International Healthcare

redefining / standards

A+ International Healthcare
General Conditions

PART I : Medical Core Plan
(Medical
& Dental & Optical Plan)

PART II : Non-medical Options
(Personal Accident cover & Loss of Income)

For policies issued in Hong Kong by AXA China Region Insurance Company Limited

AXA China Region Insurance Company Limited is the insurance underwriter of this policy and is solely responsible for all content coverage and benefit payment of the plan.

AXA China Region Insurance Company Limited is an authorized insurer in Hong Kong with its Hong Kong office at 20/F, AXA Centre, 151 Gloucester Road, Wanchai, Hong Kong.

PART I MEDICAL - CORE PLAN

1. Chapter I: GENERAL POLICY PROVISIONS

1.1. Order of precedence & purpose of the insurance

1.1.1. Order of precedence

The 'General Policy Provisions' as set out in Chapter I are only valid insofar as they are not contradicted by or in conflict with the provisions proper to the different types of cover as set out in Chapter II.
In case of contradiction or conflict, the latter take precedence over the former. Moreover, the Special Conditions will always take precedence over the A+ International Healthcare General Conditions.

1.1.2. Purpose of the Insurance

The A+ International Healthcare medical insurance plan ("the Plan") consists of several insurance plans, intended to offer social protection to employees and their Dependants. This program is not intended to replace mandatory social security types of cover in the countries where such systems exist.

1.1.2.1. Medical insurance plan

The Plan reimburses - up to the limits defined in the Plan's General Conditions - Reasonable and Customary expenses for Outpatient as well as for Inpatient medical services, provided these expenses have been incurred because of Illness, Accident or Maternity (subject to the plan selected).

1.1.2.2. Optional dental insurance

An optional dental & optical plan can be taken out by the persons who are accepted into the Plan.

1.2. Definitions (in alphabetical order)

Accident

A sudden, unexpected event, the cause of which is situated outside the victim's body, that results in bodily injury. Following events are also considered to be Accidents:

- a rescue attempt of persons or goods in peril;
- gas or vapour inhalation and the absorption of poisonous or corrosive substances;
- dislocations, distortions, ruptures and muscular lacerations provoked by a sudden effort;
- freezing;
- drowning.

Actively-at-Work

Actively-at-Work requirement means that the person is reporting for work at an approved work location and is actively and competently performing all the essential duties of his or her usual occupation, without restriction for all or most of their regularly scheduled working hours.
If the Insured's effective date is on a non-business day (public holiday, Saturday or Sunday), employees must be Actively-at-Work on the normal business days immediately before and after the non-business day.
The following employees are considered as Actively-at-Work:

i. Those on annual leave
ii. Those on study leave
iii. Those on maternity leave
iv. Those on compassion leaves

Employer must send the Insurer a report on those employee(s) who is (are) not Actively-at-Work at the Insured's effective date with the reason provided and the dates of their expected returning to work. Underwriting may be required depending on the reason provided.
Dependants' coverage, if provided, will depend on the employees 'Actively-at-Work' status, and the eligible Dependant cannot be under Treatment in hospital at the Insured's effective date.

Association

Individuals that decide to form a group in order to benefit from conditions applicable to a group contract. The Insurer may consider the group of individuals as individuals unless past claims experience of the group for the last 3 years is provided.

Claims Handler

A Plus International Services Limited, Room 4, 17th Floor, Westlands Centre, 20 Westlands Road, Quarry Bay, Hong Kong or any other entity as designated or approved by the Insurer.

Complementary Medicine Practitioner

An acupuncturist, chiropractor, homeopath or osteopath who is legally qualified and allowed to practise Complementary Medicine by the authorities in the country in which the Treatment is received.

Complication of Pregnancy

The following Complications of Pregnancy are covered in the same way as any other medical condition, so the rules and limits for the maternity benefits do not apply:

- miscarriage or when the foetus has died and remains with the placenta in the womb
- stillbirth
- abnormal cell growth in the womb (hydatidiform mole)
- foetus growing outside the womb (ectopic pregnancy)
- heavy bleeding in the hours and days immediately after childbirth (post-partum haemorrhage)
- afterbirth left in the womb after delivery of the baby (retained placental membrane)
- complications following any of the above conditions.

Complications of Pregnancy are not subject to waiting period for all medical expenses usually applicable to delivery and Maternity care.

Co-payment (Co-insurance)

Percentage of the (eligible medical) expenses to be paid by the Insured himself/herself, not reimbursed by the Plan.

Chronic Conditions

Sickness, Illness, disease or injury which has one or more of the following characteristics:

- is recurrent in nature;
- is without a known, generally recognised cure;
- is not generally deemed to respond well to Treatment;
- requires palliative Treatment;
- requires prolonged supervision or monitoring;
- leads to permanent invalidity.

Day-care treatment

Treatment in a hospital or medical day-care centre, for which the patient does not have to stay overnight.

Day surgery

Surgery requiring the use of a conventional operating theatre and performed on an in-and-out same-day basis without an overnight stay.

Deductible

The (first) part of the (eligible) medical expenses, not reimbursed by the Insurer and deducted from the amount (of eligible medical expenses) on which the reimbursement is calculated.

Dentist (or dental surgeon)

Person officially qualified and licensed to practise dentistry in the country where the Treatment is received.

Dependant

The Legal Partner, Domestic Partner and/or unmarried children, until their 26th birthday, of the Insured, who are financially dependent on the Insured.

Disability

A Sickness, disease, Illness or the entire Injuries arising out of a single or continuous series of causes.

Doctor (or Physician)

Person who graduated from a recognised medical school as listed in the WHO Directory of Medical Schools and who is licensed to practise medicine in the country where the Treatment is received.

Family Doctor or general practitioner (GP) or Medical Practitioner: a Doctor providing Medical Treatment not requiring a specialist's training.

Specialist Doctor: a Doctor having a specialised qualification in the field of, or expertise in, the Treatment of the Illness or Injury being treated.

Domestic Partner

Two adults who reside together and have chosen to share their lives in an intimate and committed relationship (eligibility as specified below in article 1.3.5). Domestic Partner(s) do not include roommates, siblings, parents and children, or persons having other similar relationships.

Eligible Medical Expenses

Medically necessary expenses incurred due to a covered Illness, Accident or Maternity (subject to the plan selected) but not exceeding the benefit limits.

Home country

Country where the Insured normally resides or used to reside and out of which he/she is expatriated to another country, as declared in the application form. If the Home Country cannot be named according to this definition, it is the country of which the Insured has the nationality and is holding a passport from.

Infertility Treatment

The Treatment of infertility, surgical or In Vitro Fertilisation (IVF) procedures and all investigative procedures necessary to establish the cause(s) of infertility (e.g. hysterosalpingography, laparoscopy, hysteroscopy).

Injury

Bodily injury caused solely by Accident.

Inpatient

Inpatient care or Treatment is Treatment for which, for medical reasons, the patient has to stay in hospital overnight or longer.

Insurance Year

A twelve months period, starting on the policy effective date of coverage as stated in the Special Conditions.

Insured

The person(s) covered by the Plan or parts thereof and whose names are mentioned in the Special Conditions.

Insurer

The insurance company underwriting the risks covered by the insurance plan: AXA China Region Insurance Company Limited. 20/F, AXA Centre, 151 Gloucester Road, Wanchai, Hong Kong.

Intensive Care Unit

A section within a hospital that is designated as an Intensive Care Unit, and which is maintained on a twenty-four (24) hour basis solely for the treatment of patients in critical condition and which is equipped to provide special nursing and medical services not available elsewhere in the hospital.

Illness (or Sickness)

A deterioration of health confirmed by a Doctor (see definition of Doctor above).

Legal Partner

A married person as recognised by Hong Kong law.

Maximum Annual Reimbursement

Benefits payable in respect of expenses incurred for Treatment provided to the Insured during the period of insurance shall be limited to overall annual limits as stated in the benefits table irrespective of type/types of Disability. In the event the overall annual limit has been exhausted, no further payments shall be made for the remaining period of the Insurance Year.

Medical Consultant

A Doctor appointed by the Insurer to decide, based on the applicant's medical questionnaire, upon acceptance of the applicant-insured into the insurance, and assigned to assess the medical situation of the applicant-insured.

Medical Emergency

Medical Emergency is defined as an accidental injury or sudden and unexpected onset of a change in a person's physical or mental condition which, if the procedure or Treatment was not performed immediately could, as determined by the Doctor in attendance, reasonably be expected to result in loss of life or limb or significant impairment to bodily function or permanent dysfunction of a body part.

Only a Treatment provided by a medical Doctor (GP or Specialist) and a hospital admission within twenty-four hours following the direct cause of the Medical Emergency will be eligible for reimbursement.

Medical Treatment

Medical examinations and/or medical procedures needed to restore health, performed or prescribed by a Doctor (see definition of Doctor above).

Medically Necessary

A medical service which is:

- consistent with the diagnosis and customary Medical Treatment for a covered condition, and
- in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits, and
- not for the convenience of the Insured or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an Inpatient), and
- not of an experimental, investigational or research nature, preventive or screening nature and for which the charges are fair and reasonable for the condition.

Midwifery

Treatment provided by a legally licensed midwife.

A midwife is a person who, having been regularly admitted to a Midwifery educational program that is duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in Midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise Midwifery.

Cover comes under "Maternity benefits" only and is within the limits of the plan chosen.

All Midwifery Treatments must be prescribed by the following obstetrician and must be Medically Necessary.

Pre-certification is always required, failing which no reimbursement will be granted.

New Born

A baby who is within the first 28 days of his/her life following birth.

Nuclear, Chemical, Biological Terrorism

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

Chemical agent shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.

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

Nursing at Home

Nursing at Home refers to the medical services of a registered nurse as prescribed by a Physician in the Insured person's home immediately after or instead of Inpatient or day-care Treatment.

Outpatient

Outpatient care or Treatment is Medical Treatment for which the patient does not have to stay overnight in a hospital.

Physician

See definition of Doctor.

Policyholder

The employer taking out the insurance for the benefit of the Insured, having to pay the appropriate premium to the Insurer on behalf of the Insured. The name of the Policyholder is mentioned in the Special Conditions.

Pre-existing Medical Conditions (or Pre-existing Conditions)

Medical conditions or any related conditions, for which symptom(s) has/have been shown at some point prior to commencement of cover, irrespective of whether any Medical Treatment or advice was sought.

Any such condition or related conditions about which the Insured or his/her Dependants know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

Prescription Drugs

Drugs/medicines, which are necessary to treat a confirmed medical diagnosis or medical condition, and which are not available without prescription by a Doctor (excluding Over The Counter drugs, OTC).

Reasonable and Customary

Medical expenses will be considered Reasonable and Customary if they correspond to the charge usually made by the health care provider for a similar service or supply and do not exceed the normal charge made under the best prevailing conditions for such a service or supply in the locality where the service or supply is received.

If usual and prevailing charges cannot be determined because of the unusual nature of the service or supply, the Claims Handler will on behalf of the Insurer determine to what extent the charge is reasonable, taking into account:

- the complexity involved;
- the degree of professional skill required;
- all other pertinent factors.

Salary

The gross Salary being paid to the Insured at the commencement of his/her insurance, before deduction of any income tax. Gross Salary does not include any benefits in kind such as car, living accommodation, bonuses or overtime. In the event of a claim, satisfactory proof of income will be required.

