INTERNATIONAL HEALTH AND HOSPITAL PLAN

International Health and Hospital Plan

Valid from 2017 • EUR/GBP/USD

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Contents

Deductible choices

The *deductible* is the contribution you make towards the cost of your *treatment* each policy year before receiving reimbursement.

EUR: Nil, 350, 1,050, 4,000, 8,000, 16,000

GBP: Nil, 250, 750, 2,750, 5,500, 11,000

USD: Nil, 400, 1,600, 5,000, 10,000, 20,000

You can choose to take out your plan with or without a *deductible*, in any of the three currencies.

Taking out a *deductible* lowers your premium.

The *deductible* does not apply to Medical Evacuation and Repatriation and/or Dental.

Change of cover*

At an *insurance* policy *anniversary date* you can change your cover by adding or removing a *deductible* or the following optional modules:

- Module 1: Non-*Hospitalisation* Benefits
- Module 2: Medicine and *Appliances*
- Module 3: Medical Evacuation and Repatriation
- Module 4: Dental and Optical

Discount on Bupa Global travel plan

With your health *insurance* you are eligible for a 10% discount if you buy *our* Single Trip or Annual Travel and a further 5% if you buy online.

* Please see the *Policy Conditions* for further information.

List of Reimbursements

Please note that the List of Reimbursements is 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 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.

Valid from 1 January 2017. All amounts are in EUR/GBP/USD.

Hospital Plan

Reimbursements under the Hospital Plan are effected according to the List of Reimbursements below. If you have chosen a *deductible*, please note that the *reimbursement rates* for the benefits listed in the List of Reimbursements will be reduced by any remaining *deductible*. Once your *deductible* has been reached, all covered expenses will be paid in line with your *reimbursement rates*. For the Hospital Plan and any additional modules the reimbursements will not in any event exceed the following amounts or the overall annual maximum cover per person per policy year of EUR 1,650,000/GBP 1,350,000/
USD 2,000,000.

Hospital Services — during Hospitalisation	**Hospital plan**
Semi-private/private room (cf also Glossary: '*Hospital accommodation*')	100%
Intensive care room	100%
Room and board for a parent accompanying an *insured* child (cf also Glossary: '*Hospital accommodation*')	100%
Surgery	100%
Medical *treatment*, laboratory tests, X-rays	100%
Medicine for use during *hospitalisation* and relevant only for the *insured* condition being treated	100%
Pacemaker	100%
Psychiatric *treatment*	100%

Pre-examinations that are medically necessary in order to perform the *surgery* or *treatment* which is to take place during *hospitalisation* are covered up to 30 days prior to *hospitalisation*.

Check-ups that are medically necessary in order to verify that the *insured* is recovering successfully from the *surgery* or *treatment* received while hospitalised are covered up to 90 days after *hospitalisation*.

Physiotherapy following *surgery* must be evaluated and pre-approved by the *Company*.

Outpatient Treatment in a Hospital or Clinic	**Hospital Plan**
Surgery	100%
Cancer *treatment* Once cancer has been diagnosed this benefit includes fees that are related specifically to planning and carrying out *active treatment for cancer*. This includes tests, diagnostic imaging, consultations and prescribed medicines (when receiving anti-hormonal drug as sole *treatment* for cancer, only the anti-hormonal drug expenses are covered)	100%

Hospital Plan (continued)

Outpatient Treatment in a Hospital or Clinic	Hospital Plan
Dialysis, intravenous drug infusion which is only available as an infusion (must be pre-approved by the *Company*)	100%
Endoscopic examinations	100%

Other *outpatient treatment* is reimbursed under Module 1 - Non-*Hospitalisation* Benefits

Childbirth (subject to a 12 month waiting period)	Hospital Plan	Hospital Plan incl. Module 1 Non-Hospitalisation Benefits
Delivery and non-medically prescribed caesarean delivery incl. pre- and postnatal *treatment* for mother and child (cf also art. 7.1.3). Max. per delivery	Covered 100% up to EUR 5,725 / GBP 3,925 / USD 7,150	Covered 100% up to EUR 9,675 / GBP 6,650 / USD 12,100
Medically prescribed caesarean, incl. pre- and postnatal *treatment* for mother and child. (cf also art. 7.1.3) Max. per delivery	Covered 100% up to EUR 10,625 / GBP 7,325 / USD 13,200	Covered 100% up to EUR 12,650 / GBP 8,575 / USD 15,400
Delivery and caesarean following fertility *treatment*. Excluding pre- and postnatal *treatment* for mother and child (cf also art. 12.2 h), max.	Covered 100% up to EUR 5,725 ./ GBP 3,925 / USD 7,150	Covered 100% up to EUR 7,150 / GBP 4,850 / USD 8,800

Childbirth / Home Delivery or delivery at birthing centre (subject to a 12 month waiting period)	
Doctor/specialist, midwife	EUR 145 / GBP 100 / USD 165
Home nursing in connection with home delivery or delivery at *birthing centre*	EUR 435 / GBP 300 / USD 490

Pre- and postnatal examinations are reimbursed under Module 1 Non-*Hospitalisation* Benefits

Organ Transplant	
Organ transplant	100%
Per diagnosis and course of *treatment* per lifetime, to include all related costs up to the financial maximum The *insurance* policy must be valid throughout the course of *treatment*. The procurement of the organ must be pre-approved by the *Company*	EUR 450,000 / GBP 315,000 / USD 500,000

