International Healthcare

redefining / standards

# A+
# International Healthcare

# General Conditions

## Medical Core Plan
## (Medical and Evacuation & Repatriation

Applicable to Easy Care+ plans

**For policies issued in France by AXA France Vie**

AXA France Vie is the insurance underwriter of this policy and is solely responsible for all content coverage and benefit payment of the plan. The authority responsible for regulation of the Insurer is the French Insurance Regulatory Commission – l'Autorité de Contrôle Prudentiel et de Résolution, located 61, rue Taitbout, 75009 Paris

AXA France Vie is an authorized insurer in France with its office at
313, Terrasses de l'Arche, NANTERRE Cedex (92 727), France

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# 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. With respect to the 'Emergency Medical Evacuation and Repatriation Cover', the provisions of Chapter III take precedence over the General Policy Provisions of Chapter I.
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 expatriates 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 or Accident (subject to the plan selected).

**1.1.2.2.** Emergency Medical Evacuation and Repatriation

Unless stated otherwise in the Special Conditions, the Plan also provides for emergency medical evacuation and repatriation services.

### 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.

### Acute
An acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

### Ancillary charges
Purchase or rental of crutches or wheelchairs are covered if necessary as part of your inpatient treatment.

### Assistance Provider
Emergency medical evacuation and assistance services provider, AXA Assistance.

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

### 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.

### Chronic
Chronic conditions are 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.
- It comes back or is likely to come back

### Co-payment
This is the dollar amount you pay for health care expenses, you pay this after you meet your deductible limit. For example, you pay a set dollar amount to your doctor for an office visit. So, if your copay is $10, you pay that amount when you go to your doctor. Copays are also used for some hospital outpatient care services in the original Medicare plan. In prescription drug plans, it is the amount you pay for covered drugs.

### 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.

### 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)

### Eligible Medical Expenses
Medically necessary expenses incurred due to a covered Illness or Accident (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.

### Host Country
Country where the Insured is expatriated to, as declared in the application form, and being the base for premium calculation according to the zone (location of work) (as specified below in article 1.8).

### 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 on 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 France Vie, 313, Terrasses de l'Arche, NANTERRE Cedex (92 727), France.

### 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 French 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 schedule of benefits 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.

### New Born
A baby who is within the first 28 days of his 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.

### 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.

### Standard Ward Room

Shared room in a hospital with corresponding Treatment rates & charges.
Deluxe, VIP, executive rooms and suites are not covered.

### 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.

### 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

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,

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), hyperlipidaemia (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.** Employees ('group cover')

The Plans are open to employers to cover their employees / members (and their Dependants) with minimum 3 employees (excluding dependants) for group coverage.
The Insurer may restrict eligibility of coverage in certain countries and areas upon enrolment.

**1.3.2.2.** Individual expatriates

The Plan is also open to individual expatriates (private persons) and their dependants who reside outside of their home country.
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')

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

**1.3.3.2.** Individual expatriates ('individual cover')

A medical questionnaire has to be completed for each person (including each dependant) and has to be sent by the candidate-insured(s) to the Medical Consultant of the Insurer through the Plan Administrator.
The Medical Consultant can define partial exclusions or total exclusion of cover (refusal of cover),

### 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 and their eligible dependants, enrolled on a compulsory basis by their employer, the age limit set for enrolment is 50 years.
- For group of 11 and more employees the maximum age of limit set for enrolment is 65 years.
- For individual expatriates and their dependants, the age limit set for enrolment is 50 years.

#### 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. 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

**1.5.2.1.** Group Cover

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.

**1.5.2.2.** Individual Expatriates cover

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 of the coverage

The coverage will automatically cease at the end of the 70$^{th}$ year of the member.

#### 1.5.4. Individual continuation of cover when leaving a group contract

The expatriate employee or member can choose to complete a medical questionnaire when entering into a group insurance contract to benefit from individual continuation of coverage. The same conditions 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 Plan group cover, and still meets the eligibility conditions. Individual premiums will be applicable as from the date of transfer to an individual cover.

- For Insured without any pre-existing conditions at the date of entry into the group contract can continue the coverage on an individual basis at applicable individual premium.

- For Insured persons with one or more pre-existing conditions at the date of entry into the group contract, the transfer to an individual policy is subject to written approval from the underwriters. Terms of cover may be subject to variations.