Semi-private Room

Dual occupancy accommodation in a hospital with corresponding Treatment rates & charges.

Deluxe, executive rooms and suites are not covered.

Semi-Private Room Restriction

(only available to residents of Hong Kong)

Cover under this option is restricted to Semi-private Room and corresponding rates when receiving Treatment as Inpatient or Outpatient.

Accommodation is limited to: standard Semi-private Room and associated charges, related cost of Doctors, surgeons and Specialists, including admittance to the Intensive Care Unit as an Inpatient or Outpatient and charges for nursing by a qualified nurse, theatre fees and other charges incurred for the Treatment of a medical condition.

Outside of Hong Kong where there are no Semi-private Room or ward rooms in the hospital where Treatment is given, we will reimburse the cost of a Standard-private Room provided the cost are no more than Reasonable and Customary charges.

Sickness

See definition of Illness.

Special Conditions

Document issued with each insurance policy, stating

- the identity of the Policyholder and of the Insured;
- the cover opted for, and the term of the policy;
- any particular agreement or any deviations from the General Conditions.

Standard-private Room

A private room is a room with one bed. A Standard private room is the lowest rate (regular) private room available in a hospital. Deluxe, executive rooms and suites are not covered.

Surgery

Any of the following medical procedures:

- to incise, excise or electro cauterize any organ or body part, except for dental services;
- to repair, revise, or reconstruct any organ or body part both invasive and non-invasive;
- to reduce by manipulation a fracture or dislocation;
- use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, oesophagus, stomach, intestine, urinary bladder, or urethra.

Third Party Administrator

A Plus International Services Limited (A+) Room 4, 17th Floor, Westlands Centre, 20 Westlands Road, Quarry Bay, Hong Kong

Treatment

See definition for Medical Treatment.

1.3. **Eligibility and acceptance into the insurance**

1.3.1. **Application**

The Plans do not cover the Treatment of Pre-existing Medical Conditions and related conditions. A pre-existing condition means any disease, Illness or Injury for which the Insured has received medication, advice or Treatment, or which the Insured has experienced symptoms, whether the condition has been diagnosed or not, at any time before the date on which the Insured's Plan starts, except where such medical conditions have been declared in the application form and subsequently accepted in writing by the Insurer.

1.3.1.1. Specific application forms are available for enrolment of Groups who may choose either Underwritten or Moratorium enrolment.

1.3.1.1.1. Underwritten enrolment:

The medical questionnaire included in the application form must be completed fully and accurately, failing to do so may invalidate the policy.

1.3.1.1.2. Moratorium enrolment:

After two years continuous membership, any pre-existing medical conditions (and related conditions) will become eligible for benefit, subject to the terms and conditions of the Insured's plan, provided the Insured has not during that period:

a) consulted any Medical Practitioner or Specialist for Treatment or advice (including check-ups) or

b) experienced further symptoms or

c) taken medication or been advised to follow special Treatment (including drugs, medicine, special diets, injections, etc.)

Examples of Pre-existing Conditions that will never be covered include diabetes, hypertension (raised blood pressure), hyperlipidemia (raised cholesterol level), ischemic heart disease, cancer, thyroid disease, and auto-immune disorders. If the Insured has suffered from any of these conditions, or any other condition for which it is generally accepted medical advice that it be monitored in any way, then the condition - and any related conditions - will never be covered. Examples of related conditions are raised cholesterol levels and heart disease and stroke. If the Insured has suffered from high cholesterol before the Insured's date of entry to the plan the Insured will never be covered for cardiac problems of strokes.

1.3.2. **Eligibility**

1.3.2.1. The Plans are open to employers and to Associations to cover their employees / members (and their Dependants) with minimum 3 employees / members (excluding dependants) for group coverage.

The Insurer may restrict eligibility of coverage in certain countries and areas upon enrolment.

1.3.3. **Acceptance into the insurance**

1.3.3.1. Employees ('group cover')

In case of compulsory affiliation by the employer and the number of enrolled employee amounts to less than 10 employees, a medical questionnaire has to be completed by each employee and for each Dependant and has to be submitted by the applicant-Insured(s) to the Medical Consultant (Physician) of the Insurer through the Third-party Administrator.

The Medical Consultant can define partial or total exclusion of cover, or, at his discretion, propose an additional premium to waive exclusions.

Members of an Association can also benefit from the same conditions, if the cover is mandatory for all members and based on the evaluation of the claim report for the last 3 years by the underwriters of the Insurer. If, however, the latter conditions are not met, the members in the Association have to complete a medical questionnaire.

In case of compulsory affiliation by the employer of a group of 10 or more employees:

a) no health declaration(s) will, in principle, be required for the medical insurance plan, meaning that there will be immediate and full acceptance into the medical insurance of both employees and Dependants and
b) waiting periods including for maternity care are not any longer in force.
c) for the other insurance plans (the optional voluntary insurance cover: Personal Accident Cover / Temporary Incapacity Cover / Permanent Disability Cover) however, the Medical Consultant can still define partial or total exclusion of cover, or, at his discretion, propose additional premium to waive exclusions.

1.3.4. **Addition of new Dependants into the insurance**

Addition of a Dependant is possible, provided that the application is based on the same procedure and conditions of acceptance, as described in article 1.3.3. and within 2 months after becoming eligible for the insurance.
Addition of a New Born is possible, provided that the application is made within 2 months following the date of birth.
A medical questionnaire must be completed when the New Born is declared to the Insurer more than 2 months after birth. The Medical Consultant can propose an additional premium to waive exclusions. Premiums for the New Born are to be paid as from the first month of affiliation.
Adopted children may also be included in the policy, enrolment of whom is subject to full underwriting.

1.3.5. **Domestic Partner eligibility**

To be an eligible Domestic Partner, the following criteria/guideline must be fulfilled.

1. To maintain the same principal place of residence, have done so for at least one year and intend to do so indefinitely
2. To be engaged in a committed relationship in mutual caring and support and are jointly responsible for each other's common welfare and financial obligations.
3. Both employee and partner are at least 18 years old of age and mentally competent to consent for a contract at the time of enrolment of the Domestic Partner under the plan.
4. To be each other's sole partner and intend to remain so indefinitely.
5. Neither of them is married
6. Evidence (e.g. utility) should be provided on demand.
7. Changes in Domestic Partner are acceptable. However the employee has the responsibility to inform the Third-Party Administrator of any termination of Domestic Partner immediately, once they do not fulfil the eligibility requirement. No backdating of termination will be allowed. Enrolment of a new Domestic Partner into the plan will only be accepted at least 12 months after the termination of the previous Domestic Partner. Any case of dishonesty or wilful misrepresentation may result in rejection of claims and termination of coverage in respect of the relevant Domestic Partner with immediate effect.

1.3.6. **Age limits for enrolment**

- For employees Actively-at-Work, enrolled on a compulsory basis by their employer, there is no specific age limit set for enrolment into the medical insurance plan. For the other optional insurance plans, reference is made to the conditions applying to each of these insurance plans.
- For Insured members of Associations, the age limit set for enrolment is 70 years. Above attained age 71, neither private persons nor their Dependants can enrol into the plan.

1.3.7. **Change level of cover**

Downgrading and upgrading is possible, but only on the renewal date of the policy. In case of upgrading, the medical questionnaire has to be filled out again.
Changing the geographical scope (territoriality) of the cover is always possible in function of the country of expatriation. However, it is not possible to change to the worldwide cover for short periods with the objective to get Treatment in the USA or Canada.
Changing to a higher or lower deductible is possible, but only on the renewal date of the policy. In case the Insured wishes to change to a lower deductible, he/she will have to complete a new medical questionnaire.

1.4. **Effective date of coverage**

The insurance cover takes effect on the date stated in the Policy Schedule, subject to the acceptance by the Insurer or Third-Party Administrator of:

- the completed application form and,
- the acceptance of the applicant-insured by the Medical Consultant into the insurance, whenever such medical acceptance is required in accordance with the specific eligibility and acceptance rules of each insurance cover, as described in the different chapters of these General Conditions.
  However claim reimbursements cannot be done until the related premium has been paid in full.

New Dependants have to be declared within 2 months following the date of marriage, birth or legal adoption and according to clause 1.3.4.
The insurance cover takes effect on the date stated in the Policy Schedule, subject to the acceptance by the Insurer or Third-Party Administrator whenever such medical acceptance is required (in accordance with the specific eligibility and acceptance rules of each insurance cover, as described in the different chapters of these General Conditions).

1.5. **Duration and termination of the insurance**

1.5.1. **Duration of the policy**

The duration of the insurance policy is fixed for a period of 12 months starting on the policy effective date of coverage as stipulated in article 1.4 above, unless otherwise agreed upon by the parties (Policyholder and Insurer). At the end of the Insurance Year, the policy will be automatically renewed by tacit agreement for another year, unless otherwise agreed by the parties.

1.5.2. **Termination of the policy**

The policy can be terminated by the Policyholder through notification by registered letter, delivered to the Insurer at least one month before the renewal date of the policy.
The Insurer reserves the right to revise or discontinue the Plan with effect from any renewal date.

1.5.3. **Termination date of cover for Dependants under the policy of the Insured**

1.5.3.1. For the Domestic Partner or Legal Partner:
The cover will end at latest at the end of the Insurance Year in which the divorce or the legal separation or the end of the Domestic Partnership has occurred.

1.5.3.2. For the unmarried children:

- upon the date of marriage;
- upon the twenty-sixth birthday;
- when they are no longer considered to be Dependants.

1.5.3.3. Aggravation of the Risk
With respect to 'Personal Accident Cover / Temporary Incapacity cover / Permanent Disability Cover', the Insured is obliged to inform the Insurer (through the Third-party Administrator) of any change in circumstances or conditions that may increase the risk to Illness or Accident (e.g. dangerous professional activity).
The Insurer may then propose new insurance conditions (within a period of one month after having received notification of the aggravation of the risk) or cancel the insurance cover (within one month) retro-actively as from the moment of the start of the aggravation of the risk.

1.6. **Return to the Home Country**

1.6.1. For non-US Citizens
Upon notification of the end of expatriation with the exact date of relocation to the home country by the Policyholder or Insured person in writing, the Plan will remain in force up to the next policy anniversary after the actual date of relocation to the home country at which date it will be automatically terminated.
The Policyholder can nevertheless request - in writing and before the termination date - cover for one additional period of 12 months (without interruption of cover), at the conditions prevailing on the first day of this additional period of 12 months. During this period the Insured (or the Policyholder) can apply for affiliation to a local social security scheme or look for another private insurance.

1.6.2. For overseas US citizens
Upon notification of the end of expatriation with the exact date of relocation to the US by the Policyholder or the Insured person in writing, the Plan will be terminated at the date of relocation.

1.7. **Premium & Premium Increase / Suspension and Cancellation of Cover**

1.7.1. **Amount and payment of the premium**

The premium is fixed by indivisible year, and is payable by the Policyholder to the Insurer (through the Third-party Administrator or its agents as required on the premium invoice) on a yearly or half yearly basis in advance. Taxes and charges as established by the applicable laws will be added to the amount of the premium, and have to be paid in full by the Policyholder.

1.7.2. **Premium Increase**

In case the Insurer increases the premium rate, the Insurer will notify the Policyholder, in writing, of said increase and of the date as from which the new premium will become effective.