Emergency Room Treatment	
Emergency room *treatment* in connection with an acute illness or accident	100%

Hospital Plan (continued)

Local medical transport	
Ground transport to and from hospital when it is medically necessary that special medical services and/or medical equipment are provided	100%
Per policy year, max.	EUR 1,500 / GBP 1,000 / USD 1,600

Inpatient Rehabilitation	
Medically prescribed inpatient rehabilitation at an authorised medical facility following *hospitalisation* for *treatment* covered by this *insurance* (must be pre-approved by the *Company*)	100%
Max. per day for max. three months per illness	EUR 330 / GBP 220 / USD 355

Home Nursing	
For expenses incurred for medically prescribed assistance in your private home by a certified nurse (must be pre-approved by *the Company*)	100%
Max. per day for max. 40 days per policy year	EUR 130 / GBP 84 / USD 135

Hospital Cash Benefit	
If room, board and *treatment* are received free of charge or at a minor admission/service fee at a public hospital, per night max. Max. 60 nights per policy year (must be pre-approved by the *Company*)	EUR 90 / GBP 60 / USD 100

Emergency Dental Treatment	
Acute emergency dental *treatment* due to serious accident requiring hospitalisation In case of doubt, the decision will be left with the *Company*'s dental consultant	100%

Module 1
Non-Hospitalisation Benefits

Reimbursements under this module are according to the List of Reimbursements below. If you have chosen a *deductible*, please note that the *reimbursement rates* for the benefits listed in the List of Reimbursements will be reduced by any remaining *deductible*. Once your *deductible* has been reached, all covered expenses will be paid in line with your *reimbursement rates*.

Reimbursements will not in any event exceed the following amounts or the annual maximum limit of EUR 35,000/GBP 25,000/USD 35,000.

Module 1
Non-Hospitalisation Benefits (continued)

General Practitioners and Specialists	
GP consultations, per consultation	EUR 125 / GBP 100 / USD 135
Chinese doctor consultation (if charged separately), per consultation	EUR 30 Max. per policy year EUR 300 GBP 22 Max. per policy year GBP 220 USD 30 Max. per policy year USD 300
Eye and ear specialists/other specialists, per consultation	EUR 150 / GBP 120 / USD 160
Psychiatrists, per consultation	EUR 125 / GBP 80 / USD 130

Expenses are reimbursed for a max. of 15 consultations within a 30-day period

Therapists	
Dietetic guidance, speech therapy per consultation Max. four consultations per policy year	EUR 50 / GBP 40 / USD 50
Physiotherapy, ergotherapy per consultation	EUR 85 Max per policy year EUR 1,050 GBP 65 Max per policy year GBP 700 USD 85 Max per policy year USD 1,200
Chiropractor/osteopath all inclusive, per consultation	EUR 65 Max per policy year EUR 1,050 GBP 50 Max per policy year GBP 700 USD 65 Max per poicy year USD 1,200

Medical Check-Up	
Medical Check-Up all inclusive, per year	EUR 540 / GBP 480 / USD 600

Examinations and other Medical Assistance	
Laboratory test, analysis Max. per test	EUR 450 / GBP 305 / USD 500
X-ray	EUR 450 / GBP 305 / USD 500

Module 1
Non-Hospitalisation Benefits (continued)

Examinations and other Medical Assistance	
ECG	EUR 450 / GBP 305 / USD 500
Scan, per examination	EUR 1,020 / GBP 780 / USD 1,200
Injection and vaccination, per injection/vaccination	EUR 85 / GBP 65 / USD 100
Acupuncture and homeopathic *treatment*, performed by a physician Acupuncture and homeopathic *treatment* shall only be covered when performed by a physician/doctor authorised in the country of practise	EUR 55 / GBP 35 / USD 60

Minor procedures or interventions	
Minor procedures or interventions (eg removal of a wart) performed at the clinics of the General Practitioners or Specialists in connection with visits to such medical practitioners	100%

Module 2
Medicine and Appliances

Reimbursements under this module are according to the list below. If you have chosen a *deductible*, please note that the *reimbursement rates* for the benefits listed in the List of Reimbursements will be reduced by any remaining *deductible*. Once your *deductible* has been reached, all covered expenses will be paid in line with your *reimbursement rates*.

Hearing Aids	
Prescribed hearing aids, per appliance, max.	Covered 50% up to EUR 300 / GBP 200 / USD 325
Max. two *appliances* are reimbursed per policy year up to max.	Covered 50% up to EUR 600 / GBP 400 / USD 650

Other Appliances	
Slings and bandages	100%
Arch support	100%
Rental of medical *appliances*	100%

Module 2
Medicine and Appliances (continued)

Medicine	
Prescribed medicine and traditional Chinese medicine	100%
Traditional Chinese medicine administered by a traditional Chinese practitioner (cf also art. 12.2 w) Limited to recognised traditional Chinese practitioners registered to practice locally	Max. per policy year EUR 375/GBP 260/USD 450 for traditional Chinese medicine
Medicine and other *appliances* are reimbursed up to an annual max. of	EUR 2,700 / GBP 1,800 / USD 3,000

There is no reimbursement for homeopathic or naturopathic medicines

Module 3
Medical Evacuation and Repatriation

Medical Evacuation and Repatriation covers transportation to the nearest appropriate place of *treatment* if you have a serious illness or injury.

