A+ International Healthcare
General Conditions

Medical Core Plan
(Medical
& Dental & Optical Plan)

For policies issued in Hong Kong by AXA General Insurance Hong Kong Limited

AXA General Insurance Hong Kong Limited is the insurance underwriter of this policy and is solely responsible for all content coverage and benefit payment of the plan.

AXA General Insurance Hong Kong Limited is an authorized insurer in Hong Kong with its Hong Kong office at 21/F, Manhattan Place, 23 Wang Tai Road, Kowloon Bay, Kowloon, Hong Kong

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 persons 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 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.

Claims Handler
APRIL Hong Kong Limited, 9th Floor, Chinachem Hollywood Centre, 1-13 Hollywood Road, Central, 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 General Insurance Hong Kong Limited, 21/F, Manhattan Place, 23 Wang Tai Road, Kowloon Bay, Kowloon, 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 a 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 owner and/or Insured taking out the insurance for his/her own benefit (and that of his/her Dependents), having to pay the appropriate premium to the Insurer. 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).

Principal Country of Residence
The country where the Insured lives or intends to live for most of the Insurance Year being 185 days or more and which will be shown as the place of residence in our records.

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.

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, esophagus, stomach, intestine, urinary bladder, or urethra.

Third Party Administrator
APRIL Hong Kong Limited
9th Floor, Chinachem Hollywood Centre, 1-13 Hollywood Road, Central, 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 individuals 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 individuals and their dependants who subscribe their Plan in Hong Kong S.A.R.

1.3.2.2. The employee or member insured under A+ group cover can choose to complete a medical questionnaire when entering into the group insurance contract to benefit from individual continuation of coverage. The same level of coverage will apply as stated in the group insurance contract, as long as the employee or member was insured for at least 6 months under the A+ group cover, and still meets the eligibility conditions. Individual premiums are applicable as from the date of transfer to an individual cover. Transfers of coverage in the limit of the General Condition to an individual policy is subject to written approval from the Insurer. Terms of cover may be subject to variations.

1.3.3. Acceptance into the insurance

1.3.3.1. Individual

A medical questionnaire has to be completed for each person (including each Dependant) who chooses Underwritten enrolment under article 1.3.1.1.1 and has to be sent by the applicant-Insured(s) to the Medical consultant of the Insurer through the Plan Administrator. The Medical consultant can define partial exclusions, total exclusion of cover (refusal of cover), or, to 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 child and ward child may also be included in the policy, enrolment of whom are subject to full underwriting. For ward child, a copy of court order or letter of guardianship must be provided.

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 Country 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 Insured and Domestic 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. joint utility bills) should be provided on demand.
7. Changes in Domestic Partner are acceptable. However the Policyholder or Insured 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

The age limit set for enrolment is 70 years. Above attained age 71, neither individuals 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 and is subject to the acceptance by the Insurer.
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 and is subject to the acceptance by the Insurer.

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 and renewal

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 renewal is arranged automatically and is guaranteed for life. The policy will be subject to the terms and conditions effective at the time of renewal. The premium payable will be determined by the Company on an annual basis for the renewal policy period. Renewal rates are subject to annual adjustments.

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.

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.

1.5.4. Dependent cover in the event of the death of the Policyholder

In the event of the death of the policyholder, the Dependents have the possibility to become Policyholders of their own plan if the following conditions are met:

1) The dependents meet the eligibility requirements of the Plan
2) A new application form has to be submitted by the spouse or children to take up the role of Policyholder, however no medical questionnaire will be requested

In the event that the above conditions are not met the policy will remain in force up to the policy anniversary and will be terminated forthwith.

1.5.5. The Insurer reserves the right to terminate the policy if

1.5.5.1. 1. the policyholder or insured member has fraudulently changed original documents, disclosed incorrect information, or withheld facts which may be regarded as being important to the Insurer, whether in the application process, the administration of the policy or the conduct of any claim.

1.5.5.2. 2. the policyholder or insured member does not qualify for the plan any longer - for example if the policyholder or insured member takes up residence in a country where the local laws prohibit a

resident from holding an offshore health insurance plan, or the policyholder or insured member takes up residence in the United States of America.

