- Status on recent claims reimbursed
- Online premium payment
- A useful health and travel guide
- Online doctors: General advice from IHI's medical consultants on lifestyle diseases, exercise etc, including second opinions and counselling on treatments

Sign up as online customer - free and easy

Our online customer solution is a service for you who wish to avoid postal delays, letters lost in the mail, sorting of insurance documents and filing in binders. Sign up on www.ihi.com under myPage now and your policy will be serviced online exclusively.

We will notify you by e-mail when we have updates related to your insurance. That way you are always fully informed of your insurance status.

If you need help

Whether you have questions regarding your cover, claims etc. or you have an emergency situation, you can feel safe knowing that IHI only employ the most caring people with excellent linguistic skills and a comprehensive understanding of cultural differences to take care of your needs – our staff go the extra mile to provide personal and professional service.

IHI Assist - 24-hour emergency service and health advice

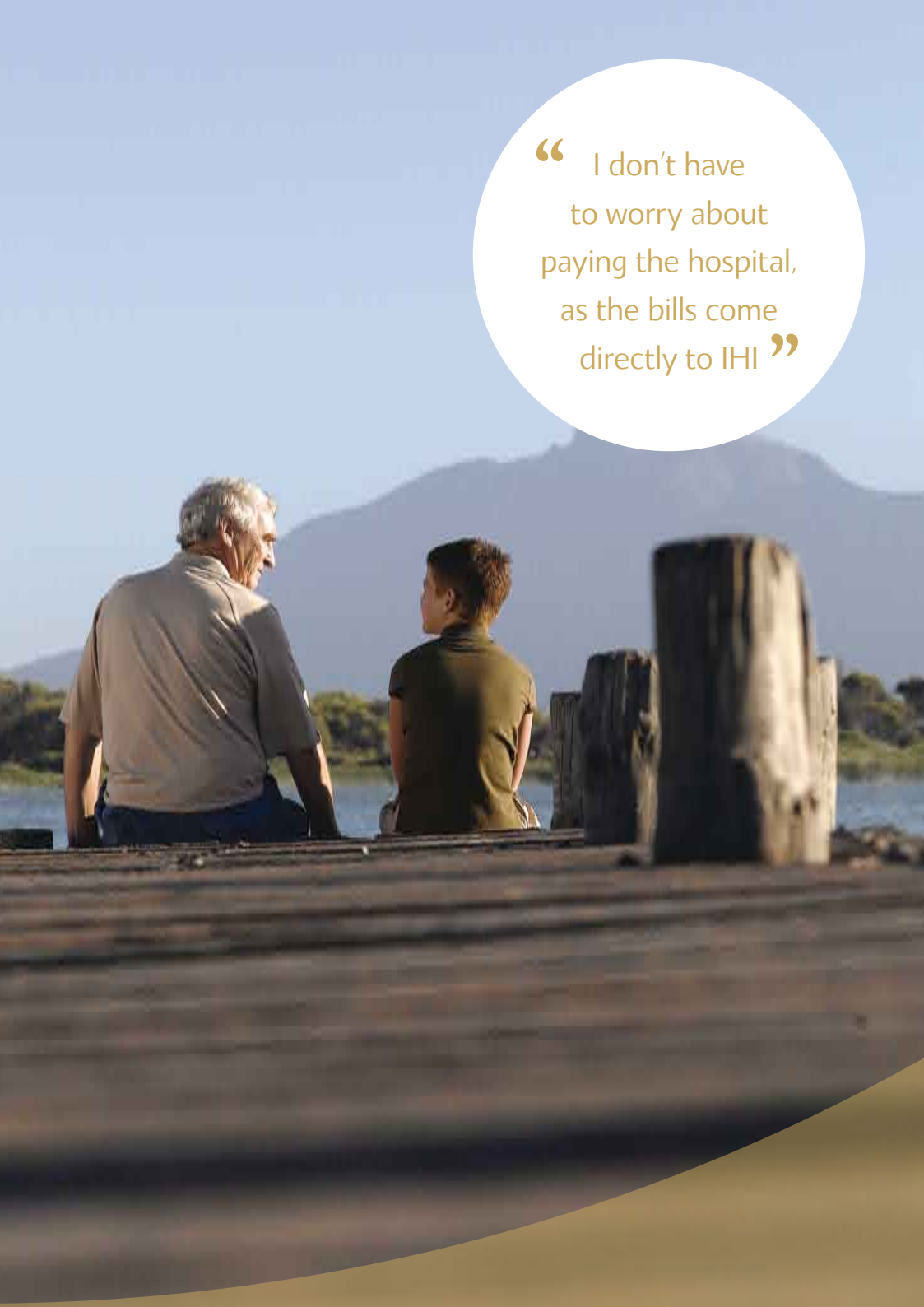
IHI Assist is at your disposal 24 hours a day, 365 days a year. IHI Assist takes care of emergencies, medical evacuations, medical advice and all the practicalities relating to a hospitalisation.

The IHI Assist staff handle approx. 100,000 inquiries a year, including medical evacuations. We take care of everything from plane ticket upgrades, for example, if you have a sprained ankle, to organising transportation in an air ambulance with an intensive care unit and doctors' team on board.