Medical Evacuation and Repatriation	
Transportation expenses by aeroplane or helicopter	100%
Accompanying person	100%
Return journey to residential address abroad/home country within three months after completion of *treatment*	100%
Statutory arrangements in case of death, such as embalming and zinc coffin Transportation of the urn/coffin	100%

Expenses are covered up to the overall annual *insurance* sum of your policy

In all circumstances, *we* must be notified before the transport takes place, either directly or through the attending physician

Medical Evacuation and Repatriation must be pre-approved by the *Company*

Modules 4A and 4B
Dental and Optical

Reimbursements under these two modules are effected at 50-80%, but they will not in any event exceed the following amounts or the respective annual maximums of Module 4A: EUR 5,000/GBP 3,500/USD 5,000 and Module 4B: EUR 7,500/GBP 5,000/USD 7,500.

Eye check performed by optician/optometrist max. two visits per policy year Module 4A max. per visit EUR 40/GBP25/USD 40 and Module 4B max. per visit EUR 50/GBP 35/USD 50.

Dental Treatment	Module 4A	Module 4B
Examinations, max.	Covered 80% up to EUR 20 / GBP 15 / USD 20	Covered 80% up to EUR 40 / GBP 30 / USD 40
Tooth cleaning, max.	Covered 80% up to EUR 40 / GBP 25 / USD 40	Covered 80% up to EUR 60 / GBP 35 / USD 60

Modules 4A and 4B
Dental and Optical (continued)

Dental Treatment	Module 4A	Module 4B
Fillings per tooth, max.	Covered 80% up to EUR 60 / GBP 40 / USD 60	Covered 80% up to EUR 110 / GBP 65 / USD 110
Root *treatment* per tooth, max.	Covered 80% up to EUR 70 / GBP 45 / USD 70	Covered 80% up to EUR 140 / GBP 96 / USD 140
Tooth extractions per tooth, max.	Covered 80% up to EUR 40 / GBP 20 / USD 40	Covered 80% up to EUR 100 / GBP 60 / USD 100
Surgery, max.	Covered 80% up to EUR 73 / GBP 50 / USD 81	Covered 80% up to EUR 174 / GBP 120 / USD 195
X-ray, max.	Covered 80% up to EUR 40 / GBP 20 / USD 40	Covered 80% up to EUR 50 / GBP 35 / USD 50
Anaesthesia, max.	Covered 80% up to EUR 15 / GBP 10 / USD 15	Covered 80% up to EUR 20 / GBP 15 / USD 20

Special Dental Treatment	Module 4A	Module 4B
Bridgework Crowns Dental implants Periodontitis Orthodontics (tooth adjustment) (subject to a 24 month wiating period) Dentures	Covered 50% Max per policy year for special dental *treatment* EUR 2,000 / GBP 1,500 / USD 2,000	Covered 50% Max per policy year for special dental *treatment* EUR 3,000 / GBP 2,250 / USD 3,000

Glasses and Contact Lenses	Module 4A	Module 4B
One pair of glasses (excl. frames)	80% Max per policy year EUR 160 / GBP 100 / USD 160	80% Max per policy year to EUR 220 / GBP 150 / USD 220
Contact lenses	80% Max per policy year EUR 100 / GBP 60 / USD 100	80% Max per policy year EUR 130 / GBP 80 / USD 130

Frames and sunglasses are not covered

Eye check	Module 4A	Module 4B
Eye check performed by optician/optometrist max. two visits per policy year	Max. per visit EUR 40 / GBP 25 / USD 40	Max per visit EUR 50 / GBP 35 / USD 50

Policy Conditions

Valid from 1 January 2017

Words written in italic in 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.

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Art. 1
Acceptance of the insurance

1.1: Bupa *Insurance* Limited, 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 the insurer, 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* 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, and the *applicant* must not have attained 60 years of age at the time of acceptance.

If the conditions in Art. 1.2 are not met and the *applicant* has not attained 80 years of age at the time of acceptance, 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: 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.

1.4: The currency chosen for the *insurance* cannot be changed after the *Company*'s acceptance of the *application*.

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 and extension of cover

3.1: When a new *insurance* contract is entered into, the right to reimbursement under the new *insurance* contract shall only take effect 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 *serious injury*, the right to reimbursement shall, however, take effect concurrently with the *commencement date* of the *insurance*.

3.1.2: In addition, the waiting periods listed below shall apply for the *insurance* contract:

a) for expenses incurred in connection with pregnancy and childbirth and consequences thereof, the right to reimbursement shall only take effect 12 months after the *commencement date* of the *insurance*.

b) for expenses incurred for orthodontics the right to reimbursement shall only take effect 24 months after the *commencement date* of the *insurance*.

3.2: The *policyholder* may change his/her *insurance* cover to another type of cover as from a policy anniversary by giving one month's notice by email, letter or phone to the *Company* and subject to proof of insurability according to Art. 1.

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

3.4: If extended cover is taken out under the *insurance* contract, the right to reimbursement under such extension shall only become effective four weeks after the *commencement date* of the extension. However, Art. 3.1.2 a) and b) shall still apply. During the *waiting period*, the previous cover shall apply.

3.4.1: In the event of *acute serious illness* and *serious injury*, the right to reimbursement under the extended cover shall, however, take effect concurrently with the *commencement date* of the extension.

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: Children under 10 years of age can be *insured* at no extra cost if the requirements for acceptance on *standard terms*, cf Art. 1.2, are met. A maximum of two children at no extra cost per paying adult, and a total maximum of four children at no extra cost per *insurance* apply.