#### 1.5.5. Termination date of cover for Dependants under the policy of the Insured or individual expatriate

**1.5.5.1.** 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.

**1.5.5.2.** For the unmarried children:

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

**1.5.5.3.** Aggravation of the Risk

With respect to insurance covers 'Emergency Medical Evacuation and Repatriation',', the Insured is obliged to inform the Insurer (through the Third-party Administrator) of any change in circumstances (e.g change of residential country) 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, Canadian or Caribbean 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 12 months 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.

#### 1.6.1. For overseas US, Canadian or Caribbean citizens

Upon notification of the end of expatriation with the exact date of relocation to the US, Canada or Caribbean Island 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, half yearly or quarterly 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. Cooling off period (for Individuals)

In accordance with article L.112-9 of the French Insurance Code, the Policyholder may reverse their decision to enroll in the plan by registered mail with proof of delivery during a period of 14 calendar days from the date on which their Policy Schedule is sent out, without having to provide reasons or pay penalties.

This cancelation should be worded as follows:

'I, the undersigned ..... (last name - first names) declare my express wish to cancel my membership of plan no. XXXX and request the reimbursement of the Premium paid under the terms and conditions defined by article L112-9 of the French Insurance Code.'

Exercising the right to cancel within the period specified in the first paragraph results in the termination of membership of the plan from the date of receipt of the registered mail referred to in the same paragraph by the Third-Party Administrator Customer Service department at:

A Plus International Services, Room 4, 17th Floor, Westlands Centre, 20 Westlands Road, Quarry Bay, Hong Kong.

Once the Member becomes aware of an event that may result in a claim under the plan, they can no longer exercise their right to cancel.
In case of cancelation, the Member is only required to pay the portion of the Premium corresponding to the period during which the risk was covered, that period being calculated until the Date of termination. The Third-Party Administrator is required to reimburse the balance no later than 30 days following the date of termination. However, the entire Premium remains due to the Insurer if the right to cancel is exercised when an event that may result in a claim under the plan, and of which the Member was not aware, occurred during the cancelation period.

#### 1.7.3. 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 on 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.

#### 1.7.4. 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 as set forth in the French Insurance Code. 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 – Zones of treatment

There are three zones (geographic areas). The Insured must choose the zone in which the Insured wants to be covered (location of work) at the time of inception of policy.
The premiums are set according to the zone:

- Zone 1: Worldwide excluding, USA, Canada and Caribbean Island
- Zone 2: EEC countries (excluding UK), and Africa (excluding South Africa)
- Zone 3: Bangladesh, Brunei, Burma/Myanmar, Cambodia, India, Indonesia, Laos, Malaysia, Philippines, Sri Lanka, Taiwan, Thailand, Vietnam

To be eligible for zone 2 or 3, your country of residence (location of work) must be within the zone.
However, during business trips or holidays, not exceeding 90 days in aggregate per Insurance Year, inpatient medical expenses incurred outside the zone of coverage, excluded USA, Canada and Caribbean Island, 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, the medical expenses are not covered. Expenses other than those related to inpatient will not be considered to be Accident or Emergency expenses, and will therefore not be covered.

### 1.9. Currency

The premiums are payable in $US and claims will be reimbursed in $US.
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

The Insurer and other service providers will not provide cover or pay claims under this policy if doing so would expose the Insurer or the service provider to a breach of international economic sanctions, laws or regulations, including but not limited to those provided for by the European Union, United Kingdom, United States of America or under a United Nations resolution.

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 of the preparation of or participation in crimes or misdemeanours;
- 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.
- Costs incurred at the Sanatorium hospital in Hong Kong will not be covered.
- Practice of extreme sports including, but not limited to;
    - Mountaineering,
    - Hiking above 4000 metres,
    - Off-piste winter sports,
    - Base and/or bungee jumping,
    - Caving and/or spelunking,
    - Scuba diving to a depth of more than 40 metres,
    - Various other sports considered hazardous in nature

**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 (see chapter III for evacuation and repatriation 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. Arbitration

Should any difference arise between the parties, the parties agree that only the Courts in Paris shall be considered competent and that French law will be applicable.