For medical advice, second opinions and in situations where you may require immediate contact with a doctor, IHI's medical consultants are here to assist and guide you. You will receive a list with several providers to choose from. You just have to inform us of your diagnosis and where in the world you wish to be treated. We can guide you, but the choice is always yours.

Tel: +45 33 15 33 00
E-mail: assist@ihi.com

On the back of your insurance card you will find information on how to contact IHI – including contact details for our 24-hour emergency service: IHI Assist.


“ I don’t have
to worry about
paying the hospital,
as the bills come
directly to IHI ”

How and when you can claim

Waiting periods

In the event of an acute, serious illness or injury, the cover will start immediately from the policy commencement date. For other conditions, there will be a waiting period of 4 weeks - with the following exceptions:

- If you switch to IHI from another international health insurance plan with another company, the cover will come into force immediately on the policy commencement date.

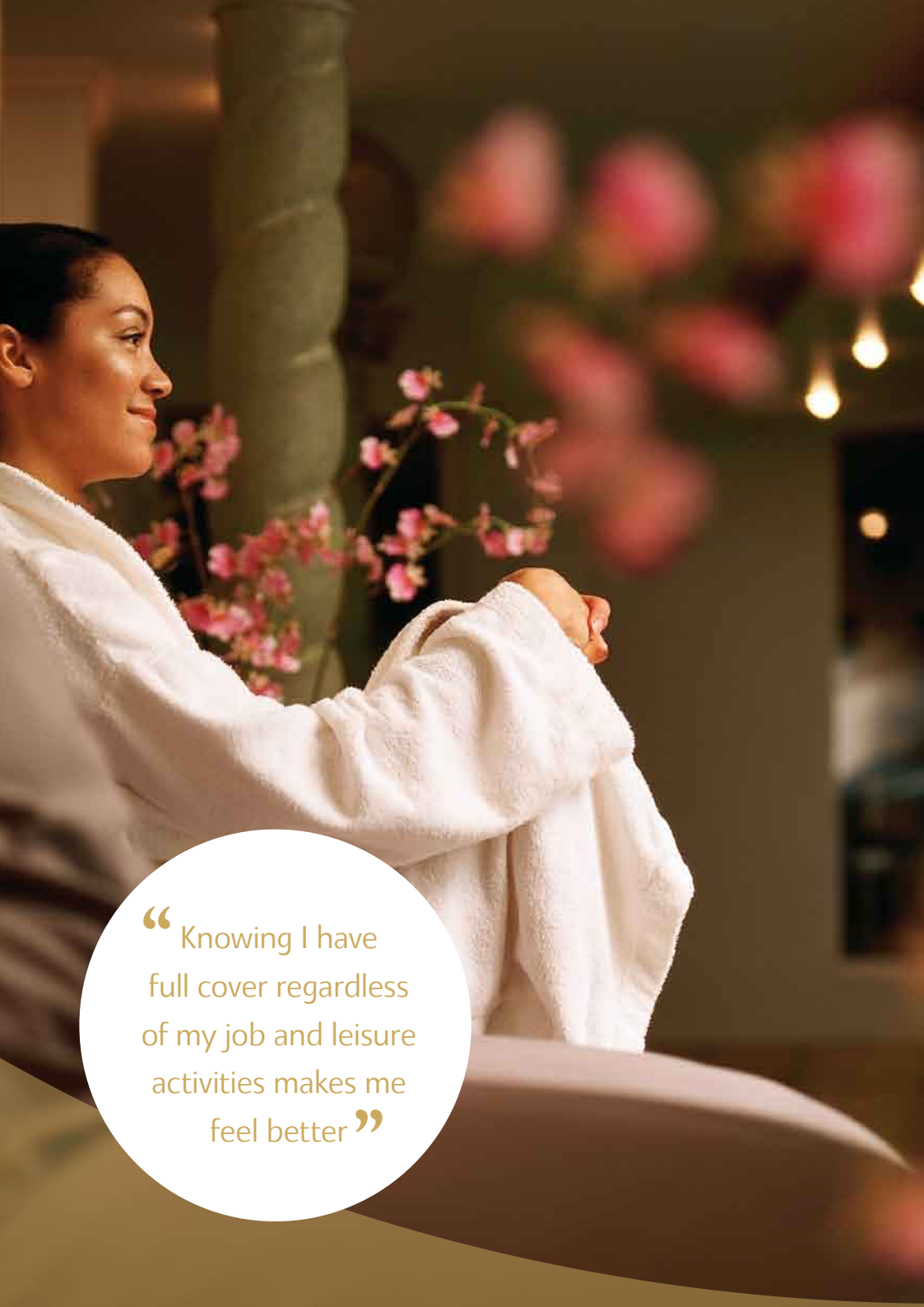
- The waiting period in connection with pregnancy and childbirth is 10 months.

Reimbursement

Reimbursements of costs incurred will be paid in accordance with the List of Reimbursements when the annual deductible has been met.

In the event that a hospitalisation takes place in the U.S.A., co-insurance will be deducted from the reimbursement.