The new premium rates will become effective as of the next renewal date, starting on or after January 1st of the next calendar year. The Policyholder will receive a written notification.

For Group policies which are subject to experience rating the Insurer may at the end of any policy year adjust the premium rates, but no increase shall be retroactive. On each such policy renewal date after the policy start date (as specified in the Special Conditions) the group policy is renewable subject to the consent of the Insurer for an additional annual period by the payment of the premium at the Insurer's premium rates in effect at the time of such renewal.

If the Policyholder does not agree with the new premium conditions, he can terminate the policy through notification of cancellation to the Insurer by registered letter, delivered to the Insurer or the Third-party Administrator at least 30 days before the renewal date of his policy.

1.7.3. **Suspension of cover and cancellation of the insurance due to non-payment of premium**

In case of failure by the Policyholder to pay the premium on the due date, the Insurer has the right to suspend or cancel the insurance policy. The Insurer will first notify the Policyholder by means of a registered letter, reminding the Policyholder of the amount of the premium that has to be paid, and informing him of the consequences of non-payment. If the premium shall then not have been paid within 30 days following service or posting of the registered letter, the insurance cover will be suspended automatically. Payment by the Policyholder of the premiums due, together with interest, if any, shall terminate suspension. The Insurer may cancel the policy during the period of suspension. In this case, cancellation shall take effect on the expiry of the period of 30 days, starting from the first day of suspension. Claims incurred during the period of suspension are not covered.

1.8. **Territorial scope of the insurance**

Zone

There are three zones (location of work) and the Insured must choose the country / area in which the Insured will be located / stationed for work at the time of inception of policy. The premiums are set according to the zone (location of work).

- Zone 1: Rest of World (excluding Hong Kong/ China/ USA/ Canada)
- Zone 2: Hong Kong/ China
- Zone 3: USA/ Canada

With respect to the medical insurance plan and the optional dental cover, the Policyholder can choose between 2 geographic areas of elective treatment:

- Worldwide cover
- Worldwide cover with exception of medical expenses incurred in the United States of America (USA) and Canada.
  However, during business trips or holidays, not exceeding 90 days in aggregate per Insurance Year, medical expenses incurred in the USA or Canada as a direct consequence of an Accident or a Medical Emergency are covered up to the limits of the policy. If the medical condition concerned already existed prior to the travel to the USA or Canada, the medical expenses are not covered. Expenses related to pregnancy (and complications thereof) and/or childbirth will not be considered to be Accident or Emergency expenses, and will therefore not be covered.

For the optional dental and optical cover, the same geographic area will apply as for the other medical expenses.

The choice of geographic area has to be made before the coverage takes effect, and can only be changed at the annual renewal date.

1.9. **Currency**

The medical plan and all additional options can be taken out in $ (US Dollar). Premiums shall be payable in USD. Claims are reimbursed in the currency of the policy or in Hong Kong dollars.

With respect to expenses incurred in another currency than the currency of the policy, the conversion will be based on the European Central Bank daily Rate of Exchange in effect on the date the medical service has been billed. The Claims Handler may settle medical bills in a currency other than the currency of the insurance policy, viz. in the original currency, especially in case of direct payment to hospitals insofar as allowed under the local legislation of the country concerned.

1.10. **General Exclusions**

No (re) insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment or such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanction, laws or regulations of the European Union, United Kingdom or United States of America.

The coverage described in this policy does not extend to:

- Consequences of active participation in war or terrorism: by the Insured (and/or his/her covered Dependants);
- Consequences of a voluntary or intentional act : committed by the Insured person or his/her beneficiary; or consequences of hazardous competitions;
- Consequences of insurrections or riots: if by taking part the Insured or his/her beneficiary has broken the applicable laws,
- Consequences of brawls, fights and all kinds of disturbances: and measures taken to combat them, except in case of self-defence or if the Insured falls victim to the above mentioned disturbances.
- Consequences arising directly or indirectly from the preparation of or participation in any illegal act; Consequences of drug-addiction and alcoholism;
- Any losses directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with radioactive contamination whether direct or indirect or any act of Nuclear, Chemical, Biological Terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss. This exclusion is not applicable to medical radiations required by covered Medical Treatment;
- Events related to bets or challenges;
- Expenses resulting from any kind of competition with motor vehicles;
- Consequences of the Insured participation in any sport as a professional or under contract providing compensation, as well as any preparatory training to such activities;
  Flight risk: the insurance covers the use, as a passenger, of all planes, hydro-planes or helicopters duly authorised to transport persons, as long as the Insured is not a member of the crew and does not exercise in the course of the flight a professional or other activity, in relation with the plane or the flight; however this exclusion is not applicable to the health insurance cover and the dental cover.

Important remark:

For the optional specific exclusions relating to each separate insurance cover of the insurance plan, reference is explicitly made to the provisions proper to the different types of cover.

1.11. **War & Terrorism**

The Insurer will not pay for Treatment of any condition resulting directly or indirectly from, or as a consequence of war, acts of foreign hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, or attempted overthrow of government, or any acts of terrorism, unless the Insured person is an innocent bystander (only applicable to medical core plan).

1.12. **Dispute Settlement**

1.12.1. **Non-medical disputes**

Before resorting to arbitration, the parties shall attempt to settle in good faith all disputes or differences which arise between them out of or in connection with this insurance policy, by negotiation between them in good faith, and, in the event of failure of such negotiations, the parties may, if they so agree, attempt to resolve any such dispute or difference by the use of a procedure known as alternative dispute resolution (i.e. mediation, conciliation, expert determination or mini-trial).

1.12.1.1. **Arbitration**

For any dispute arising out of or in connection with the contract, the Policyholder and the Insurer agree to set out their position in writing and meet in order to reach an amicable settlement of the dispute. The dispute will be heard in English. Any dispute for which an amicable settlement cannot be reached within 3 months following the day, on which either party first dispatched its position in writing, shall be settled in Hong Kong. Hong Kong law shall apply.

Arbitration fees and expenses will be shared equally between the parties unless otherwise awarded by the Arbitrator(s).

1.12.2. **Medical disputes**

In case the Insured does not agree with decisions of the Medical Consultant of the Insurer, he/she can call upon his/her own treating Doctor to assist him/her, and both the Doctors of the Insurer and the Doctor of the Insured will try to reach agreement on the issue. If both Doctors fail to reach an agreement, they can jointly appoint a third Doctor to settle the dispute. If the two Doctors cannot agree on the choice of a third Doctor, he/she will be appointed by the Hong Kong Medical

Association, Duke of Windsor Social Service Building, 5th Floor, 15 Hennessy Road, Hong Kong. Each party has to pay the fees of their own Doctor, the fees of the third Doctor to be paid half by each of the parties.

1.13. **Personal Information Collection Statement**

The Insurer recognises its responsibilities in relation to the collection, holding, processing, use and/or transfer of personal data under the Personal Data (Privacy) Ordinance (Cap. 486) ("PDPO"). Personal data will be collected only for lawful and relevant purposes and all practicable steps will be taken to ensure that personal data held by the Insurer is accurate. The Insurer will take all practicable steps to ensure security of the personal data and to avoid unauthorised or accidental access, erasure or other use.

Please note that if you do not provide us with your personal data, we may not be able to provide the information, products or services you need or process your request.

Purpose: From time to time it is necessary for the Insurer to collect your personal data which may be used, stored, processed, transferred, disclosed or shared by us for purposes ("Purposes"), including:

1. offering, providing and marketing to you the products/services of the Insurer other companies of the Insurer Group ("our affiliates") or our business partners (see "Use and provision of personal data in direct marketing" below), and administering, maintaining, managing and operating such products/services;
2. processing and evaluating any applications or requests made by you for products/services offered by the Insurer and our affiliates;
3. providing subsequent services to you, including but not limited to administering the policies issued;
4. any purposes in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Insurer and/or our affiliates, including investigation of claims;
5. evaluating your financial needs;
6. designing products/services for customers;
7. conducting market research for statistical or other purposes;
8. matching any data held which relates to you from time to time for any of the purposes listed herein;
9. making disclosure as required by any applicable law, rules, regulations, codes of practice or guidelines or to assist in law enforcement purposes, investigations by police or other government or regulatory authorities in Hong Kong or elsewhere;
10. conducting identity and/or credit checks and/or debt collection;
11. complying with the laws of any applicable jurisdiction;
12. carrying out other services in connection with the operation of the Insurer's business; and
13. other purposes directly relating to any of the above.

Transfer of personal data: Personal data will be kept confidential but, subject to the provisions of any applicable law, may be provided to:

1. any of our affiliates, any person associated with the Insurer, any reinsurance company, claims investigation company, your broker, industry association or federation, fund management company or financial institution in Hong Kong or elsewhere and in this regard you consent to the transfer of your data outside of Hong Kong;
2. any person (including private investigators) in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Insurer and/or our affiliates;
3. any agent, contractor or third party who provides administrative, technology or other services (including direct marketing services) to the Insurer and/or our affiliates in Hong Kong or elsewhere and who has a duty of confidentiality to the same;
4. credit reference agencies or, in the event of default, debt collection agencies;
5. any actual or proposed assignee, transferee, participant or sub-participant of our rights or business; and
6. any government department or other appropriate governmental or regulatory authority in Hong Kong or elsewhere.

For our policy on using your personal data for marketing purposes, please see the section below "Use and provision of personal data in direct marketing".

Transfer of your personal data will only be made for one or more of the Purposes specified above.

Use and provision of personal data in direct marketing: the Insurer intends to:

1. use your name, contact details, products and services portfolio information, transaction pattern and behaviour, financial background and demographic data held by the Insurer from time to time for direct marketing;
2. conduct direct marketing (including but not limited to providing reward, loyalty or privileges programmes) in relation to the following classes of products and services that the Insurer, our affiliates, our co-branding partners and our business partners may offer:
   a) insurance, banking, provident fund or scheme, financial services, securities and related products and services;
   b) products and services on health, wellness and medical, food and beverage, sporting activities and membership, entertainment, spa and similar relaxation activities, travel and transportation, household, apparel, education, social networking, media and high-end consumer products;
3. the above products and services may be provided by the Insurer and/or:
   a) any of our affiliates;
   b) third party financial institutions;
   c) the business partners or co-branding partners of the Insurer and/or affiliates providing the products and services set out in (2) above;
   d) third party reward, loyalty or privileges programme providers supporting the Insurer or any of the above listed entities
4. in addition to marketing the above products and services, the Insurer also intends to provide the data described in (1) above to all or any of the persons described in (3) above for use by them in marketing those products and services, and the Insurer requires your written consent (which includes an indication of no objection) for that purpose;

Before using your personal data for the purposes and providing to the transferees set out above, the Insurer must obtain your written consent, and only after having obtained such written consent, may use and provide your personal data for any promotional or marketing purpose.

You may in future withdraw your consent to the use and provision of your personal data for direct marketing.

If you wish to withdraw your consent, please inform us in writing to the address in the section on "Access and correction of personal data". The Insurer shall, without charge to you, ensure that you are not included in future direct marketing activities.

Access and correction of personal data: Under the PDPO, you have the right to ascertain whether the Insurer holds your personal data, to obtain a copy of the data, and to correct any data that is inaccurate. You may also request the Insurer to inform you of the type of personal data held by it.