1.6. Return to the Home Country

1.6.1. For non-US or non-Hong Kong 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 for up to the policy anniversary after the actual date of relocation to the home country at which date it will be automatically terminatedWe also reserve the right to automatically terminate this policy if the change results in a breach of any laws or regulations.

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, subject to the acceptance by the Insurer. 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.

Semi-annual and quarterly payments are payment frequency options only, therefore the Policyholder is responsible in paying the full policy year premium to the insurer.

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.

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. Failure of which will result to non-payment of pending claims and claims that are yet to be reported which were incurred within the policy year. 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.

1.7.4. Cooling off period

If the Insured is not completely satisfied with the policy, the Insured may: return the policy, and attach a letter, signed by the Policyholder, requesting cancellation.

The Insurance Policy will then be cancelled from the policy date and the premium paid by the Insured will be refunded.

The Insured will not be entitled to receive any benefits or amounts (if any) attaching to the Insurance Policy.

This cooling-off right has the following conditions:
1. The Insured's request to cancel must be signed by the Insured and sent directly to the Third Party Administrator's Customer Service department at

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within 15 days after the delivery of the policy or issue of a notice (informing about the availability of the policy and the expiry date of the cooling-off period) to the Insured or the Insured's representative, whichever is the earlier; and
2. No refund can be made when a claim has been admitted.
3. If a claim has been reimbursed, the same amount will be deducted from the premium. In case the claim paid is higher than the premium, the balance must be reimbursed by the Insured.

1.8. Territorial scope of the insurance

There are three zones of residence and the Insured must state the Principal Country of Residence at the time of inception of policy. The premiums are set according to the zone of residence.

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

21/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 APRIL Hong Kong Limited, 9th Floor, Chinachem Hollywood Centre, 1-13 Hollywood Road, Central, Hong Kong.

If not satisfied the Insured should write then to AXA General Insurance Hong Kong Limited, 21/F, Manhattan Place, 23 Wang Tai Road, Kowloon Bay, Kowloon, 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 MEDICAL INSURANCE COVER

2.1. 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 insurance can be taken out by the persons who are accepted into the Plan.

2.1.1. 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.

2.1.2. 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.

2.2. 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.

2.3. Description of benefits

2.3.1. Inpatient Treatment

Pre-certification as stated in clause 2.5. 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%.

2.3.2. 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).

2.3.3. 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.

2.3.4. 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.

2.3.5. 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.

2.3.6. 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.

2.3.7. Hospital cash benefit

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

2.3.8. 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) an hospitalisation for Illness or Surgery and with a maximum of days according to the Plan level chosen.

2.3.9. 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.

2.3.10. 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.

2.3.11. 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.

2.3.12. 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 2.3.13. below apply.

2.3.13. 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.

2.3.14. 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.

2.3.15. Treatments performed by complementary Medical Practitioners

- Chiropractor
- Osteopath
- Acupuncturist
- Homeopath

These Treatments must be prescribed by a registered Doctor.

2.4. 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:

2.4.1. 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.

2.4.2. 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.

2.4.3. 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.

2.4.4. 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.

2.4.5. 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.

2.4.6. Medical aids

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

2.4.7. 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.

2.4.8. 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.

2.4.9. Dental treatment following accident

Dental surgery is only covered if required to restore damage to natural teeth.

2.4.10. 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.

2.4.11. 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.

2.4.12. 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.

2.5. 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.

2.5.1. Direct settlement

In the event of a planned admission to hospital on an In-Patient or Day-Patient basis, it is possible for the Claim 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.

2.6. 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.

2.7. Claims Procedure / Coordination of Benefits - Other Insurance / Claims Payment

2.7.1. 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.

2.7.2. 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 2.2. ('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.

2.7.3. 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.

2.8. 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.

2.9. 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 2.5 '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.

3. Optional Dental & Optical Insurance

3.1. 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).

3.2. 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.

3.3. 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 ('Provisions proper to the different types of cover') also apply to the dental & optical insurance plan.