“ Two of us are covered free of charge because we are under 10 years old ”


“Knowing I have full cover regardless of my job and leisure activities makes me feel better”

Day case and inpatient/hospitalisation treatment in and out of network

Please let us know of any admission to hospital as soon as possible so that we can arrange for direct settlement of your bills and leave you to concentrate on getting better. When you contact us, please let us know:

- Date of admission
- Diagnosis
- Treatment
- Expected date of discharge

Expenses in connection with the notification of a hospital admission will be refunded by IHI (eg your call to IHI from another country).

You can freely choose to receive treatment in any hospital or clinic. Day case and inpatient/hospitalisation treatment that takes place outside the U.S.A. will be reimbursed in full. If the treatment takes place in the U.S.A. within IHI's network of providers all day case and inpatient/hospitalisation benefits, after any deductible and co-insurance, will also be reimbursed in full. Please notice that it is a requirement that you contact IHI for pre-approval of any treatment within IHI's network of providers for reimbursement to be paid in full. If, in case of an emergency, you are not reasonably able to contact us for pre-approval you must in any event let us know of any admission to a network hospital within 72 hours.

If the provider of your choice in the U.S.A. is not part of IHI's network of providers, the out of network limits in the valid List of Reimbursements will apply.

We have a quality assured network of providers including more than 400,000 hospitals, clinics and medical practitioners. This means that you can rest assured that you will receive the very best treatment within IHI's network of providers, and most of your expenses can be settled directly with your medical facility. You can get further information regarding IHI's network of providers by contacting IHI or visiting myPage on www.ihi.com.

Other treatment

You are also free to choose any provider for outpatient treatment, such as medical consultations and physiotherapy. These expenses should be paid by the insured before claiming reimbursement.

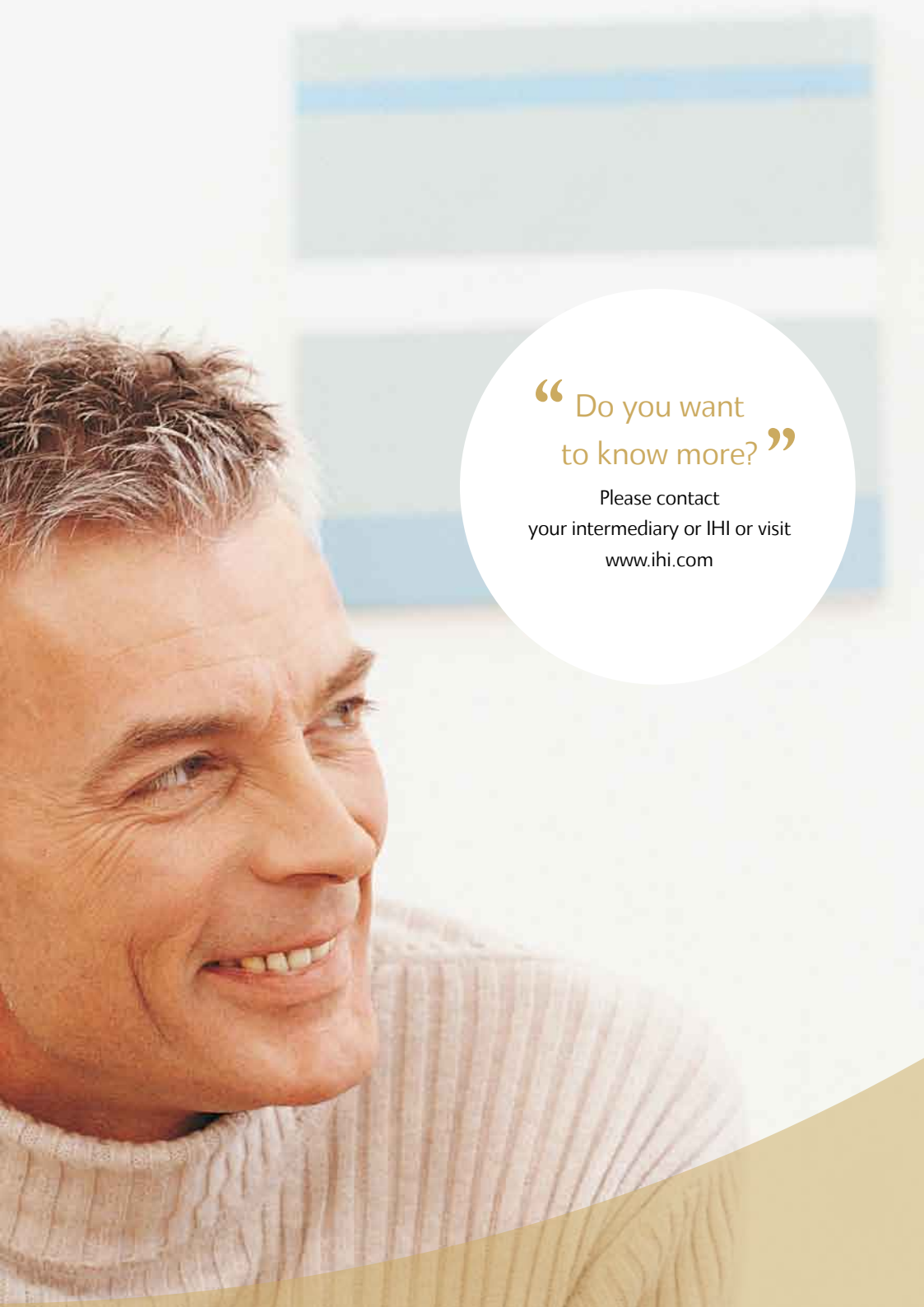
To claim reimbursement for expenses for outpatient treatment, please submit:

- Official, original and itemised bills and receipts
- A completed Claim Form

On receipt of the completed Claim Form we will process your claim and reimburse you in USD or any other convertible currency of your choice.