Requests for access and correction or for information regarding policies and practices and kinds of data held by the Insurer should be addressed in writing to:

Data Privacy Officer
AXA China Region Insurance Company Limited
Employee Benefit Services – Unit 2201-2206, 22/F, Manhattan Place, 23 Wang Tai Road, Kowloon Bay, Kowloon, Hong Kong

A reasonable fee may be charged to offset the Insurer's administrative and actual costs incurred in complying with your data access requests.

1.14. **Subrogation**

The Insurer has full rights of subrogation for any benefits paid within the framework of this insurance policy.

Therefore, when asked to confirm this right to the Insurer in order to assist the Insurer in recovering from a third party any amount paid or which will be paid by the Insurer to the Insured or expenses made on behalf of the Insured, the Insured shall be obliged to provide this confirmation in writing to the Insurer.

1.15. **Defence**

Any defence inherent in the insurance contract which the Insurer may raise against the Policyholder may also be raised against the Insured, whoever he/she may be.

1.16. **Complaints Procedure**

If an Insured has any complaint regarding the standard of service received under this insurance contract, the following procedure is available to restore the situation the Insured should write to A Plus International Services Limited, Room 4, 17th Floor, Westlands Centre, 20 Westlands Road, Quarry Bay, HONG KONG. If not satisfied the Insured should write then to AXA China Region Insurance Company Limited, 20/F, AXA Centre, 151 Gloucester Road, Wanchai, HONG KONG.

1.17. **Governing Law**

Without prejudice to article 1.12, this contract shall be governed by, construed and interpreted in accordance with Hong Kong Law. All and any documents issued pursuant to this contract will be written in English. The English version of this contract is leading.

1.18. **Contracts (Rights of Third Parties) Ordinance (Cap 623 of the Laws of Hong Kong)**

Any person or entity who is not a party to this Policy shall have no rights under the Contracts (Right of Third Parties) Ordinance (Cap 623 of the Laws of Hong Kong) to enforce any terms of this Policy.

2. Chapter II: BENEFITS AND PROVISIONS OF THE DIFFERENT COVER TYPES

2.1. **Health Insurance Cover**

2.1.1. **Medical Insurance**

2.1.1.1. Purpose of the Plan

The Plan reimburses - up to the limits defined in the present General Conditions - Reasonable and Customary expenses for Outpatient as well as for Inpatient medical services, provided these expenses have been incurred because of Illness, Accident or maternity (subject to the plan selected).
On an optional basis, an optional dental & optical insurance can be taken out by the persons who are accepted into the Plan.

2.1.1.2. Eligibility and acceptance into the medical insurance plan

With respect to eligibility and acceptance into the Plan, reference is made to conditions as set out in article 1.3, Chapter I of the General Policy Provisions.

2.1.1.3. Levels of Medical Cover

With respect to Plan, there are four different levels of cover:

- Level 1 = Hospitalisation
- Level 2 = Global 80
- Level 3 = Global 100
- Level 4 = Global 100 Plus

The level chosen by the Policyholder is mentioned in the Special Conditions of the insurance policy. Each level corresponds to a different level of benefits, details of which are mentioned in the benefits table hereafter.
Levels can only be changed at the renewal date of the insurance policy. The change of level has to be requested at least one month in advance, in writing, to the Third-party Administrator. In case of upgrading of the Plan level, the medical questionnaire has to be filled out again.

2.1.2. **Benefits**

Eligible medical expenses, subject to the exclusions, limits and ceilings mentioned in this Plan, are listed in the benefits table in force for the time being. The Plan reimburses eligible Reasonable and Customary expenses for Outpatient as well as for Inpatient medical services, provided these expenses have been incurred because of Illness, Accident or maternity (subject to the Plan level selected).
Moreover, to qualify for reimbursement, treatments and procedures have to be Medically Necessary and appropriate (consistent with the diagnosis as established by a Doctor). They have to be prescribed by a Doctor, and performed by a Doctor or by a legally qualified and duly licensed Medical Practitioner.
The reimbursement ceilings (i.e. the maximum amount of reimbursement) for certain types of medical services are - unless indicated otherwise in the benefits table - always applicable per Insured and per Insurance Year. This means that each ceiling is applicable for a 12 months period of uninterrupted coverage, starting on the effective date of coverage of the Insured.
Note: The Benefits Table as published in the Third Party Administrator's website, brochure or other documents available to the general public may differ from the Benefits Table of a Policyholder under the policy in force. Insured members of that policy are requested to check carefully their particular cover and in case of doubt to check with the Claims Handler.

2.1.3. **Description of benefits**

2.1.3.1. **Inpatient Treatment**

Pre-certification as stated in clause 2.1.3.4. below is always required except in case of Medical Emergency. Failure to comply with the pre-certification requirement will lead to a reduction of the reimbursement with 25%.

2.1.3.1.1. Hospital room and board

Reimbursement of the Reasonable and Customary charges Medically Necessary for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the hospital during the Insured's confinement. If a Standard-private Room (or Semi-private Room if this option is chosen by the client) is not available at the time of admission, then the next lower level of accommodation available must be chosen. Under no circumstance will the Insurer pay for a higher level cost than the lowest rate for a Standard-private Room (or Semi-private Room).

2.1.3.1.2. Intensive Care Unit

Reimbursement of the Reasonable and Customary charges Medically Necessary for actual room and board incurred during confinement as an inpatient in the Intensive Care Unit of the hospital. This benefit shall be payable equal to the actual charges made by the hospital.
No hospital room and board benefits shall be paid for the same confinement period where the daily Intensive Care Unit benefit is payable.

2.1.3.1.3. Doctors' fees

a. Surgical fees

Reimbursement of the Reasonable and Customary charges for a Medically Necessary Surgery by the Specialists, but within the maximum indicated in the benefits table. If more than one (1) Surgery is performed for any one Disability, the total payments for all the surgeries performed shall not exceed the maximum stated in the benefits table.

b. Anaesthetist fees

Reimbursement of the Reasonable and Customary charges by the anaesthetist for the Medically Necessary administration of anaesthesia not exceeding the limits as set forth in the benefits table.

2.1.3.1.4. Other medical expenses

a. Operating theatre

Reimbursement of the Reasonable and Customary operating and recovery room charges incidental to the surgical procedure.

b. Hospital supplies and services

Reimbursement of the Reasonable and Customary charges actually incurred for Medically Necessary general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, medical imaging (x-ray, CT, MRI, etc.), medical aids, laboratory examinations, electrocardiograms, physiotherapy, logopaedic treatment, speech therapy, occupational therapy and ergo therapy.

2.1.3.1.5. Parent accommodation

Reimburses up to stipulated limits stated in the benefits table the expenses for meals and lodging to accompany a dependent child who is the Insured (aged below sixteen (16) years) in the hospital.

2.1.3.1.6. Hospital cash benefit

Hospital cash benefit is the daily allowance, only when room, board & treatment are received free of charge.

2.1.3.1.7. Convalescence and rehabilitation

Convalescence and rehabilitation rest/care (in a recognised centre and when the admission is medically motivated) is covered when the admission immediately follows (within five (5) days) a hospitalisation for Illness or Surgery and with a maximum of days according to the Plan level chosen.

2.1.3.2. **Outpatient treatment**

This benefit provides for the reimbursement of actual expenses incurred for Outpatient care subject to the stated sub-limit set forth in the benefits table.

2.1.3.2.1. Doctor's fees

Consultation with a legally registered General Practitioner, Family Doctor, Specialist as a result of common sicknesses and bodily Injuries, where hospitalisation is not required.

2.1.3.2.2. Diagnostic tests

Reimbursement of the Reasonable and Customary charges for Medically Necessary tests (ECG, x-ray, laboratory tests etc.) which are performed for diagnostic purposes on account of an injury or illness, within the amount as set forth in the benefits table and which are recommended by a qualified Medical Practitioner.

2.1.3.2.3. Prescription medicines/drugs
Only drugs that are prescribed by a Doctor and that are not available without prescription can be reimbursed. Medicines that do not qualify for reimbursement: lifestyle products, dietary products, vitamins, food supplements etc.
For vaccines, the special provisions of clause 2.1.3.2.4. below apply.

2.1.3.2.4. Preventive care and wellness benefits
- well baby care;
- vaccinations (adults and children);
- one routine eye test per Insurance Year;
- one adult physical examination every 2 years including:
  - one (bilateral) mammogram every 2 years [for Insured females as of age thirty-five (35) years];
  - one pap-smear test every 2 years [for Insured females as of age thirty-five (35) years];
  - one PSA-test every 2 years [for Insured males as of age fifty (50) years].

A waiting period of 12 months applies to preventive care and wellness benefits.
Preventive care and wellness benefits for New Borns born into the policy, and prescribed vaccinations for children are not subject to this waiting period.

2.1.3.2.5. Physiotherapy
Physiotherapy prescribed by a Doctor, including mensendieck physiotherapy, is covered on the condition that the medical prescription clearly mentions the need for this specific form of physiotherapy AND if the care provider is a certified physiotherapist.
2.1.3.2.6. Treatments performed by complementary Medical Practitioners
- Chiropractor
- Osteopath
- Acupuncturist
- Homeopath

These Treatments must be prescribed by a registered Doctor.

2.1.3.3. **Other Medical Treatments**
These benefits provide for the reimbursement of actual expenses incurred subject to the stated sub-limit of the overall annual limit per Insured per Insurance Year (unless stated otherwise) for:

2.1.3.3.1. Maternity care (covered on a per pregnancy basis)

a. Pregnancy
Costs are reimbursed according to the type of Outpatient Treatment.

b. Childbirth
The covered amount includes reimbursement for Doctors' fees, hospital accommodation, other related medical expenses incurred during hospital stay.
Elective caesarean surgery is excluded from cover.

c. Waiting period
There is a twelve (12) month waiting period for all medical expenses related to delivery and maternity care, meaning that only expenses incurred as from the thirteenth (13^{th}) month after acceptance into the insurance can be eligible for reimbursement.
This waiting period can be waived for larger groups if at the time of affiliation they had been benefiting from a similar cover. Such waiver is only valid if explicitly mentioned in the Special Conditions attached to this policy.

2.1.3.3.2. Expenses related to sterilisation
One sterilisation per Insured and per lifetime
There is a twelve (12) months waiting period for all medical expenses related to sterilisation.

2.1.3.3.3. Cancer treatment
If an Insured is diagnosed with Cancer as defined below, the Insurer will reimburse the Reasonable and Customary charges incurred for the Medically Necessary treatment of cancer performed at a legally registered Cancer Treatment centre subject to the limit of this disability as specified in the benefits table. Such treatment (e.g. radiotherapy or chemotherapy, consultation, examination tests, take home drugs, excluding experimental treatment) must be received as an Inpatient or as an Outpatient at a hospital or a registered Cancer Treatment centre following discharge from hospital confinement or Surgery.
Cancer is defined as the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist treatment or surgery (excluding endoscopic procedures alone) is considered necessary. The Cancer must be confirmed by histological evidence of malignancy.

2.1.3.3.4. Organ transplant
Reimburses Reasonable and Customary Charges incurred on transplantation surgery for the Insured being the recipient of the transplant of an organ. Payment for this benefit is applicable whilst the policy is in force and shall be subject to the limit as set forth in the benefits table. The covered amount includes doctor's fees, hospital accommodation (Standard-private Room) and other related medical expenses during hospital stay. Prior approval of the Insurer's Medical Consultant is always required.
Following expenses are excluded from cover:
- costs related to the search for a donor;
- costs for acquisition of the organ (in case a price is charged for the organ);
- costs incurred for removal of organ from the donor.