4.2.1: Cover at no extra cost for children shall furthermore be subject to:

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

4.3: An *application* must be submitted for each person the *policyholder* whishes to add to the *insurance*, including newborn children.

4.3.1: If the *insurance* of one of the parents has been valid for a minimum of 12 months, newborn children of the parent can be *insured*, irrespective of Art. 1.2, without submitting an *application*, cf however, Art. 12.2 h). A copy of the birth certificate must, however, be submitted within three months after the birth.

If the birth certificate is not submitted to the *Company* within three months after the birth, a Medical Questionnaire must be submitted for the child who has to undergo the standard underwriting procedure according to Art. 1.2. Registration of the child will take place from the date the Medical Questionnaire has been signed.

4.3.2: In case of adoption and for children born as a result of fertility *treatment* and/or born by a surrogate, the *insured* must submit a Medical Questionnaire for such children.

Art. 5
Where is cover provided?

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

Art. 6
What is covered by the insurance?

6.1: The *insurance* shall cover the medical expenses incurred by the *insured* in accordance with the cover chosen and the applicable List of Reimbursements. The benefits for which expenses are covered and the *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 the receipted and itemised bills, provided with the policy number, have been received by the *Company*. (cf also 'Quick Reference Guide').

6.3: Once the covered expenses have met the annual *deductible*, the reimbursable amount will be paid. The *deductible* shall be reduced by amounts not exceeding the maximum rates specified in the valid List of Reimbursements. The *deductible* shall apply per person per policy year.

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

6.4: Medical practitioners performing *treatment* must have authorisation in the country of practice. Medical providers and facilities must also be authorised (cf also art. 12.2 p).

6.5: In no event shall the amount of reimbursement exceed the amount shown on the bill. If the *insured* receives reimbursement from the *Company* in excess of the amount to which he/she is entitled, the *insured* shall be under the obligation to repay the *Company* 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 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.

6.9: The *Company*'s global health *insurance* products are non-*US insurance* products and accordingly are not designed to meet the requirements of the *US* Patient Protection and Affordable Care Act (the Affordable Care Act). The *Company*'s *insurance* products may not qualify as minimum essential
coverage or meet the requirements of the individual mandate for the purposes of the Affordable Care Act, and the *Company* is unable to provide tax reporting on behalf of those *US* taxpayers and other persons who may be subject to it. The provisions of the Affordable Care Act are complex and whether or not the *insured* is subject to its requirements will depend on a number of factors. The *insured* should consult an independent professional financial or tax advisor for guidance. For customers whose coverage is provided under a group *insurance*, the *insured* should speak to the group health *insurance* administrator for more information.

Art. 7
Hospital Plan

7.1: The Hospital Plan must be taken out before any other supplementary module(s) can be added. The following terms shall also apply:

7.1.1: The Hospital Plan shall cover the medical expenses incurred by the *insured*'s *hospitalisation* in accordance with the *deductible* chosen and the applicable *reimbursement rates* as stated in the List of Reimbursements. It is required that the *insured* is hospitalised in order to get reimbursement under this plan.

7.1.2: The *Company* shall be notified immediately of any stays in hospital in accordance with Art. 13.3.

7.1.3: Maternity benefits are covered in accordance to the benefit limits listed in the List of Reimbursements and include routine postnatal care for the newborn. Routine postnatal care includes *treatment* of physiological jaundice if not caused by an underlying disease and the newborn's hospital stay does not exceed the mother's hospital stay.

Art. 8
Module 1: Non-Hospitalisation Benefits

8.1: If the *insurance* has been extended to include Module 1, the following terms shall also apply:

8.1.1: Module 1 can only be taken out as a supplement to the Hospital Plan.

8.1.2: Module 1 shall cover the *insured*'s expenses in accordance with the *deductible* chosen and the applicable *reimbursement rates* as stated in the List of Reimbursements.

8.1.3: Any bill for expenses incurred by *outpatient treatment* shall be reported by submitting the receipted and itemised bills provided with the policy number to the *Company*. Physician's bills must also include a diagnosis of the illness being treated.

Art. 9
Module 2: Medicine and *Appliances*

9.1: If the *insurance* has been extended to include Module 2, the following terms shall also apply:

9.1.1: Module 2 can only be taken out as a supplement to the Hospital Plan.

9.1.2: Module 2 shall cover the expenses in accordance with the *deductible* chosen and the applicable *reimbursement rates* as stated in the List of Reimbursements.

9.1.3: Any bill for expenses incurred by *outpatient* medicine and *appliances* shall be reported by submitting the receipted and itemised bills provided with the policy number to the *Company*. Bills for medicine should also be accompanied by a copy of the prescription.

Art. 10
Module 3: Medical Evacuation and Repatriation

10.1: If the *insurance* has been extended to include Module 3, the following terms shall also apply:

10.1.1: Module 3 can only be taken out as a supplement to the Hospital Plan.

10.1.2: Module 3 shall cover the reasonable expenses incurred for the *insured*'s medical evacuation/ repatriation in the event of *acute serious illness*, *serious injury* or death in accordance with the applicable *reimbursement rates* as stated in the List of Reimbursements.

10.1.3: Cover shall be provided subject to the attending physician and the *Company*'s medical consultant agreeing on the necessity of transferring the *insured* and agreeing whether the *insured* should be transferred to his/her *country of residence* /home country or to the nearest appropriate place of *treatment*. In case of disagreement, the decision of the *Company*'s medical consultant shall prevail. The evacuation expenses for an eligible transportation are only covered if the transportation is arranged or pre-approved by the *Company*.