Medical evacuation

Regardless of the circumstances, you must inform us before the transportation is commenced, either directly or through the attending physician. Medical evacuation services must be pre-approved and arranged by IHI. In consultation with the attending physician, our medical consultants will choose an alternative place of treatment. We will take care of every detail to ensure that the transportation and the hospitalisation are managed as efficiently as possible.



“Do you want to know more?”

Please contact your intermediary or IHI or visit www.ihi.com

List of Reimbursements

Valid from 1 January 2007

Expenses will be reimbursed according to the following rates. Reimbursement will be paid when the total reimbursable amount exceeds the selected deductible. The List of Reimbursements forms part of the Policy Conditions. It is therefore recommended to read both the List of Reimbursements and the Policy Conditions carefully.

Words written in *italic* in the List of Reimbursements and the Policy Conditions are 'defined terms' which are specific terms relevant to your cover. Please check their meaning in the Glossary at the end of this product guide.

All amounts are in USD

Maximum coverage	Diamond	Gold
Maximum cover, per person per policy year	2 million	1.5 million

Day case and inpatient/hospitalization benefits		
Treatment outside the U.S.A.: If treatment takes place outside the U.S.A., all the below *day case* and *inpatient/hospitalisation* benefits will be reimbursed in full The below maximum days and rules of pre-approval still apply **Treatment in network of providers in the U.S.A.:** If the Company's *network of providers* is chosen, all the below *day case* and *inpatient/hospitalisation* benefits will be reimbursed in full The below maximum days and rules of pre-approval still apply Treatment in *network of providers* must be pre-approved by the Company	100%	
Treatment out of network in the U.S.A.: If a hospital or clinic in the U.S.A. not in the Company's *network of providers* is chosen, reimbursement of the expenses will be made according to the following maximum *reimbursement rates*		
Doctors' fees for surgical and medical services	100%	100%
Private or semi-private room, per day	1,350	1,000
Intensive care room, per day	3,750	3,000
Related services: nursing, theatre fees, medicine and dressings	100%	100%

Day case and inpatient/hospitalisation benefits (Continued)	Diamond	Gold
Room and board at the hospital for a relative accompanying an *insured* person, per day	400	300
Medically prescribed *inpatient rehabilitation* (hospital or rehabilitation centre) due to *serious accident*/illness Max. per day all-inclusive For max. 30 days per incident *Inpatient rehabilitation* must be pre-approved by the Company	675	525
Medical treatment and tests, including outpatient *surgery*	100%	100%
Emergency room treatment in connection with acute illness or accident	100%	100%
Prostheses, corrective devices and medical appliances which are medically required and implanted during *surgery*	100%	100%
Acute emergency dental treatment due to *serious accident* up to 30 days after discharge from hospital In case of doubt the decision will be left with the Company's dental consultant	100%	100%
Co-insurance will be applied to each hospitalisation in the U.S.A.		

Other benefits	Diamond	Gold
Chemotherapy/medicine and radiation for treatment of cancer	100%	100%
Dialysis for kidney failure	100%	100%
Organ transplant, lifetime max. per diagnosis and course of treatment, all-inclusive Only cover for transplant of human organs. The procurement of the organ must be pre-approved by the Company	750,000	600,000
Medically prescribed home nursing by a registered nurse following hospitalisation due to *serious accident*/illness Max. per day all-inclusive Limited to 30 days per incident Home nursing must be pre-approved by the Company	300	250
Hospice and *terminal care*: *day case*, inpatient or outpatient treatment Max. per policy year Hospice and *terminal care* must be pre-approved by the Company	15,000	10,000
Emergency local road ambulance to and from hospital	100%	100%

Maternity	Diamond	Gold
Normal delivery, complicated delivery and elective caesarean delivery, incl. pre- and postnatal treatment	8,500	7,000
Medically prescribed caesarean delivery, incl. pre- and postnatal treatment	13,000	10,000
There is a *waiting period* of ten months before the maternity benefits come into force		