2.1.3.3.5. Kidney dialysis
If an Insured is diagnosed with Kidney Failure as defined below, the Insurer will reimburse the Reasonable and Customary charges incurred for the Medically Necessary treatment of kidney dialysis performed at a hospital or at a legally registered dialysis centre subject to the limit of this disability as specified in the benefits table.
Kidney Failure means end stage renal failure presenting as chronic, irreversible failure of both kidneys to function as a result of which renal dialysis is initiated.
These benefits exclude all experimental treatments.

2.1.3.3.6. Medical aids
The Insurer reimburses Reasonable and Customary charges for hearing aids, orthopaedic appliances & stockings, artificial limbs, wheelchair, etc.

2.1.3.3.7. Local ambulance to the nearest hospital
Reimbursement of the Reasonable and Customary charges incurred for necessary domestic ambulance services (inclusive of attendant) to and/or from the hospital of confinement. Payment is subject to the maximum limit set forth in the benefits table.

2.1.3.3.8. Psychiatric care
Outpatient psychiatric care reimburses only care prescribed by or performed by a Doctor. The covered amount includes fees of Doctor and/or (Treatment fees of) Medical Practitioner, but does not include drugs. Drugs are covered according to the provisions of Prescription drugs.
Following expenses will also fall under the same ceiling as Outpatient psychiatric care: ergotherapy, logopaedics and/or speech therapy, occupational therapy.

2.1.3.3.9. Dental treatment following accident
Dental surgery is only covered if required to restore damage to natural teeth.

2.1.3.3.10. Hospice and palliative care in case of terminal illness
In-Patient, Day-Patient or Out-Patient Treatment following the diagnosis of terminal condition given on the advice of a Medical Practitioner or Specialist for the purpose of offering temporary relief of symptoms. Charges for hospital or hospice accommodation, nursing care by a qualified nurse and prescribed drugs and dressings are covered subject to the sub-limit of the overall lifetime limit set forth in the benefits table.

2.1.3.3.11. Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS)
The Insurer will reimburse medical expenses, which arise from or are in any way related to HIV and/or HIV related illnesses, including AIDS or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof. Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, drugs and dressings (except experimental or those unproven), hospital accommodation and nursing fees.
Pre-certification by the Insurer or Third-party Administrator is required before this benefit can be considered. Authorization for this benefit is subject to review.

2.1.3.3.12. Vegetative State
If the Insured is declared to be in a vegetative state, Medically Necessary Treatments, up to 90 days from the date of such declaration, are covered subject to the limits of the Plan selected.

2.1.3.4. **Pre-certification requirement - Direct settlement**
All Inpatient Medical Treatments (except emergency hospital admissions), as well as Day surgery and Day-care treatment are subject to pre-certification.
This means that in case of non-emergency hospitalisation, Day surgery or Day-care treatment, for which the diagnosis of the medical condition has been established more than 15 days before actual admission into hospital (or before the start of the Day-care treatment or Day surgery), the Claims Handler has to be informed - in writing - at the latest 15 days before the Treatment will be performed (in case of childbirth, 15 days before the delivery will take place).
Following information is required:
- diagnosis;
- description of the required Medical Treatment;
- name and address of the hospital where the Treatment will be given;
- expected length of stay in the hospital;
- estimated cost of the Treatment.

In case of an emergency hospitalisation, the Claims Handler has to be informed as soon as possible (normally within 48 hours) and at the latest before discharge from the hospital.
In case of failure to comply with the pre-certification requirement, the Insurer reserves the right to apply a penalty of twenty-five (25) percent. This means that the reimbursement of the eligible expenses will be reduced to seventy-five (75) percent of the amount the Insured would normally be entitled to (Reasonable and Customary charges) if he/she had duly fulfilled the said requirements.

2.1.3.4.1. Direct settlement
In the event of a planned admission to hospital on an In-Patient or Day-Patient basis, it is possible for the Claims Handler to send the medical provider a Guarantee of Payment (GOP). In this case it is important that the Insured contacts the Claims Handler at least five working days prior to the Insured's scheduled admission in order that the Claims Handler may, wherever possible, arrange for the direct settlement of any eligible bills that the Insured incurs when receiving Medical Treatment.

2.1.3.5. **Restrictions and Exclusions**
In addition to the exclusions mentioned in article 1.10 ('General Exclusions') of Chapter I (General Policy Provisions), the following items or services are excluded from cover:
- non prescribed Medical Treatments;
- periodic preventive health examinations except those explicitly mentioned in the table of medical benefits;
- complementary (and/or alternative) Medical Treatments other than those explicitly mentioned in the benefits table;
- rejuvenation- and spa-cures, cosmetic treatments and convalescent rest;
- rehabilitation (unless admission follows immediately an hospitalisation)
- facilities for the aged, primarily giving custodial, educational and rehabilitation care;
- expenses resulting from maternity (subject to the plan selected) and childbirth during the first 12 months after the inception date of cover; (unless explicitly waived in the Special Conditions);
- non prescribed drugs;
- OTC ('over-the-counter') medicines: lifestyle products, dietary products, vitamins, food supplements and food products, baby food, mineral waters, tonics, cosmetic products etc. – even if prescribed by Doctor.
- expenses related to sterilisation (unless specified in the benefits table);
- contraceptive and birth control drugs, even if prescribed by a Doctor;
- costs related to abortion except in case of absolute medical necessity;
- consequences of drug-addiction and alcoholism;
- cosmetic/aesthetic treatment except restorative treatment following Accident;
- surgical procedures costs related to corrective eye surgery (keratectomy and keratotomy, including LASIK- and LASEK-procedures) are excluded from coverage, except in case of refractive illness of the cornea in which case they are covered as any other surgical expenses;
- remedial teaching;
- orthoptics;
- sunglasses, even if prescription lenses;
- elective caesarean delivery expenses;
- sex change operations and all related treatments.

2.1.3.6. **Claims Procedure / Coordination of Benefits - Other Insurance / Claims Payment**

2.1.3.6.1. Claims Procedure
Each claim has to be submitted to the Claims Handler, in writing or via e-mail by using scanned copies, using the special claim forms made available by the Claims Handler (e.g. through the dedicated website) as soon as possible after the event giving rise to the claim. The claim has to be accompanied by the original supporting documentation including all relevant invoices, and proof of payment whenever requested by the Insurer. Diagnosis and full details (name and dosage) of prescribed medicine must be stated on the original bill and the claim form.
Moreover, in case of Accident, the Insured has to provide following additional information:
- date and detailed description of circumstances and place of the Accident;
- identity of persons involved, as well as of witnesses and persons possibly liable;
- official report from local authorities (police or other).

As indicated above, the Insured can choose to send scanned copies of the claims and all supporting documents by e-mail, on the condition that the claimed expenses are equal to or lower than 675 USD. Should the Insured choose to send scanned copies of the invoice and the claim form via email, he shall keep the original invoices for a minimum period of 12 months. During this period, the Insurer reserves the right to ask for the original invoices at any time.

2.1.3.6.2. Coordination of Benefits - Other Insurance
If the Insured is entitled to a reimbursement by another insurer or social security system, the amount reimbursed by the other insurance will be deducted from the amount of reimbursement as determined in accordance with the provisions of article 2.1.2. ('Benefits'). In that case the Insured has to attach (to his/her claim) copies of the pertaining medical bills and the original settlement notes (with details of the amount reimbursed) provided by the other insurer or the social security system concerned.
Total reimbursement for any given claim will never exceed the total amount of expenses actually incurred by the Insured.

2.1.3.6.3. Payment of Medical Claims
The Claims Handler shall effect reimbursement of the covered Reasonable and Customary medical expenses (up to the limits defined in these General Conditions) following the receipt of the claim form and the relevant and complete written evidence of the medical expenses (original invoices of medical providers etc.).
Reimbursements shall be made to the Insured, but if the Insured has deceased, payment shall be made at the sole discretion of the Insurer, or to any person submitting satisfactory evidence that he/she is entitled to such payment.
Benefits may be assigned to hospitals directly.

2.1.3.7. **Medical Information and Examination**
Whenever required for the smooth settlement of the claims related to the insurance cover provided by the Plan, and in accordance with the Hong Kong legislation regarding the protection of personal data, the Insured is obliged to provide (directly or through his/her Doctor) all the necessary medical information requested by the Insurer through the Claims Handler. Confidential information may be forwarded under sealed envelope to the Insurer's Medical Consultant.
Whenever deemed necessary for the assessment of a claim, the Insurer is allowed to request a medical examination of the Insured, performed by a Doctor appointed by the Insurer, at the Insurer's expense. The Insured can ask for his/her own Doctor to be present at this examination, the costs for the own Doctor to be borne by the Insured.

In case the Insured and/or the Insured's Dependants do not comply with above obligations to provide the requested medical information or examination, the Insurer can refuse payment of benefits.

2.1.3.8. **Time limitation**
Claims should be reported to the Claims Handler as soon as possible after their occurrence.
For some Treatments, pre-certification is required (see article 2.1.3.4. 'Pre-certification requirement').
In any case, claims have to be received by the Insurer (through the Claims Handler) no later than two (2) years after the event giving rise to the claim occurred.
Beyond this maximum term of two (2) years, no claim will qualify for payment by the Insurer.
In case of policy cancellation by the Policyholder, all claims must be received by Insurer within 10 months of cancellation. Beyond which no claim will qualify for reimbursement.

2.1.4. **Optional Dental & Optical Insurance**

2.1.4.1. Eligibility
The optional dental & optical insurance is only open to persons a) who are accepted into the Plan and b) who are contracting into the Global 80, Global 100 or Global 100 Plus Plan level.
Dental & optical plans are not available with deductible of $ 6,750.
The choice for taking out the dental insurance has to be made on a per Plan level in that sense that all members of the same Plan, i.e. all members and their Dependants who are accepted into the Plan, have to:
a) take out the dental insurance or not (i.e. all members or none);
b) opt for the same dental and optical plan (dental & optical standard or dental & optical plus).

2.1.4.2. Benefits
Only expenses that are Reasonable and Customary can qualify for reimbursement, subject to the limits and ceilings as mentioned in the benefits table. Waiting period as mentioned in the benefits table may apply.

2.1.4.3. Other provisions
Apart from the General Policy Provisions as set out in Chapter I of these General Conditions, the provisions of articles 1.8 up to and including 1.10 of title I 'Medical Insurance' of Chapter II ('Provisions proper to the different types of cover') also apply to the dental & optical insurance plan.

PART II - NON-MEDICAL . PERSONAL ACCIDENT & LOSS OF INCOME

3. Chapter III: GENERAL POLICY PROVISIONS
All articles and clauses contained in the General Conditions Core Plan (Medical) Part I are deemed to be part of and are applicable in full and in every respect to these General Conditions Optional covers (Personal Accident and Temporary Incapacity & Permanent Disability)

3.1. **Order of Precedence & Purpose of the Insurance**

3.1.1. **Order of Precedence**
The 'General Policy Provisions' as set out in Chapter I, are only valid insofar as they are not contradicted by or in conflict with the provisions proper to the different types of cover as set out in Part II.
In case of contradiction or conflict, the latter take precedence over the former.
Moreover, the Special Conditions will always take precedence over the Plan's General Conditions.