10.1.4: The expenses for transportation covered under the *insurance*, but not arranged by the *Company*, shall only be compensated with an amount equivalent to the expenses the *Company* would have incurred, had the *Company* arranged the transportation.

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

10.1.6: One transportation is covered in connection with one course of an illness.

10.1.7: Module 3 shall only apply if the illness is covered under the *insurance*.

10.1.8: In the event that the *insured* is evacuated/ repatriated for the purpose of receiving *treatment*, he/she and the accompanying person, if any, shall be reimbursed for the expenses for a return journey to the *insured*'s place of residence/home country. The return journey shall be made within three months after *treatment* has been completed. Cover shall only be provided for travel expenses equivalent to the cost of an aeroplane ticket on economy class, as a maximum.

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

10.1.10: In the event of death, expenses shall be reimbursed for home transportation of the deceased and for 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.

10.1.11: 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. 11
Modules 4A and 4B: Dental and Optical

11.1: If the *insurance* has been extended to include Module 4, the following terms shall also apply:

11.1.1: Module 4 can only be taken out as a supplement to the Hospital Plan.

11.1.2: Module 4 shall cover the *insured*'s expenses for dental *treatments* and glasses and lenses in accordance with the applicable *reimbursement rates* as stated in the List of Reimbursements.

11.1.3: Any bill for expenses incurred by dental *treatment* and glasses and lenses shall be reported by submitting the receipted and itemised bills provided with the policy number to the *Company*.

Art. 12
Exceptions to cover

12.1: The *insurance* shall not cover 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*.

12.2: Furthermore, the *Company* shall not be liable for any expenses which concern, are due to or are incurred as a result of:

a) non-medically essential and cosmetic *surgery* and *treatment* unless medically prescribed and pre-approved by the *Company*,

b) obesity *surgery* and *treatment* (including diet pills),

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 of the policy. The HIV-virus will also be covered if proven to be contracted as the result of an accident occurring during the course of only the following occupations: doctors, dentists, nurses, laboratory personnel, ancillary hospital workers, medical and dental assistants, ambulance personnel, midwives, fire brigade personnel, policemen/women, and prison officers. The *insured* shall notify the *Company* within one week after such accident and at the same time provide a negative HIV antibody test,

d) any use or misuse of alcohol, drugs and/or medicines unless it can be documented that the illness or injury is unrelated thereto,

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, including expenses for pregnancy, pre- and postnatal *treatments* of the mother and the newborn child/children. An *application* must therefore 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) sexual problems and gender issues: sexual problems, such as impotence, whatever the cause, or sex changes or gender reassignments,

j) hospital stay when it is used solely or primarily for any of the following purposes: receiving general nursing care or any other services which do not require the *insured* to be in a hospital and could be provided in a nursing home or other establishment that is not at hospital; receiving services which would not normally require trained medical professionals (eg help in walking and bathing) and pain management,

k) *treatment* by naturopaths or homoeopaths and naturopathic or homoeopathic medications and other alternative methods of *treatment*, unless specified in the List of Reimbursements,

l) health certificates,

m) *treatment* of diseases during military service,

n) *treatment* for sickness or injuries directly or indirectly caused by the *insured* putting him/herself in danger by entering a known area of conflict as listed below or the *insured* was an active participant or the *insured* has displayed a blatant disregard for his/her personal safety:
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 an *unrecognised medical practitioner*, *provider or facility*,

q) *treatment* for or arising from any *epidemic* disease and/or *pandemic* disease, including vaccinations, medicines or preventive *treatment* for or related to any *epidemic* disease and/or *pandemic* disease,

r) *treatment* by a psychologist,

s) *treatment* or *surgery* to correct refractive errors in the eyesight (due to eg myopia, hyperopia/ hypermetropia, astigmatism and presbyopia) such as laser *treatment*, refractive keratotomy and photorefractive keratectomy, clear lens extraction, or accommodative intraocular lenses,

t) any diagnostic testing, *treatment* or medicine which is experimental based on *acceptable current clinical evidence* and practice,

u) any *treatment* or medicine which is not proven to be effective based on *acceptable current clinical evidence* and practice,

v) medication and equipment used for purposes other than those defined under their licence.

w) any of the following traditional Chinese medicines: cordyceps; ganoderma; antler; cubilose; donkey-hide gelatin; hippocampus; ginseng; red ginseng; American Ginseng; Radix Ginseng Silvestris; antelope horn powder; placenta hominis; Agaricus blazei murill; musk; and pearl powder, rhinoceros horn and substances from Asian Elephant, Sun Bear, and Tiger or other endangered species.

x) inpatient *treatment* for more than 90 continuous days for permanent neurological damage or when the *insured* is in a *persistent vegetative state*.

y) Artificial Life Maintenance, including mechanical ventilation, when the patient is in a state of profound unconsciousness and/or with no sign of awareness or a functioning mind, where such *treatment* will not or is not expected to result in the *insured*'s recovery or restore the *insured* to the *insured*'s previous state of health. This means, eg cover is not provided when the *insured* is unable to feed or breathe independently and requires percutaneous endoscopic
gastrostorny (PEG) or nasal feeding for a period of more than 90 continuous days.

z) any genetic testing, unless medically necessary as the result of the test will directly impact the *treatment* of an existing covered disease, or prenatal
testing due to suspicion of fetal abnormality

Art. 13
How to report a claim

13.1: Any claim for reimbursement of expenses incurred for *treatment* by a physician or specialist as well as hospital *treatment* and medicine shall be reported by submitting receipted and itemised bills provided with the policy number to the *Company*. (cf also 'Quick Reference Guide'). The *Company* scans submitted bills upon receipt. Any retrieval of the submitted bills is not possible.