As both parties subscribed to this policy in good faith, in the event that the two parties do not agree on the application of the policy, they agree, prior to any recourse to the Courts, to refer to the decision given by two arbitrators chosen respectively by each party. In case the two arbitrators do not arrive at an agreement, they shall designate a third arbitrator. If they fail to agree on the choice of this third arbitrator, the Tribunal de Grande Instance de Paris, upon request of the most diligent party, will choose the arbitrator. Each party will pay for the cost of the arbitrator whom it designated. The fees of third arbitrator, including the cost for his designation, are shared equally by the two opposing parties.

## 1.13. Personal Information Collection Statement

The policyholder binds himself to communicate to the Insurer all the information concerning the Insured, respecting solemnly the legislation related to private data.

Those information could be communicated to reinsurers, professionals organisms, and also to all organisms intervening in management and execution of the policy.

In exchange, Insured will be free to access to information concerning them, according to the current aforesaid legislation. To consult them, oppose to them, or ask their correction, Insured will have to contact Quality Service- Customers Relationship of AXA Solutions Collectives. (313, Terrasses de l'Arche - 92727 NANTERRE Cedex, France).

## 1.14. Subrogation

With payments being of a compensatory nature and being paid in reimbursement of costs incurred by the Insured, should the case arise, the provisions set out in Article L. 121-12 of the code of insurance may apply:
"The Insurer is subrogated, up to the amounts paid by him, in the rights and actions of the Insured, against any third party responsible."

## 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 Holdings Limited, Room 4, 17th Floor, Westlands Centre, 20 Westlands Road, Quarry Bay, HONG KONG.

If not satisfied the Insured should write then to AXA Entreprise Customer Relations Department, 313, Terrasses de l'Arche, NANTERRE Cedex (92 727), France.

If the matter is not settled by this means, customer service indicates how to appeal to the mediator of the insurer.

As an independent part from the Insurer, the mediator has to state on the cases he has been requested for, in the three months following his assignment. His statement does not involve the parties who, each of them, keep the right to revert to the jurisdiction

## 1.17. Governing Law

Without prejudice to article 1.12, this contract shall be governed by, construed and interpreted in accordance with French 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. Prescription

Any share deriving from the contract is prescribed by two years, according to articles L 114-1 and L114-2 of the French Code of Insurances.

Prescription may be cancelled:
- By a summons, a command or a seizure,
- By several experts designation due to a claim,
- By registered letter concerning the non-payment of the premium or benefits.

## 1.19. Review of Policy

The Policyholder and the Insurer agree to notify each other as soon as they know about it of any fact or legal that is likely to materially modify the pre-existing conditions to the Policy.

When a legislative or regulatory decision has materially modified the pre-existing conditions or the application of the Insurer's commitments, the latter will proceed, should the need arise, on the effective date of the modifications in question, with the revision of the insurance conditions.

# 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 or Accident (subject to the plan selected).

#### 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 = Plan 1:** Inpatient treatment
- **Level 2 = Plan 2:** Inpatient treatment with enhanced benefits
- **Level 3 = Plan 3:** Inpatient and Outpatient treatment
- **Level 4 = Plan 4:** Inpatient and Outpatient treatment with enhanced benefits

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 table of benefits 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 table of benefits 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 or Accident(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 table of benefits - 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.

### 2.1.3. Description of benefits

Treatments are subject to maximum limits of the chosen plans.

#### 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

- For Zone 1 (Worldwide cover excluding, USA, Canada and Caribbean Island) and Zone 2 (EEC countries excluding UK, and Africa excluding South Africa) reimbursement of the Reasonable and Customary charge 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. Under no circumstance will the Insurer pay for a higher level cost than the lowest rate for a Standard Ward room. Where a standard private or standard semi-private room is established as the only available accommodation at the hospital visited, the insurer will apply a 20% co-insurance to doctor's fees, hospital accommodation and other related medical expenses during hospital stay.
- For Zone 3 (Bangladesh, Brunei, Burma/Myanmar, Cambodia, India, Indonesia, Laos, Malaysia, Philippines, Sri Lanka, Taiwan, Thailand, Vietnam), reimbursement for room accommodation and meals are up to the benefit limit stated below. The amount of the benefit shall be equal to the actual charges made by the hospital during the Insured's confinement. Under no circumstance will the Insurer pay for a higher level cost than the benefit limit stated below:
    - For Plan 1 and Plan 3: up to US$ 100 per night
    - For Plan 2 and Plan 4: up to US$ 150 per night

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 schedule of benefits. 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 schedule of benefits.