3.1.2. **Purpose of the Insurance**
The Plan consists of several insurance plans, intended to offer social protection to persons and their Dependants:

3.1.2.1. Optional Voluntary Insurance Cover
Persons insured under the Plan can also apply for the following optional voluntary insurance cover as optional extension to their Plan (Part I Medical – Core Plan).
3.1.2.2. Personal Accident Insurance (Accidental Death & Dismemberment cover):
This insurance can be taken out as an optional cover to the medical insurance plan, and guarantees the payment of a lump sum in case of accidental death or in case of permanent disability caused by an Accident.

3.1.2.3. Temporary Incapacity Cover (Loss of Income Protection):
This insurance can be taken out as an optional cover on top of the medical insurance plan, and guarantees payment of a monthly allowance in case the Insured is totally unable to perform his/her professional activities because of Illness and/or Accident.

3.1.2.4. Permanent Disability Cover (Permanent Disability caused by an Illness and/or accident).
This insurance can be taken out only as a supplement to the Temporary Incapacity Cover and guarantees the payment of a lump sum to the Insured who is affected by a permanent disability, caused by an Illness or Accident.

3.2. **Definitions**
Refer to "Definitions" in Chapter I

3.3. **Eligibility and acceptance into the insurance**
Refer to clause "Eligibility and acceptance into the insurance" in Chapter I
NOTE: The covers for "Personal Accident" and "Temporary Incapacity & Permanent Disability" are available exclusively as optional covers to the Plans and to people eligible to these plans and who are at least 18 years old.

3.4. **Effective date of coverage**
Refer to clause "Effective date of coverage"

3.5. **Duration and termination of the insurance**
Refer to clause Duration and termination of the insurance in Chapter I

3.6. **Return to the Home Country**
Refer to clause "Return to home country" in Chapter I

3.7. **Premium & Premium Increase / Suspension and Cancellation of Cover**
Refer to clause "Premium & Premium Increase/Suspension and Cancellation of Cover" in Chapter I

3.8. **Territorial scope of the insurance**
Cover is available worldwide as long as the Medical Core plan is in force

3.9. **Currency**
Refer to clause "Currency" in Chapter I

3.10. **General Exclusions**
Refer to clause "General Exclusions" in Chapter I
Additional General Exclusion to:
- Personal Accident cover,
- Temporary Incapacity and Permanent Disability cover

Consequences of war or acts of war and terrorism: to the extent mentioned in article 4.11. hereafter.
Important remark

For the optional specific exclusions relating to each separate insurance cover of the Plan, reference is explicitly made to the provisions proper to the different types of cover.

3.11. **War and Terrorism**

War and terrorism are defined as follows:

3.11.1. **War:**

- War: armed conflict, declared or undeclared, between one State and another, an invasion or a state of siege. Are considered as acts of War: all sort like actions, the use of military force by a sovereign nation to achieve certain economic, geographic, nationalistic, political, racial, religious or other ends.
- Civil war: armed conflict between two or several parties belonging to one and the same state the members of which are of different ethnic origin, religion or ideology. Are considered as acts of Civil War: an armed rebellion, a revolution, sedition, an insurrection, a coup d'état, the consequences of martial law and border closings ordered by a government or by local authorities.

3.11.2. **Terrorism:**

- any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption.
- commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not.
- robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorists acts.

Terrorism shall include any act that is verified or recognised by the (relevant) government as an act of terrorism.

3.11.3. **With respect to the risks and consequences of war and terrorism:**

All consequences of active participation of the Insured (and/or his/her covered Dependants) in operations of war and terrorism are explicitly excluded from coverage. In case the Insured is victim of activities of war and terrorism without any active involvement on behalf of the Insured or his/her beneficiaries in these activities, the insured is covered within the limits and the ceilings of the coverage. However, the Insurance cover is not valid when the Insured (or covered Dependants) was travelling to or from or residing in a country or a region within a country publicly known to be in state of war or civil war at the time damages (bodily injury, or death) to Insured or his/her covered Dependants happened. In case of dispute concerning the fact whether a given country is known to be in state of war or civil war, the outbound Travel Alert of the Security Bureau (SB)on travel advice as published on the official website (www.sb.gov.hk/eng/ota/) of The Government of the Hong Kong Special Administrative Region, will be decisive.

In case the Insured is surprised abroad by the sudden occurrence of a new (outbreak of) war or warlike situations and activities, the insurance cover remains valid during 14 days starting from the beginning of the hostilities.

3.12. **Dispute Settlement**

Refer to "Dispute Settlement" in Chapter I

3.13. **Data Protection**

Refer to clause "Data Protection" in Chapter I

3.14. **Subrogation**

Refer to clause "Subrogation" in Chapter I

3.15. **Defence**

Refer to clause "Defence" in Chapter I

3.16. **Complaints Procedure**

Refer to clause "Complaints Procedure" in Chapter I

3.17. **Governing Law**

Refer to clause "Governing Law" in Chapter I

3.18. **Cross-Border Provision**

3.18.1. **Source of Funds; No Money Laundering, No Tax Evasion**

The Policyholder and the Insured jointly and severally represent, warrant and certify to the Insurer that (i) all amounts invested in this policy have been or will be properly declared to relevant tax authorities in the jurisdiction of their respective tax residence and/or any other jurisdictions as necessary or appropriate in accordance with applicable laws and regulations, and (ii) none of the funds derive, directly or indirectly, from illegal activities or sources and/or tax evasion.

3.18.2. **Breach of Representations; Insurer Right to Rescind and Impose Surrender Charge; Right to Freeze Refund Amount**

The Policyholder and the Insured acknowledge that in the event of a violation of the representation and warranty stated under the above section titled "Source of Funds; No Money Laundering, No Tax Evasion", the Policyholder and the Insured hereby, jointly and severally, expressly acknowledge and agree that the Insurer shall, to the fullest extent permitted by applicable law and regulation, have the right to

- terminate this policy immediately;
- notwithstanding the actual date of termination pursuant to clause (i) of this section, impose the maximum surrender and any other charges imposable on the Policyholder and the Insured under this policy, as if the policy had been surrendered immediately after issuance;
- notify relevant governmental authorities and furnish all information deemed necessary or appropriate in the entire discretion of the Insurer concerning the Policyholder, the Insured and/or this policy; and
- if deemed appropriate after consultation with governmental authorities and legal counsel, either (a) refund to the Policyholder premiums and other amounts paid to the Insurer through the date of such termination less applicable surrender and other charges in accordance with clause (ii) of this section (the "Refund Amount"), or (b) if requested or required to do so by competent governmental authorities, freeze or pay over to relevant governmental authorities all or a portion of the Refund Amount or take such other actions as competent governmental authorities may request or require.

3.18.3. **Policy of Cooperating with Tax and Other Governmental Authorities; Consent to Disclose Information to Tax and Other Governmental Authorities**

The AXA Group and the Insurer have a longstanding policy of cooperating with tax and other governmental authorities to combat money laundering, tax evasion or other illegal activities. In cases where the Policyholder or the Insured is not a tax resident of the jurisdiction in which this policy is issued, the AXA Group may disclose to the home country tax and/or other governmental authorities of the Policyholder and the Insured the identity of the Policyholder and the Insured and certain information concerning this policy, and the Policyholder and the Insured hereby, jointly and severally, consent and agree that the Insurer may, in its discretion, make such disclosure.

4. Chapter IV: BENEFITS AND PROVISIONS OF THE DIFFERENT COVER TYPES

4.1. **Optional Voluntary Insurance**

4.1.1. **Personal Accident Cover (Accidental Death & Dismemberment)**

4.1.1.1. Purpose and eligibility

The purpose of the Personal Accident Cover is to guarantee:

- payment of a lump sum in case of accidental death;
- payment of a lump sum in case of permanent disability of at least 20%, caused by an Accident.

The Personal Accident Cover can be taken out for or by the Insured as well as by his/her Dependants insofar as these persons are also accepted in and covered by the Plan.

4.1.1.2. Definition of Accident

Refer to clause 1.2, Chapter I

4.1.1.3. Time limits for the declaration of the Accident, claim assessment and benefits payment

4.1.1.3.1. Time limit for the declaration of the Accident

Any Accident resulting in - or which may result in - permanent disability or death of the Insured, has to be declared in writing to the Insurer or the Claims Handler within a fortnight after the Accident occurred.
The declaration of the Accident should contain detailed information relating to the cause of the Accident and the nature of the Injuries.

4.1.1.3.2. Time limit for claim assessment and benefits payment

In case of accidental death, which has to occur within 12 months after the date of the Accident causing the death, a lump sum payment will be effected to the designated beneficiaries of the deceased Insured as indicated in the Insurer's records.
In case of permanent disability, the Disability must be medically recognised at the latest 1 year after the date of the Accident. However, if the Insured's condition has not entirely stabilised within 2 years after the date of the Accident, the degree of permanent disability will be assessed on the basis of the Insured's state of health at the end of that 2 years' period.

4.1.1.4. Amount of the sum insured

The amount of the sum insured is specified in the Special Conditions.
The minimum and maximum sum shall be insured according to the amounts stated in the benefits table.
Premiums and benefits (lump sum) are calculated on the basis of the sum insured.
For group insurance plans, benefits under the Accidental Death cover deriving from One Single Event shall be limited to $ 5,400,000. If this limit is met, the $ 5,400,000 will be apportioned between the beneficiaries.

4.1.1.5. Insured Benefits

4.1.1.5.1. Accidental Death

In case of death of the Insured, caused by an Accident, the lump sum payable by the Insurer (to the beneficiaries of the Insured) will be equal to 100% of the sum insured, the amount of which is mentioned in the Special Conditions.
In case the Insurer paid a benefit for accidental permanent disability, the benefit payable in case of ensuing death (within the time frame as mentioned in article 3 of the present chapter) caused by the same Accident which led to the Disability will be reduced by the amount already paid for the Disability.

4.1.1.5.2. Permanent Disability (following an accident)

In case of permanent disability of the Insured caused by an Accident, the lump sum payable by the Insurer (to the Insured) will be equal to the amount of the sum insured (as mentioned in the Special Conditions) multiplied by the degree of Disability (percentage), the latter being determined in accordance with the 'Table of Dismemberment' hereafter. Permanent disability of a degree of less than 20% will not qualify for payment of any benefit.
If the permanent disability caused by the accident amounts to 20% or more than 20% according to the 'Table of Dismemberment' hereafter, the benefit amounts to the corresponding percentage (%) of the sum insured.