The *Company* reserves the right at any time to require provision of original bills from the *insured*. If an original bill is not provided upon request the *Company* may deny reimbursement of the expenses to which the bill relates.

13.2: Any claim shall be reported to the *Company* immediately and no later than three months after the circumstances underlying the claim have become known to the *insured*.

13.3: 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 email; the *Company* shall defray all expenses incurred in this connection.

Art. 14
Cover by third parties

14.1: Where there is cover by another *insurance* policy or healthcare plan, this must be disclosed to the *Company* when claiming reimbursement, and the cover under this *insurance* shall be secondary to any such other *insurance* policy or healthcare plan.

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

14.3: If the claim is 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.

14.4: 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.

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

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

Art. 15
Payment of premium

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

15.2: The premium is age-related and will therefore also be adjusted on the first policy anniversary after the *insured*'s birthday.

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

15.4: Changes in the terms of payment can only be made at 30 days' notice by email, letter or phone prior to the policy anniversary.

15.5: The premium is due on the *due date* stated in the premium notice.

15.6: The *policyholder* shall be responsible for punctual payment of the premium to the *Company*. If the premium has not been received by the *Company* on the *due date*, the *Company*'s liability shall cease.

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

15.8: Other charges, such as *Insurance* Premium Tax (IPT), or other taxes, levies or charges, depending on the laws of the *policyholder*'s *country of residence* may apply. If they apply to the *policyholder*'s *insurance* premium, they will be included within the total that has to be paid on the premium notice. The charges may apply from the *commencement date* or the anniversary of the *commencement date*. The *policyholder* must pay these charges to *us* when paying the premiums, unless otherwise required by law.

Art. 16
Information necessary to the Company

16.1: The *policyholder* and/or the *insured* shall be under the obligation to notify the *Company* by email, letter or phone of any changes of name or address, change in residency, and changes in health *insurance* cover with another company, including a consolidated company. The *policyholder* is required to immediately notify the *Company* if any of the *insured* become a permanent resident of the USA, as described under Article 17.7. The *Company* must also be notified in the event of death of the *policyholder* or an *insured*. The *Company* shall not be liable for the consequences if the *policyholder* and/or the *insured* fails to notify the *Company* in such events.

16.2: The *policyholder* and/or the *insured* shall also be under the obligation to provide the *Company* with all information reasonably required for the *Company*'s handling of the *policyholder*'s and/or the *insured*'s claims against the *Company*, including provision of original bills upon request from the *Company*.

16.3: In addition, the *Company* shall be 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* shall be entitled to obtain any medical records or other written reports and statements concerning the *insured*'s state of health.

Art. 17
Assignment, cancellation and expiry

17.1: 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*.

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

17.2.1: The *insurance* may be terminated by the *policyholder* with effect from the end of a calendar month with one month's prior notice by email, letter or phone.

17.2.2: The *policyholder* has the right to withdraw from the purchase of the *insurance*. The period during which the *insurance* can be withdrawn lasts 28 days and begins on the date on which the *policyholder* has entered into the *insurance* agreement. This will normally be on the date on which the *policyholder* has purchased the *insurance* and/or received the *insurance documents*.
Under the Danish *Insurance* Contracts Act the *policyholder* has a right to receive certain information about the right to cancel the *insurance* and about the *insurance*. The notice period for cancellation does not commence before the *policyholder* has received this information in writing (e.g. on paper or by email).
If, for example, the *policyholder* receives the *insurance documents*, and also has received the above information, eg on Monday the 1st, he/she can cancel the *insurance* until and including Monday the 29th. If the period expires on a public holiday, Saturday or Sunday, the *policyholder* can wait until the following day.
If the *insurance* has entered into force before the withdrawal, the *policyholder* will be charged premium for the time he/she has been covered. The *Company* will refund the difference between the premium that would be payable for the shorter period of cover and the
premium paid. If the *policyholder* wants to withdraw the *insurance* the *Company* must be notified by letter, email or phone.The *Company*'s contact details are listed at the end of this document. It is sufficient that the *Company* is contacted before the expiry of the notice period.

17.3: 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*.

17.4: 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.

17.4.1: In the event that the *insurance* contract is considered void, according to Art. 17.3 or Art 17.4, the *Company* shall be entitled to a service charge which is set as a specified percentage of the premium paid.

17.5: 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 in-correct information had not been disclosed.

17.6: The *Company* can stop or suspend an *insurance* product at three months' notice prior to the policy anniversary, and offer the *insured* an equivalent *insurance* cover.

17.7: The *policyholder* is required to immediately notify the *Company* by email, letter or phone if any of the *insured* become a permanent resident of the USA, failing which the *Company* may terminate the *insurance* with immediate effect or (where permitted to continue the *insurance* until such date) with effect from the policy anniversary. The *Company* may terminate the *insurance* with immediate effect or (where permitted to continue the *insurance* until such date) with effect from the policy anniversary, if the law of the country in which the *insured* is located, or the *insured*'s *country of residence* or nationality, or any other law which applies to the *Company* or this *insurance*, prohibits the provision of healthcare cover by the *Company* to local nationals, residents or citizens.