Outpatient benefits	Diamond	Gold
Doctors, specialists and/or psychiatrists Max. 30 consultations per policy year	100%: treatment in *Latin America*, excl. Mexico 80%: treatment in rest of the world	
Surgical intervention		
Laboratory test, x-ray, endoscopy (eg gastroscopy, colonoscopy, cystoscopy), electrocardiogram, echocardiography, biopsy and ultrasound		
MRI, CAT and PET scans		
Therapy, incl. doctor's consultations and treatment: physiotherapy, chiropractic treatment, osteopathy, acupuncture, homoeopathic treatment, occupational treatment and medically prescribed short term speech therapy in connection with an illness or injury Max. 60 consultations in total per policy year		
Prescribed dietetic guidance by an authorised dietician Max. 4 consultations per policy year		
Health check-up, all-inclusive Max. per policy year	600	300
Prescribed medicine following hospitalisation and outpatient *surgery* for the purpose of covered treatment Max. per person per policy year The medicine must be related to the treated diagnosis and a hospital prescription must be enclosed with the Claim Form	3,200	1,000
Prescribed medicine for the purpose of covered outpatient treatment Max. per person per policy year A prescription must be enclosed with the Claim Form. There is no cover for medicines that are freely available for self-administration	700	400

Medical evacuation	Diamond	Gold
Evacuation services	100%	100%
Transportation to the nearest suitable location in the event of an *acute serious illness* or *serious injury* where no qualified treatment can be obtained locally	100%	100%
Expenses for a family member or a friend accompanying the *insured* during the transportation	100%	100%
Expenses for the return journey upon completion of the treatment to the place from where the *insured* was evacuated; for the *insured* and any accompanying person	100%	100%
In case of death, transportation of the deceased and statutory arrangements, such as embalmment and zinc coffin	100%	100%
Evacuation services must be pre-approved by the Company and the arrangements made by the Company		

Online services

- Manage your policy online, eg online payments, status on recent claims
- General health advice and second opinions from IHI's medical consultants
- Access to a range of health related information
- and much more...

Supplementary option

All amounts are in USD

IHI Travel (not automatically included)	
Annual insurance sum	300,000
• Cover for sudden unexpected illness or injury when travelling outside your country of residence • Next of kin accompaniment • Repatriation in case of a relative falling seriously, acutely ill • No *deductible* is applied	
The conditions regulating IHI Travel are found in a separate brochure	

Policy Conditions

Valid from 1 January 2007

In accordance with the Danish Insurance Contracts Act.

Index

Art. 1 Acceptance of the insurance

1.1: International Health Insurance danmark a/s, hereinafter called the Company, shall decide whether the *insurance* can be accepted. In order for the *insurance* to be accepted and the Company to become liable, the *application* must be approved by the Company and the necessary premium paid to the Company.

1.2: In order for the *insurance* to be accepted by the Company, an *application* must be submitted prior to the *applicant* attaining the age of 75 (seventy-five). The Company has the right to waive this requirement in exceptional cases.

1.3: In order for the *insurance* to be accepted by the Company on *standard terms*, the *applicant* must be of sound health at the time of acceptance and must not suffer nor have suffered from any recurring disease, illness, injury, bodily infirmity or physical disability.

1.3.1: If the conditions in Art. 1.3 are not met, the Company may offer the *insurance* on *special terms*. If the Company decides to offer the *insurance* on *special terms*, the *policyholder* will receive a *policy schedule* in which these terms are stated.

1.3.2: All underwriting and issuance of *policy schedules* are made from the Company's headquarters in Copenhagen, Denmark. The Company may choose to have data processed in or outside the EU.

1.4: In the event of a change in the *applicant*'s state of health after the *application* has been signed and before the Company's approval thereof, the *applicant* shall be under the obligation to notify the Company of such change immediately.

Art. 2 Commencement date

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

Art. 3 Waiting periods in connection with new insurance contracts

3.1: When a new insurance contract is entered into, the right to reimbursement under the new insurance contract shall only take effect 4 (four) weeks after the *commencement date* of the *insurance*. However, this does not apply when the *policyholder* can prove simultaneous transference from an equivalent insurance with another international health insurance company.

3.1.1: In the event of *acute serious illness* and/or *serious injury*, the right to reim-

bursement shall, however, take effect concurrently with the *commencement date* of the *insurance*.

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

3.2: The *insured* may change his/her insurance cover to another type of cover as from a policy anniversary by giving 1 (one) month's written notice to the Company and subject to proof of insurability according to Art. 1.

3.3: The Company will process an extension of cover as a new *application* in accordance with Art. 1.

Art. 4 Who is covered by the insurance?

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

4.2: Per *family*, two children under 10 (ten) years of age can be insured free of charge if the requirements for acceptance on *standard terms*, cf. Art. 1.3, are met.

4.2.1: Free cover of children shall be subject to:

- the child being registered with the Company, and
- one of the *insured* persons having legal custody of the child.

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

4.3.1: If the *insurance* of one of the parents has been valid for a minimum of 10 (ten) months, newborn children of the parent can be insured, irrespective of Art. 1.3, without submitting an *application*, cf. however Art. 8.2 h). A copy of the birth certificate must, however, be submitted within 3 (three) months after the birth. If the Company does not receive the birth certificate within 3 (three) months after the birth, the newborn child will have to undergo the standard underwriting procedure, according to Art. 1.

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

Art. 5 Where is cover provided?

5.1: The *insurance* shall provide cover in the region stated in the *policy schedule*.

Art. 6 What is covered by the insurance?

6.1: The *insurance* shall cover the *insured's* medical expenses in accordance with the cover chosen and the applicable *reimbursement rates*. The valid *reimbursement rates* are stated in the List of Reimbursements.