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 schedule of benefits.

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. 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.

2.1.3.1.6. Hospice Care

Care rendered either on an inpatient basis or in the home setting for a terminally ill patient. Often referred to as "palliative" or "supportive" care, hospice care emphasizes the management of pain and discomfort and the emotional support of the patient and family

2.1.3.1.7. Internal Prosthetic devices:

Internal prosthetic implants and appliances surgically inserted into tissue as part of the treatment to form permanent parts of your body, such as artificial limbs, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers (excluding dental implants).

2.1.3.1.8. 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 schedule of benefit. The covered amount includes doctor's fees, hospital accommodation 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.

**2.1.3.2. 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 schedule of benefits within the limits of the plan chosen

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 schedule of benefits 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.

2.1.3.2.4. Physiotherapy

Physiotherapy prescribed by a Doctor, , 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

2.1.3.2.5. Treatments performed by complementary Medical Practitioners

- Chiropractor
- Osteopath
- Acupuncturist
- Homeopath

These Treatments must be prescribed by a registered Doctor.

2.1.3.2.6. Dental treatment following accident

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

2.1.3.2.7. 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.

Pre-Authorization by the Insurer or Third-party Administrator is required before this benefit can be considered. Authorization for this benefit is subject to review.

2.1.3.2.8. 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

#### 2.1.3.3. Other Medical Treatments

##### 2.1.3.3.1. 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 schedule of benefits. 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.

##### 2.1.3.3.2. 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 schedule of benefits.
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.

##### 2.1.3.3.3. 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.

#### 2.1.3.4. Pre-Authorization 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, , the Claims Handler has to be informed - in writing - at the latest 15 days before the treatment will be performed

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 Third-Party Administrator 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 Third-Party Administrator to send the medical provider with a Guarantee of Payment (GOP). In this case it is important that the Insured contacts the Third-Party Administrator at least five working days prior to the Insured’s scheduled admission in order that we may, wherever possible, arrange for the direct settlement of any eligible bills that the Insured incurred 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:

- pre-existing 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, except where such medical conditions have been declared in the application form and subsequently accepted in writing by the Insurer;
- non prescribed Medical Treatments;
- costs of hospitalisation in a Deluxe, VIP, executive rooms and suites
- vaccinations and/or periodic preventive health examinations
- complementary (and/or alternative) Medical Treatments other than those explicitly mentioned in the table of medical benefits;
- rejuvenation- and spa-cures, cosmetic treatments and convalescent rest;
- rehabilitation (unless admission follows immediately an hospitalisation and explicitly mentioned in the table of medical benefits);
- costs related to ergotherapy, logopaedics and/or speech & occupational therapy
- facilities for the aged, primarily giving custodial, educational and rehabilitation care; expenses resulting from maternity and childbirth whether complicated or not, including termination of pregnancy and all foetal surgeries
- 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;
- contraceptive and birth control drugs, even if prescribed by a Doctor;
- costs related to abortion
- consequences of drug-addiction and alcoholism;
- cosmetic/aesthetic treatment and pre and post consequences, except restorative treatment following Accident;
- surgical procedures costs related to corrective eye surgery (keratectomy and keratotomy, including LASIK- and LASEK-procedures) and pre and post consequences, 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;
- sex change operations and all related treatments and pre and post consequences,.
- organ and bone marrow transplants, search, harvesting, tissue matching test, organ transport, admin costs, donor removal and complications except when explicitly mentioned in the table of medical benefits;
- costs related to providing or fitting any external prosthetic devices, medical aids or appliances;
- Hormone Replacement Therapy (HRT);
- experimental treatments; costs related to fertility treatment or sterilisation;
- costs related to dental treatment except those explicitly mentioned in the table of medical benefits; costs related to routine eyesight or hearing tests or the cost of eyeglasses, contact lenses, hearing aids or cochlear implants, eye surgery to correct vision
- costs related to psychiatric treatment;
- hospice and palliative care when diagnosed as terminal except when explicitly mentioned in the table of medical benefits;
- costs related to the treatment of cancer or kidney failure except when explicitly mentioned in the table of medical benefits;
- costs related to treatment of any medical conditions arising from Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) except when explicitly mentioned in the table of medical benefits;
- costs related to outpatient Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) or Computed Tomography (CT) except when explicitly mentioned in the table of medical benefits;
- costs for outpatient physiotherapy except when explicitly mentioned in the table of medical benefits;

### 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 Third-Party Administrator, in writing or via e-mail by using scanned copies, using the special claim forms made available by the Third-Party Administrator (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 Third-Party Administrator shall effect reimbursement of the covered reasonable and customary medical expenses (up to the limits defined in these General Conditions and the benefits table) 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 in the sole discretion of the Insurers, 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 French 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 Third-Party Administrator. 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 himself/herself.
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 Third-Party Administrator 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 Third-Party Administrator) 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 2 years of cancellation. Beyond which no claim will qualify for reimbursement.