Without limitation to the foregoing, the *insurance* shall not be renewed at the next policy anniversary if the *policyholder* becomes a permanent resident of the USA, and, if an *insured* who is not the *policyholder* becomes a resident of the USA, their cover under the *insurance* shall not be renewed at the next policy anniversary. 'Permanent resident' shall mean a person residing in the USA who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in the USA, and 'USA' shall include the Commonwealth of Puerto Rico for this purpose.

This Art. 17.7 only applies to insurances with a *commencement date* after 31 December 2015.

17.8: Sanction clause
The *Company* will not provide cover nor pay claims under this *insurance* policy if the *Company*'s obligations (or the obligations of the *Company*'s group companies and administrators) under the laws of any relevant jurisdiction, including UK, European Union, the United States of America, or international law, prevent the *Company* from doing so. The *Company* will normally tell the *policyholder* if this is the case unless this would be unlawful or would compromise the *Company*'s reasonable security measures. This *insurance* policy does not provide cover to the extent that such cover would expose the *Company* (or the *Company*'s group companies and administrators) to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, UK or United States of America, or under other relevant international law. This Art. 17.8 only applies to insurances with a *commencement date* on or after 1 January 2016.

17.9: The *Company*'s liability in connection with the *insurance*, including liability for reimbursement for medical expenses for ongoing *treatment*, after-effects or consequential damages in connection with an injury or illness incurred or treated during the *insurance* period, shall automatically cease upon expiry, cancellation or termination of the *insurance*.

Accordingly, upon expiry, cancellation or termination of the *insurance*, an *insured*'s right to claim reimbursement shall cease. Claims for reimbursement of medical expenses incurred during the *insurance* period must be filed within six months of the date of expiry, cancellation or termination of the *insurance* in order to be eligible for reimbursement.

Art. 18
Complaints

18.1: How to file a complaint
We are always pleased to hear about any aspect of the *insurance* cover that the *insured* has particularly appreciated, or which may have caused the *insured* any problems.

If something does go wrong, *we* have a simple procedure to ensure that all concerns are dealt with as quickly and effectively as possible.

For any comments or complaints, the *Bupa Global* Customer Service can be contacted at the phone number +45 70 23 00 42, by email at Complaints-Global@ihi.com, or by writing to *us* at:

Bupa Global
Palægade 8
DK-1261 Copenhagen K
Denmark

18.2: External appeal
It's very rare that *we* can't settle a complaint, but if this does happen, the complainant may be entitled to refer the complaint to an independent organisation for review. Which organisation it will be depends on the nature of the complaint and the location of the *Bupa Global* office where the cause of the complaint occured. *We* will advise the complainant at the time. In most cases this will be either the Danish *Insurance* Complaints Board or the UK Financial Ombudsman Service.

Further information about the Danish *Insurance* Complaints Board can be
requested by:

- writing to them at Anker Heegaards Gade 2, 1. DK-1572 Copenhagen V, Denmark
- calling them on +45 33 15 89 00

More details can be found on their website www.ankeforsikring.dk

Further information about the UK Financial Ombudsman Service can be requested by:

- writing to them at Exchange Tower, London E14 9SR, UK
- calling them on 0800 023 4 567 from a UK landline, or 0300 123 9 123 from a UK mobile telephone, or for calls from outside of the UK +44 20 7964 0500
- More details can be found on their website www.financial-ombudsman.org.uk

A full copy of *our* complaints procedure can be requested by contacting *Bupa Global*. (None of these procedures affect the complainant's legal rights.)

Art. 19
Confidentiality

19.1: The confidentiality of patient and customer information is of paramount concern to the companies in the Bupa group. To this end, *Bupa Global* fully complies with applicable data protection legislation and medical confidentiality guidelines. *Bupa Global* sometimes uses third parties to process data on *our* behalf. Such processing, which may be undertaken outside the EEA (European Economic Area), is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the applicable data protection legislation.

Art. 20
The Financial Services Compensation Scheme (FSCS)

20.1: The *Company* is covered by the FSCS. In the unlikely event that the *Company* cannot meet the *Company*'s financial obligations, the *insured* may be entitled to compensation from the FSCS, if the *insured* is usually a resident of the EEA (European Economic Area). More information is available from the FSCS by calling +44 (0) 20 7892 7301 or on its website fscs.org.uk

Art. 21
Applicable Law

21.1: The policy is governed by Danish law. Any dispute that cannot otherwise be resolved will be dealt with by courts in Denmark. If any dispute arises as to the interpretation of this document, then the English version of this document shall be deemed to be conclusive and taking precedence over any other language version of this document. A copy can be obtained at any time by contacting *our* Customer Service on +45 70 23 00 42 or write an email to ihi@ihi.com.

Glossary

This Glossary with definitions is part of the *Policy Conditions*.