4.1.1.6. Assessment of the degree of permanent disability and use of the 'Table of Dismemberment'

4.1.1.6.1. Table of Dismemberment

Following Table of Dismemberment will be used to determine the degree of disability:

Total paralysis	100%
Total blindness	100%
Incurable and total mental disability	100%
Amputation or the permanent loss of the use of:	
- both arms or both hands	100%
- both legs or both feet	100%
- one arm or hand and one leg or foot	100%
Total loss of sight of one eye with removal of the eye	50%
Total loss of sight of one eye	45%
Loss of bone of the skull forming a hole in the skull over:	
a) an area of at least 6 cm²	40%
b) an area of 3 to 6 cm²	20%
c) an area of less than 3 cm²	10%
Incurable total loss of hearing in both ears	100%
Incurable total loss of hearing in one ear	50%
Amputation of the lower jaw	
a) total	70%
b) partial (upright branch plus the whole or half of the maxillary bone)	40%
Loss of top and bottom teeth and their sockets (impossibility of fitting dental prosthesis)	10 to 30%
In the case of possible prosthesis with established functional improvement	1 to 10%

	Right	Left
Loss of arm or hand	75%	60%
Total paralysis of an upper limb	65%	55%
Total paralysis of the circumflex nerve	20%	15%
Total paralysis of the median nerve	45%	35%
Total paralysis of the cubital nerve at the elbow	30%	25%
Total paralysis of the nerve of the hand	20%	15%
Total paralysis of the radial nerve above the triceps	40%	30%
Complete ankylosis of the shoulder:		
a) with immobilisation of the shoulder-blade	65%	55%
b) with mobility of the shoulder-blade	35%	25%
Non-consolidated fracture of the upper arm: (constitution of pseudo-arthrosis)	30%	25%
Total loss of movement of the elbow:		
a) in an unfavourable position	40%	35%
b) in a favourable position	25%	20%

Non-consolidated fracture of the fore-arm: (constitution of pseudo-arthrosis)		
a) both bones	25%	20%
b) a single bone	10%	8%
Total loss of movement of the wrist		
a) in an unfavourable position (flexion, forced extensions or supination)	40%	30%
b) in a favourable position (straight or prone)	20%	15%
Amputation of a thumb		
a) total	20%	18%
b) partial (ungual phalanx)	10%	8%
Ankylosis of a thumb		
a) total	15%	12%
b) partial (ungual phalanx)	10%	8%
Amputation of index-finger		
a) total	16%	14%
b) two phalanxes	12%	10%
c) one phalanx	6%	5%

Amputation of second finger	12%	10%
Amputation of third finger	10%	8%
Amputation of fourth finger	8%	6%
Total paralysis of a lower limb		60%
Complete paralysis of the internal popliteal sciatic nerve		30%
Complete paralysis of the external popliteal sciatic nerve		30%
Complete paralysis of both popliteal sciatic nerves		40%
Shortening of a lower limb		
a) at least 5 cm		30%
b) from 3 to 5 cm		20%
c) from 1 to 3 cm		10%
Complete ankylosis of the hip:		
a) in a bad position (flexion, adduction or abduction)		60%
b) in a straight position		40%
Amputation of the thigh:		
a) upper half and leg		60%
b) lower half and leg		50%
Non-consolidated fracture of the thigh or both bones of the leg		
(constitution of pseudo-arthrosis)		50%
Complete ankylosis of the knee:		
a) in flexion (from 130 degrees)		50%
b) straight or almost straight		25%
Chronic gonarthrosis according		
to the degree of muscular atrophy		3 to 20%
Non-consolidated fracture of the knee-cap with wide		
separation of the fragments and considerable difficulty		
in extension of the leg from the thigh		40%
Amputation of a leg		50%
Tibio-tarsian ankylosis		15%
Amputation of a foot:		
a) total (tibio-tarsian disarticulation)		50%
b) sub-astragalian		40%
c) media-tarian		35%
d) tarso-metatarsian		30%
Amputation of all toes		20%
Amputation of big toe		10%
Amputation of a toe other than big toe		3%
Ankylosis of the big toe		3.5%

4.1.1.6.2. Permanent nature of the disability
In order to qualify for payment of the insured benefit, the Disability has to be of a permanent nature, meaning that it has been medically determined that continuation of the Medical Treatment will not lead to any significant improvement of the person's state of health, and that the Disability will therefore be definitive and irreversible.

4.1.1.6.3. Pre-existing state of infirmity
A pre-existing state of infirmity of limbs or organs, cannot be taken into account for the assessment of the injuries that are caused by the Accident.

4.1.1.6.4. Maximum degree of disability
The degree of permanent disability can never exceed 100%.
Under no circumstances the sum payable by the Insurer will exceed 100% of the sum insured.

4.1.1.6.5. Several injuries affecting the same limb
In case of several injuries or infirmities resulting from the same Accident or from successive Accidents, each Injury or infirmity will be assessed separately, but the sum of Injuries or infirmities affecting a limb may not lead to a degree of Disability exceeding the degree of Disability corresponding to the full loss of the limb concerned.

4.1.1.6.6. Events or infirmities not listed in the Table of Dismemberment
For events or infirmities not listed in the 'Table of Dismemberment', the degree of Disability shall be determined by reference to the listed events or infirmities: the 'Table of Dismemberment' will be used as a guide to assess the degree of disability by analogy with listed items.
The sum payable will in no case be less than the amount payable for any reasonably analogous event or infirmity, listed in the Table of Dismemberment.

4.1.1.6.7. Total loss of use of a limb
Total loss of use of a limb will be considered being equal to the loss of the limb itself.

4.1.1.6.8. Left-handed persons
Left-handed persons, upon declaration of left-handedness in the place indicated on the declaration of state of health, shall receive scaled benefits related to the upper right limb instead of upper left limb, and vice-versa.

4.1.1.6.9. Aggravating facts
In the case of aggravation of the consequences of an Accident as a result of infirmities, Sickness or circumstances independent of the accidental cause, the degree of Disability cannot be superior to the one that would have been determined if the Accident had struck a healthy organism.

4.1.1.7. Additional exclusions
In addition to the general exclusions mentioned under article 4.10 and 4.11, Chapter IV of these General Conditions, following exclusions shall apply to the Personal Accident Cover (Accidental Death & Dismemberment):

- Accidents resulting from obviously foolhardy and/or reckless acts by the Insured, or Accidents he/she has intentionally caused or provoked;
- the consequences of suicide or of suicide attempts;
- Accidents occurring in a state of intoxication or under the influence of non-prescribed drugs except if it is established by the insured or the beneficiaries that such state was not the cause of the Accident;
- Accidents provoked by ionising radiations other than the medical radiations required by covered Medical Treatment;
- Disability and/or death resulting from an Illness.
- Accidents occurring during the Insured's participation in an air sport (including hang gliding, paragliding, gliding) or in any of the following sports: skeleton, bobsleigh, ski-jumping, mountain-climbing with roping, rock-climbing, skin diving with self-contained apparatus, spelunking, bungee-jumping, skydiving;
- Any losses directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with radioactive contamination whether direct or indirect or any act of Nuclear, Chemical, Biological Terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss. This exclusion is not applicable to medical radiations required by covered Medical Treatment;

4.1.1.8. Obligations to be fulfilled by the insured

4.1.1.8.1. Declaration of Accident
Any Accident that leads or that could lead to Disability or death must be declared in writing to the Insurer (through the Claims Handler) within a fortnight after the Accident occurred.
The declaration must contain all information relating to the Accident, including:
- place, date and detailed circumstances of the Accident;
- names and addresses of persons involved;
- names and addresses of witnesses and of persons possibly liable;
- the official report from the local authorities (e.g. police report or other relevant documents).

A medical certificate must be attached to this declaration, indicating the nature and extent of the Injuries of the Insured and the probable duration of the Disability.

4.1.1.8.2. Changes to the extent of the Disability
Any changes to the extent of the Disability must be communicated by the Insured to the Insurer (through the Claims Handler) within a month. In the absence of such communication, any amount unduly paid to the Insured person will have to be refunded by him/her to the Insurer.

4.1.1.8.3. Medical information
The Insured shall authorise his/her attending Physician to communicate all relevant information concerning the Insured's state of health to the Insurer's Medical Consultant.

4.1.1.8.4. Force Majeure
There shall be no loss of cover if the Insured can prove that the obligations, as stipulated by this article, have not been fulfilled as a result of circumstances totally beyond his/her control ('force majeure'), or if the good faith of the Insured cannot be called into question.

4.1.1.8.5. Payment of the Benefit
In case of death caused by an Accident, the Insurer will pay the lump sum insured to the Insured's designated beneficiaries (or the lawful heir(s) in case no beneficiaries have been declared on the said form) within a month of receiving :
- the documents mentioned under article 5.1.1.8.1. ('Declaration of Accident'), and
- copy of the birth certificate of the deceased or a certificate of civil status, and
- an original death certificate, and
- a medical certificate, established by a Doctor, stating the cause of death,

Before the claim can be paid, the causal link between the Accident and death should have been established.
The burden of proof lies with the beneficiaries.
In case of permanent disability caused by an Accident, the Insurer will pay the lump sum insured to the Policyholder. Following documents have to be provided to the Claims Handler:
- the documents mentioned under 5.1.1.8.1. ('Declaration of Accident')
- copy of the birth certificate of the Insured concerned or a certificate of civil status
- a detailed medical certificate , established by the attending Physician, stating the cause of the Disability, accompanied by all relevant documents needed to accurately assess the disability (see article 5.1.1.6. above)

After all documents have been received by the Claims Handler and the condition of the Insured concerned has sufficiently stabilised to allow the Insurer's Medical Consultant to assess degree of Disability (according to the provisions as set out in article 5.1.1.6. 'Assessment of the degree of permanent disability'), payment of the Insured sum due will be made within one month.

4.1.1.8.6. Nomination of Beneficiary
At the inception of the policy, the Policyholder has to provide the Third-Party Administrator with a 'Nomination of Beneficiaries' form duly signed by the Insured. Any change of beneficiary must be done on the 'Change of Beneficiary Form' and duly signed by the Insured. Beneficiaries are kept up to date by the Claims Handler.

4.1.2. **Temporary Incapacity Cover (Loss of Income)**

4.1.2.1. Purpose and Eligibility
The purpose of the Temporary Incapacity Cover is to guarantee to the Insured, after the waiting period as defined hereafter, the payment of a monthly allowance during a maximum period of 2 years, in case the Insured is totally unable to perform his/her professional occupation.
The Temporary Incapacity Cover can only be taken out for or by an Insured and his Domestic Partner or Legal Partner and is not available to children of the Insured.
If the Domestic Partner or Legal Partner of the Insured wishes to subscribe for the Temporary Incapacity Cover, he/she has to have a professional occupation and must provide proof of income.

4.1.2.2. Medical Acceptance into the Insurance
Joining the Temporary Incapacity Cover is subject to the acceptance of the applicant-insured into the insurance by the Insurer's Medical Consultant. If one subscribes to the temporary incapacity cover on a later date than the medical cover, a new medical questionnaire has to be filled out.

4.1.2.3. Temporary Incapacity Benefit
The Temporary Incapacity cover provides for a monthly allowance in case the Insured - further to an Accident or an Illness - is totally unable to perform his/her own professional occupation (i.e. the usual professional occupation at the time the incapacity started).

4.1.2.4. Waiting Period
The allowance is payable after a waiting period of 90 days (for which no benefits are due) of uninterrupted total incapacity to perform the own professional occupation.
The waiting period shall commence on the starting date of the incapacity, as determined by the treating Physician.

4.1.2.5. Assessment of the Incapacity
The incapacity has to be supported by sufficient medical evidence, to be presented by the Insured or his/her Physician to the Medical Consultant of the Insurer.
The Insurer's Medical Consultant has the right to ask for relevant additional information and/or have the Insured medically examined to assess the incapacity.

4.1.2.6. Amount and duration of the Benefit
The amount of the monthly allowance in case of total incapacity of the Insured to perform his/her own professional occupation is mentioned in the Special Conditions.
The minimum and maximum amounts (monthly allowance) to be insured is specified in the benefits table. The amount insured cannot exceed 80% of the gross (monthly) salary of the Insured.
The Policyholder shall submit to the Third-party Administrator a copy of the latest salary statement of the Insured.
After the waiting period of 90 days, the allowance will be paid as long as the Insured is unable to perform his/her occupation, limited however to a maximum period of 2 years.