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

6.3: Once the covered expenses have met the annual *deductible*, the reimbursable amount will be paid. The *deductible* shall be reduced with amounts not exceeding the maximum *reimbursement rates* specified in the valid List of Reimbursements. The *deductible* shall apply per person per policy year. However, a maximum of two *deductibles* per *family* per policy year shall apply. (The sum of the two highest *deductibles* on the policy is the maximum *deductible* drawn on the policy per policy year). Each hospitalisation in the U.S.A. is subject to *co-insurance*. Once the applicable *deductible* and specific limits have been met, the Company will reimburse 80% of the first USD 5,000 and 100% of sums in excess of USD 5,000 up to the relevant *reimbursement rates*.

6.3.1: In case of *serious accident*, no *deductible* or *co-insurance* shall apply for the period of the first hospitalisation.

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

6.5: In no event shall the amount of reimbursement exceed the amount shown on the bill. If the *insured* receives compensation from the Company in excess of the amount to which the *insured* is entitled, the *insured* shall be under the obligation to repay the Company for the excess amount immediately, otherwise the Company will set off the excess amount in any other account between the *insured* and the Company.

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

6.7: Any discount, which has been negotiated directly between the Company and providers, will be specifically used by the Company for the overall benefit of the *insured* persons within the insurance product as a whole.

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

Art. 7 Medical evacuation

7.1: For cover of medical evacuation the conditions listed below shall apply.

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

7.1.2: The evacuation expenses for a transportation covered under the *insurance* shall only be compensated if the transportation is arranged by the Company.

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

7.1.4: The *insurance* shall cover reasonable and medically necessary transportation expenses only for one person accompanying the *insured*.

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

7.1.6: Medical evacuation cover shall only apply if the illness is covered under the *insurance* and if the *insured's* cover includes the country to which the *insured* is being transported.

7.1.7: In the event that the *insured* is transported for the purpose of receiving treatment, he/she and the accompanying person, if any, shall be reimbursed for the expenses for a return journey to the place from where the *insured* was evacuated. The return journey shall be made at the latest 90 (ninety) days after the treatment has been completed. Cover shall only be provided for travelling expenses equivalent to the cost of an aeroplane ticket on economy class, as a maximum.

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

7.1.9: In the event of death, expenses shall be reimbursed for home transportation of the deceased and for the statutory arrangements such as embalming and a zinc coffin. The next-of-kin have the following options:

a) cremation of the deceased and home transportation of the urn, or

b) home transportation of the deceased.

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

Art. 8 Exceptions for reimbursement

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

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

a) cosmetic surgery and treatment, unless medically prescribed and approved by the Company,

b) obesity surgery, unless approved by the Company,

c) venereal diseases, AIDS, AIDS-related diseases and diseases relating to HIV antibodies (HIV positive). However, diseases relating to AIDS and HIV antibodies (HIV positive) are covered if proven to be caused by a blood transfusion received after the *commencement date*. The HIV virus will also be covered if proven to be contracted as the result of an accident occurring during the course of a *normal occupation*. The *insured* shall notify the Company within 14 (fourteen) days after such accident and at the same time provide a negative HIV antibody test,

d) abuse of alcohol, drugs and/or medicines,

e) intentional self-inflicted bodily injury,

f) contraception, including sterilisation,

g) induced abortion unless medically prescribed,

h) any kind of fertility test and/or treatment, including hormone treatment, insemination, or examinations and any procedures related hereto. An *application* must be submitted for children born as a result of fertility treatment and/or born by a surrogate mother. The *application* will undergo the standard underwriting procedure, according to Art. 1,

i) treatment of sexual dysfunction,

j) any kind of care which is experimental, not part of a medical or surgical treatment, including stays in long-term care establishments, health resorts, convalescent homes and similar institutions,

k) treatment by naturopaths or homoeopaths and naturopathic or homoeopathic medications and other alternative methods of treatment, unless specified in the List of Reimbursements, and mental health inpatient stay that is purely for the purpose of treatment by a psychologist,

l) routine medical examinations, unless specified in the List of Reimbursements, vaccinations, the issuing of medical certificates and attestations and examinations as to suitability for employment or travel,

m) treatment of diseases during military service,

n) treatment for sickness or injuries directly or indirectly caused while actively engaging in:

war, invasion, acts of a foreign enemy, hostilities (whether war has been declared or not), civil war, terrorist acts, rebellion, revolution, insurrection, civil commotion, military or usurped power, martial law, riots or the acts of any lawfully constituted authority, or army, naval or air services operations, whether war has been declared or not,

o) nuclear reactions or radioactive fallout,

p) treatment performed by the *insured* and/or his/her family or any enterprise owned by or connected with one of the aforesaid persons,

q) epidemics which have been placed under the direction of public authorities,

r) treatment by psychologists,

s) medicine, whether given by injection or otherwise, medical articles and auxiliary appliances which have not been administered during *hospitalisation*, unless specified in the List of Reimbursements,

t) *hospitalisation* if the sole purpose is administration of medicine, treatment by a therapist or complementary medical practitioner or any other treatment when this could take place as outpatient treatment,

Art. 9 How to report a claim

9.1: For each *claim*, a fully completed Claim Form must be submitted to the Company. The Claim Form must be completed and signed by the attending physician and accompanied by the official, original and itemised bills and receipts for the treatment received. The bills and receipts shall be denominated in the currency of the country, where the treatment is provided. Photocopies shall not be regarded as acceptable documentation.