Defined term	Description
Acceptable current clinical evidence:	International medical and scientific evidence which include peer-reviewed scientific studies published in or accepted for publication by medical journals that meet internationally recognised requirements for scientific manuscripts. This does not include individual case reports, studies of a small number of people and clinical trials which are not registered.
Active treatment for cancer	*Active treatment for cancer* is chemotherapy, radiotherapy and immunotherapy.
Acute serious illness:	An "*acute serious illness*" shall be determined to exist only after review and agreement by both the attending physician and the *Company*'s medical consultant.
Appliances:	Durable medical equipment that: ○ can be used more than once ○ is not disposable ○ is used to serve a medical purpose ○ is not used in the absence of a disease, illness or injury ○ is fit for use in the home.
Applicant:	A person named on the *Application* Form and the Medical Questionnaire as an *applicant* for *insurance*.
Application:	The *Application* Form and Medical Questionnaire.
Birthing centre:	A medical facility often associated with a hospital that is designed to provide a homelike setting during childbirth.
Bupa Global (incl. *we/us/our*):	Bupa *Insurance* Limited. *Bupa Global* is a trading name of Bupa *Insurance* Limited.
Commencement date:	The date indicated in the *policy schedule* on which the *insurance* commences, unless otherwise stated in the *Policy Conditions*.
Company, the	Bupa *Insurance* Limited, a *company* registered in England No. 3956433. *Our* address is: Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA, UK.

Defined term	Description
Country of residence:	The country where the *insured* is living/spending most of his/her time. This should be the country in which the relevant authorities (such as tax authorities) will consider the *insured* to be resident for the duration of the *insurance*.
Deductible:	The total amount of money noted in the *policy schedule* which each *insured* agrees to pay each policy year before being reimbursed by the *Company*.
Documents:	Any written information related to the *insurance* including bills, policy schedules and the like.
Due date:	Date on which a premium is due to be paid.
Epidemic:	An outbreak of a contagious and infective disease that spreads quickly, affecting more persons than expected in a given time period, in a locality where the disease is not permanently prevalent or its normal prevalence have been exceeded.
Family members:	Persons of a family relationship (related to you by blood or by law or otherwise). A full list of the family relationships falling within this definition is available on request.
Hospital accommodation:	Coverage of a room that is no more expensive than the hospital's standard single room with a private bathroom. Charges for the *insured*'s standard meals and refreshments are also covered. The charges will be paid for the length of stay that is medically appropriate for the procedure the *insured* is admitted for and any accompanying relative (if covered under the *insurance* plan).
Hospital cash benefit:	This benefit is paid instead of any other benefit for each night you receive elegible in-patient *treatment* without charge or at a minor admission/service fee at a public hospital. To claim this benefit, the customer needs to ask the hospital to sign and stamp a letter stating that the *insured* was treated with no charge or at a minor admission/service fee.

Defined term	Description
Hospitalisation:	*Surgery* or medical *treatment* in a hospital or clinic as an in-patient when it is medically necessary to occupy a bed overnight.
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*.
Outpatient:	*Treatment* provided at a hospital, *outpatient* clinic or associated facility where it is not medically necessary to occupy a bed overnight.
Pandemic:	An *epidemic* occurring over a widespread area (multiple countries or continents) and usually affecting a substantial proportion of the population.
Persistent vegetative state	*Persistent vegetative state*: • state of profound unconsciousness, with no sign of awareness or a functioning mind, even if the person can open their eyes and breathe unaided, and • the person does not respond to stimuli such as calling their name, or touching. The state must have remained for at least four weeks with no sign of improvement, when all reasonable attempts have been made to alleviate this condition.
Policy Conditions:	The terms and conditions of the *insurance* purchased.
Policy anniversary:	Each anniversary of the date the *policyholder* joined the *insurance*.
Policy schedule:	Policy details showing the type of *insurance* purchased, *deductible* and any *special terms*.
Policyholder:	The person identified as the *policyholder* on the *Application* Form.
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*

Defined term	Description
Rehabilitation (Multidisciplinary rehabilitation):	*Treatment* in the form of a combination of therapies such as physical, occupational and speech therapy aimed at restoring full function after an event such as a stroke.
Reimbursement rates:	The maximum amount of money which will be paid by way of reimbursement of medical expenses as further detailed in the List of Reimbursements.
Renewal:	The automatic *renewal* of the *insurance* as per the policy anniversary.
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 standard *insurance* terms with no special restrictions, limitaitons or condtions.
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 medical procedure that involves the use of instruments or equipment which are inserted into the body. This does not apply to minor surgical procedures e.g. removal of wart.
Terminal phase:	When the advent of death is highly probable and medical opinion has rejected active therapy in favour of the relief of symptoms and support of both patient and family. This decision must be confirmed by the *Company*'s medical consultants.
Treatment:	Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a condition, disease, illness or injury.

Defined term	Description
Unrecognised medical practitioner, provider or facility:	An *unrecognised medical practitioner*, *provider or facility* includes: ○ *treatment* provided by a medical practitioner, *provider or facility* who is not recognised by the relevant authorities in the country where the *treatment* takes place as having specialised knowledge, or expertise in, the *treatment* of the disease, illness or injury being treated. ○ *treatment* by any medical practitioner, provider or in any facility to whom *we* have sent a written notice that *we* no longer recognise them for the purposes of *our* plans. ○ *treatment* provided by *family members* or anyone with the same residence as the *insured*, including the *insured* him-/herself.
Waiting period:	A period of time from the *commencement date* where the *insurance* provides no cover unless as per specification in Art. 3.

Call *Bupa Global* Customer Service for questions on your policy, payment, coverage etc.

Open 8am - 9pm (CET) weekdays
Tel: +45 70 23 00 42
Fax: +45 33 32 25 60
Email: ihi@ihi.com

Palægade 8
DK-1261 Copenhagen K
Denmark

Call *Bupa Global* Assistance for 24-hour emergency service and medical help

Tel: +45 70 23 24 60
Fax: +45 33 32 25 60
Email: emergency@ihi.com

Calls will be recorded and may be monitored.

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