4.1.2.7. Partial resumption of work
Persons who (after the 90 days waiting period) are benefiting from the monthly allowance and whose condition is improving to such an extent that they are capable of partially resuming work, may continue (within the limits of the maximum period of 2 years after the waiting period) to receive an allowance. The amount of this allowance will however be reduced, and will be calculated by multiplying the (total monthly) sum insured by the percentage of the (remaining) incapacity.
In case the incapacity would become less than 30%, the allowance will be discontinued.

4.1.2.8. Relapse
In the event of a relapse, the payment of the allowance shall be resumed without application of a new waiting period. By a relapse is meant the incapacity to work, which arises within three months of the end of incapacity covered by this insurance policy, and which is caused by the same Illness or the same Accident.
Any additional incapacity resulting from another cause shall be subject to a new waiting period of 90 days.

4.1.2.9. Benefit payment
The incapacity allowance shall be payable, to the Policyholder, at the end of each month, and for the first time at the end of the month following the expiration of the waiting period. If the incapacity to work comes to an end in the course of a month, the allowance shall be proportional to the number of days lapsed in that month.
Payments shall cease at the event of one of the following occasions:
- when the degree of incapacity becomes less than 30%;

- on the death of the Insured person;
- at the end of the period of 2 years of payment of the allowances;
- in the event of the insurance policy being terminated for the non-payment of premium;
- on the renewal date after the 65th birthday of the Insured person;
- when the Insured fully resumes work.

4.1.2.10. Additional exclusions
In addition to the general exclusions mentioned in articles 4.10 and 4.11 Chapter IV of these General Conditions, the following exclusions apply to the Temporary Incapacity cover:

4.1.2.10.1. Maternity leave and childbirth
Maternity leave and incapacity to work because of childbirth are not covered. They will not be taken into account for the calculation of any waiting period and will not give rise to any benefits.
In case the Insured would however be in receipt of benefits for temporary incapacity for other reasons
(than childbirth or maternity leave) during which period the maternity leave would start, the payment of benefits will be suspended to resume only after the end of the maternity leave, and only in case if the Insured is then still unable to resume work.
If on the expiry date of the normal maternity leave of a female Insured, a health condition exists which prevents the Insured from fully resuming her usual professional occupation (total inability to work), the waiting period will start as from that date.

4.1.2.10.2. Dangerous sports
The practice of any sport activity in deliberate breach of public rules of security in such a manner that the Insured could not ignore the risk, including the consequences of an Accident during the Insured's participation in an air sport (including hang gliding, paragliding, gliding) or in any of the following sports: skeleton, bobsleigh, ski-jumping, mountain-climbing with roping, rock-climbing, skin diving with self-contained apparatus, spelunking, bungee-jumping, skydiving.

4.1.2.10.3. Nuclear, Chemical and Biological Terrorism
Any losses directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with radioactive contamination whether direct or indirect or any act of Nuclear, Chemical, Biological Terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss. This exclusion is not applicable to medical radiations required by covered Medical Treatment;

4.1.2.11. Obligations to be fulfilled by the Insured and/or the Policyholder

4.1.2.11.1.1. Notification of incapacity
In case of incapacity to perform the usual professional occupation because of Illness or Accident,
Such incapacity has to be notified by the Policyholder to the Claims Handler in writing as soon as possible and at the latest on the 91st day of the incapacity. At the same time, a medical report, established by the treating Physician of the incapacitated person, indicating the nature and extent of the incapacity of the Insured as well as the probable duration of the incapacity, has to be forwarded to the Claims Handler, for the attention of the Insurer's Medical Consultant. Furthermore, a proof of income has to be provided.

4.1.2.11.1.2. Changes to the extent of the incapacity
Any changes to the extent of the incapacity must be communicated by the Insured or his/her Doctor to the Insurer's Medical Consultant (through the Claims Handler) within a month. In the absence of such communication, any amount unduly paid to the Insured person will have to be refunded by him/her to the Insurer.

4.1.2.11.1.3. Medical information
The Insured shall authorise his/her attending Physician to communicate all relevant information concerning the Insured's state of health to the Insurer's Medical Consultant.

4.1.2.11.1.4. Force Majeure
There shall be no loss of cover if the Insured can prove that the obligations, as stipulated by this article, have not been fulfilled as a result of circumstances totally beyond his/her control ('Force Majeure'), or if the good faith of the Insured cannot be called into question.

4.1.3. **Permanent Disability Cover (resulting from illness and/or accident)**

4.1.3.1. Purpose and eligibility

4.1.3.1.1. Purpose
The purpose of the Permanent Disability Cover is to guarantee payment of a lump sum benefit to the Insured who is affected before the age of 65 by a permanent disability caused by an Illness or Accident, prohibiting him/her from fully or partially continuing his/her professional occupation, therefore leading to a total or partial loss of income.
The insurance covers permanent disability caused by an Illness or Accident and amounting to a degree exceeding 33.33%.
Moreover, in case the degree of disability exceeds 66.67%, and if the Insured needs the assistance of a third person to perform the basic activities of daily living, the insurance guarantees an additional lump sum benefit, in accordance with the provisions as set out below.

4.1.3.1.2. Eligibility
The Permanent Disability Cover can only be taken out as an optional insurance (supplement) to the Temporary Incapacity Cover. The Permanent Disability Cover can only be taken out for or by an Insured and his Domestic Partner or Legal Partner and is not available to children of the Insured.
If the Domestic Partner or Legal Partner of the Insured wishes to subscribe for the Temporary Incapacity Cover, he/she has to have a professional occupation and must provide a proof of income.

4.1.3.2. Medical Acceptance into the Insurance
Joining the Permanent Disability Cover is subject to the acceptance of the applicant-insured into the insurance by the Insurer's Medical Consultant.

4.1.3.3. Definition of Permanent Disability (resulting from illness and/or accident)

4.1.3.3.1. Disability
An Insured is considered to be disabled because of Illness or Accident, if:
- his/her ability to work, i.e. the ability to perform his/her normal professional occupation (occupation at the time the disability started) or any other gainful occupation for which he/she is reasonably fitted by training, education or experience;
- his/her ability to function in general has been reduced because of the Illness or Accident concerned.

In order to qualify for the insured benefits, it has to be medically determined that the Insured's Disability is of a permanent nature and that the degree of (the combination of both) occupational and functional disability exceeds 33.33% according to the disability table hereafter (article 4.1.3.5. – Assessment of disability).

4.1.3.3.2. Permanent
'Permanent' means that continuation of the Medical Treatment will not lead to any significant improvement of the person's state of health, and that the Disability will therefore be definitive and irreversible.

4.1.3.4. Waiting period
The Permanent Disability Cover is a supplement to the Temporary Incapacity Cover.
Benefit payment will therefore start at the earliest after the allowances paid by the Insurer within the framework of the Temporary Incapacity Cover have come to an end.

4.1.3.5. Assessment of disability
The degree of permanent disability will be determined by means of a medical examination.
To this end, the Insurer (or the Claims Handler on behalf of the Insurer) will appoint a Doctor to determine the degree of Disability in accordance with the disability table hereafter:

Disability table	**Degree of functional disability**								
Degree of occupational disability	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**
10%						36.59	40,00	43.27	46.42
20%				36.94	41.60	46.10	50.40	54.51	58.48
30%			36.54	42.17	47.62	52.78	57.69	62.40	66.94
40%			40.00	46.20	52.42	58.09	63.50	68.68	73.68
50%		35.57	43.09	50.00	56.46	62.57	68.40	73.99	79.37
60%		37.80	45.79	53.13	60.00	66.49	72.69	78.62	84.34
70%		39.79	48.20	55.93	63.16	70.00	76.52	82.79	88.79
80%		41.60	50.40	58.48	66.04	73.19	80.00	86.54	92.83
90%		43.27	52.42	60.82	68.68	76.12	83.20	90.00	96.55
100%	34.20	44.81	54.29	63.00	71.14	78.84	86.18	93.22	100.00

4.1.3.6. Amount and duration of the benefit

4.1.3.6.1. Calculation of the amount of benefit

Sum Insured

The amount of the sum insured is mentioned in the Special Conditions.

Deductible

No benefits will be due for Disabilities of less than 33.33 % (=1/3).

Degree of permanent disability between 33.33 % (= 1/3) and 66.67 % (=2/3)

If the degree of disability, as determined in accordance with the stipulations of articles 5.1.3.3. and 5.1.3.5. above, is situated between 33.33 % and 66.67 %, then the amount of the disability lump sum will be calculated as follows:

((3 x n) – 1) x sum insured , 'n' being the degree of disability (%)

Degree of permanent disability exceeding 66.67 % (=2/3)

If the degree of Disability, as determined in accordance with the stipulations of articles 5.1.3.3. and 5.1.3.5. above, exceeds 66.67 %, then the amount of the disability lump sum will be equal to the amount of the sum insured (100%).

4.1.3.6.2. Additional lump sum benefit in case of need of assistance of a third person

If from the start of the Disability (i.e. as from the start of the payment of the disability allowance) the degree of permanent disability exceeds 66.67%, and if the Insured, as from the start of the Disability, needs the assistance of a third person to be able to perform the following activities of daily living:

- feeding oneself (taking and eating prepared food);
- dressing oneself;
- washing oneself;
- being continent;
- moving around (transferring from a bed to a chair or vice versa, and ability to move on level surfaces);

then the Insurer will pay a once-only optional benefit as specified in the benefits table (single lump sum) to the Insured.

4.1.3.7. Benefit payment

Before payment can be made, the Claims Handler should receive a copy of the Insured's birth certificate or a certificate of civil status.

4.1.3.8. Additional exclusions

In addition to the general exclusions mentioned in 4.10. and 4.11., Chapter IV of these General Conditions , the following exclusions apply to the Permanent Disability Cover:

The practice of any sport activity in deliberate breach of public rules of security in such a manner that the Insured couldn't ignore the risk including the consequences of an accident during the Insured's participation in an air sport (including hang gliding, paragliding, gliding) or in any of the following sports: skeleton, bobsleigh, ski-jumping, mountain-climbing with roping, rock-climbing, skin diving with self-contained apparatus, spelunking, bungee-jumping, skydiving.

Any losses directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with radioactive contamination whether direct or indirect or any act of Nuclear, Chemical, Biological Terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss. This exclusion is not applicable to medical radiations required by covered Medical Treatment;

4.1.3.9. Obligations to be fulfilled by the insured

Assessment of disability - Medical information

The Disability has to be supported by sufficient medical evidence, to be presented by the Insured or his/her Physician to the Medical Consultant of the Insurer.

The Insured shall authorise his/her attending Physician to communicate all relevant information concerning the Insured's state of health to the Insurer's Medical Consultant.

The Insurer's' Medical Consultant has the right to ask for relevant additional information and/or have the insured person medically examined to assess the incapacity.

Proof of income has to be provided by the Insured or his/her Domestic Partner or Legal Partner.

Changes to the extent of the disability

Any changes to the extent of the disability must be communicated by the Insured to the Insurer (through the Claims Handler) within a month. In the absence of such communication, any amount unduly paid to the Insured person will have to be refunded by him/her to the Insurer.