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

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

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

9.3.1: All *day case* and *inpatient/ hospitalisation treatment* within the Company's *network of providers* in the U.S.A. must be pre-approved by the Company. If the Company is not contacted for pre-approval, the expenses will be reimbursed according to the *out of network* limits stated in the valid List of Reimbursements. If, due to an emergency, the *insured* is not reasonably able to contact the Company for pre-approval the *insured* must let the Company know of any admission to hospital within 72 hours.

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

Art. 10 Cover by third parties

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

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

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

10.4: The *policyholder* and any *insured* person undertake to co-operate with the Company and to notify the Company immediately of any *claim* or right of action against third parties.

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

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

Art. 11 Payment of premium

11.1: Premiums are determined by the Company and shall be payable in advance. The Company adjusts the premiums once a year as from the *anniversary date* on the basis of changes in the covers and/or the loss experience in the insurance class during the previous calendar year.

11.2: The premium is age-related and will therefore also be adjusted on the first premium *due date* after the *insured's* birthday.

11.2.1: In the case of a child turning 10 (ten) a pro rata premium will be charged on the *due date* prior to the child's 10th (tenth) birthday.

11.3: The initial premium shall fall due for payment on the *commencement date*. The *policyholder* may choose between quarterly, semi-annual and annual premium payments.

11.4: Changes in the term of payment can only be made at 30 (thirty) days' written notice prior to the policy anniversary.

11.5: There are 10 (ten) days of grace on each premium *due date*.

11.6: The *policyholder* shall be responsible for punctual payment to the Company and, if a premium is not received by the Com-

pany within the 10 (ten) days' grace period at any premium *due date*, the Company's liability shall lapse.

11.7: In the event of the death of a *policyholder*, who is also insured on the policy, the premium on the policy may be waived for a period of 12 (twelve) months from the upcoming premium *due date*. The death must have been caused by a condition which would have been covered under this policy had the *policyholder* survived. The waiver applies only to the spouse or partner and their children under the age of 24 who remain insured under the existing policy and will automatically terminate in the event of marriage of the remaining spouse or partner. The waiver does not apply to any supplementary *insurance*.

11.8: The *policyholder*'s attention is drawn to Art. 6.5 regarding payment of outstanding amounts.

Art. 12 Information necessary to the Company

12.1: The *policyholder* and/or the *insured* shall be under an obligation to notify the Company in writing of any changes of name or address and changes in health insurance cover with another company. If the *policyholder* and/or the *insured* change address to a different premium zone, the premium applicable to the new zone will apply from the first coming *anniversary date*. The Company must also be notified in the event of the death of the *policyholder* or an *insured*. The Company shall not be liable for the consequences if the *policyholder* and/or the *insured* fail to notify the Company of such events.

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

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

Art. 13 Assignment, cancellation and expiry

13.1: Without the prior written consent of the Company, no party shall be entitled to create a charge on or assign the rights under the *insurance*.

13.2: The *insurance* is automatically renewed on each policy *anniversary date*.

13.2.1: The *insurance* can be cancelled by the *policyholder* as from the *anniversary date* with 3 (three) month's written notice. The *insurance* shall be effective for 12 (twelve) months as a minimum.

13.3: Where, upon taking out the *insurance* or subsequently, the *policyholder* and/or the *insured* has fraudulently changed original *documents* or disclosed incorrect information or withheld facts which may be regarded as being of importance to the Company, the insurance contract shall be void and shall not be binding on the Company.

13.4: Where upon taking out the *insurance* or subsequently, the *policyholder* and/or the *insured* has disclosed incorrect information, the insurance contract shall be void, and the Company shall not be liable if the Company would not have accepted the *insurance* if the correct information had been disclosed. If the Company would have accepted the *insurance* but on other terms, the Company shall be liable to the extent to which the Company would have undertaken the obligations in accordance with the agreed premium.

13.4.1: In the event that the insurance contract is considered void, according to Art. 13.3 or Art. 13.4, the Company shall be entitled to a service charge which is set as a specified percentage of the premium paid.

13.5: Where, upon taking out the *insurance*, the *policyholder* and/or the *insured* neither knew nor should have known that the information disclosed by him/her was incorrect, the Company shall be liable as if such incorrect information had not been disclosed.

13.6: The Company can stop or suspend an insurance product at 3 (three) month's notice prior to the policy anniversary, and offer the *insured* an equivalent insurance cover.

13.7: Upon expiry of the *insurance*, the right to compensation shall cease. However, expenses covered under the *insurance* and defrayed during the insurance period shall be reimbursed up to 3 (three) months after the expiry of the *insurance*. After-effects of an injury or illness incurred during the insurance period shall not be covered after the expiry of the *insurance*.

Art. 14 Disputes, venue, etc.

14.1: Any disputes arising out of or in connection with the insurance contract shall be settled in accordance with Danish law, with Copenhagen as the agreed venue. The Company is affiliated to:
Ankenævnet for Forsikring
Anker Heegaards Gade 2
1572 Copenhagen V, Denmark
(The Insurance Appeal Board).

Glosario

Este Glosario y las definiciones en él contenida forman parte de las Condiciones de la Póliza.

Acute serious illness: an *acute serious illness* shall be determined to exist only after review and agreement by both the attending physician and the Company's medical consultants.

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

Applicant: a person named on the Application Form and the Medical Questionnaire as an *applicant* for *insurance*.

Application: the Application Form and Medical Questionnaire.

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

Co-insurance: the part of the medical expenses the *insured* must pay if hospitalised in the U.S.A.

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

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

Deductible: the amount of money noted in the *policy schedule* which each *insured* agrees to pay each policy year before being compensated by the Company.

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

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

Family: mother and/or father and children under the age of 24. Children aged 24 and older will be transferred to a separate policy.

Inpatient/hospitalisation treatment: *surgery* or medical treatment in a hospital or clinic when it is medically necessary to occupy a bed overnight.

Inpatient rehabilitation: treatment aimed at restoring physical health and/or mobility taking place during hospitalisation or as inpatient treatment at an authorised rehabilitation centre following hospitalisation due to *serious accident*/illness.

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

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

Latin America: the countries south of the U.S.A.: South America, Central America and the Caribbean, excluding Mexico.

Network of providers: the Company's service partner in the U.S.A. This service partner operates a national network of hospitals, clinics and medical practitioners. When eligible *day case* and *inpatient/hospitalisation treatment* takes place using the Company's *network of providers*, benefits are paid at 100% after any *deductible* and *co-insurance*. Information regarding the *network of providers* can be obtained by contacting the Company or visiting myPage on www.ihi.com.

Normal occupation: *normal occupation* in accordance with Art. 8.2. c) includes only the following professions: doctors, dentists, nurses, laboratory personnel, ancillary hospital workers, medical and dental assistants, ambulance personnel, midwives, fire brigade personnel, policemen/-women, and prison officers.

Out of network: eligible treatment that takes place in the U.S.A. with other providers than those participating in the Company's *network of providers*. When treatment takes place *out of network*, benefits are paid according to the valid List of Reimbursements after any *deductible* and *co-insurance*.

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

Policyholder: the person identified as the *policyholder* on the Application Form.

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

Pre-existing condition: the medical history, including the illnesses and conditions listed in

the Medical Questionnaire, which may affect the Company's decision to insure or not to insure or to impose *special terms*.

Reimbursement rates: the maximum amount of money which will be paid by way of reimbursement of medical expenses in one year from the *commencement date* or from each *anniversary date*, as further detailed in the *Policy Conditions*.

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

Serious accident: a fortuitous serious injury occurring without the *insured's* intention which has a sudden external and violent impact on the body, resulting in demonstrable bodily injury, and which requires immediate hospitalisation.

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

Special terms: restrictions, limitations or conditions applied to the Company's *standard terms* as detailed in the *policy schedule*.

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

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

Surgery: a surgical treatment/intervention, which does not include endoscopies and scans even though these examinations may require anaesthesia.

Terminal care: care that the *insured* receives following diagnosis of a terminal condition, including physical, psychological and social care, as well as accommodation in a bed, nursing care and prescribed drugs. This care must be pre-approved by the Company.

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

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

Valid from 1 January 2007
E. & O. E.

20XE7-11/10.2006

IHI.COM

International Health Insurance danmark a/s

Denmark - Copenhagen
Head office
8, Palaegade
DK-1261 Copenhagen K
Denmark

Opening hours for telephone inquiries:
08:00 a.m. - 10:00 p.m. (CET) on weekdays.

Tel: +45 33 15 30 99
Fax: +45 33 32 25 60
E-mail: ihi@ihi.com

IHI ASSIST
(24-hour emergency service)
Tel.: +45 33 15 33 00
E-mail: assist@ihi.com
www.ihi.com

Reg. No. CVR 88076516

Spain - Fuengirola (Málaga)
Tel: +34 952 47 12 04 • E-mail: spain@ihi.com

France - Nice
Tel: +33 (0)4 92 17 42 42 • E-mail: france@ihi.com

Isle of Man
Tel: +44 1624 677 412 • E-mail: iom@ihi.com

Morocco - Casablanca
Representative office
Tel: +212 22 99 04 34 • E-mail: ihimaroc@menara.ma

USA - Miami
Tel: +1 (305) 270-3944 • E-mail: us@ihi.com
• Toll Free Number: 1-888-5DANMARK

Bolivia - Santa Cruz
Tel: +591 3 3412842 / +591 3 3412841
• E-mail: bolivia@ihi.com

Mexico - Mexico City
Tel: +52 (55) 5202-5870 • E-mail: mexico@ihi.com

Hong Kong
Tel: +852 2529 2723 • E-mail: hongkong@ihi.com

Japan -Tokyo
Representative office
Tel: +81 3 34 05 07 94 • E-mail: info@ihidanmark.jp

A member of the BUPA group

International Health Insurance **danmark a/s**