# 3. Chapter III: EMERGENCY MEDICAL EVACUATION AND REPATRIATION COVER

## 3.1. Purpose and eligibility

The purpose of the cover is to provide to the Insured the services mentioned in article 3.5 ('Benefits') hereafter, in particular the worldwide medical evacuation and repatriation services.
Every person who is accepted into the Plan can automatically enjoy these services, except when stated otherwise in the Special Conditions. New Born children however can only be covered under the Emergency Medical Evacuation and Repatriation Plan after the 31st day from the date of birth.
No claim for reimbursements shall be accepted unless such claim has been pre-approved. (Refer to clause 3.6.)

**Aggravation of the Risk**

With respect to insurance covers 'Emergency Medical Evacuation and Repatriation', 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.

## 3.2. Guarantee of Service Delivery

The Insurer guarantees the Insured the delivery of the Emergency Medical Evacuation and Repatriation services as described in these General Conditions. To this end, the Insurer has contracted the services out to a worldwide specialised medical assistance services provider (hereafter referred to as the Assistance Provider), AXA Assistance, which will deliver the services concerned on behalf of the Insurer. In its capacity as the underwriting insurer of the Plan and in particular of the Emergency Medical Evacuation and Repatriation guarantee, the Insurer remains committed to providing to the Insured the services to the extent mentioned in the present Chapter III of the General Conditions, and consequently, will endeavour to fulfil - by its own means or through contracting out to another third party - the contractual obligations and the continuity thereof (e.g. in case of unexpected dissolution or winding up of the operations of AXA Assistance).

## 3.3. Definitions

Assistance Provider
Emergency Medical Evacuation and Assistance Services Provider: AXA Assistance.

Insured
The person(s) covered by the insurance plan or parts thereof, whose names are mentioned in the special conditions of the insurance policy.

Insurer
AXA France Vie, 313, Terrasses de l'Arche, NANTERRE Cedex (92 727), France.

User
The Insured who uses the Medical Evacuation and Repatriation Plan service.

**Other definitions (in alphabetical order):**

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

Home Country
The country out of which the User is expatriated abroad (in or outside Europe)

Limit of Indemnity
The maximum amount of third party expenses for which the Assistance Provider shall be responsible in the provision of any Services to the User during any one event, subject to the terms and conditions as defined hereunder.

Pre-existing Condition

Any medical condition in respect of which the User has been hospitalised during the 12-month period immediately prior to the first day the User is included in the Medical Evacuation and Repatriation Plan or any medical condition that has been diagnosed or treated by a Medical Practitioner including prescribed drugs within the six month period immediately prior to the first day the User is included in the Medical Evacuation and Repatriation Plan.

Serious Medical Condition

Condition which in the opinion of the Assistance Provider constitutes a serious Medical Emergency requiring urgent remedial treatment to avoid death or serious impairment to the User's immediate or long-term health prospects. The seriousness of the medical condition will be judged within the context of the User's geographical location, the nature of the Medical Emergency and the local availability of appropriate medical care or facilities.

Services or the Medical Evacuation and Repatriation Plan

The medical and travel assistance to be provided by the Assistance Provider as set out in article 3.5 ('Benefits').

Usual Country of Residence

Any given country, out of which the User goes or is sent on assignment abroad (in or outside Europe)

## 3.4. Territorial Scope

The Services provided by the Assistance Provider are rendered on a worldwide basis. The Assistance Provider shall use its best endeavours to provide the Services but any help and intervention depends upon, and is subject to local availability and has to remain within the scope of national and international law and regulations and intervention depends on the Assistance Provider obtaining the necessary authorisations issued by the various authorities concerned. The Assistance Provider shall not be required to provide Services to the User/s, who in the sole opinion of the Assistance Provider are located in areas that represent war risks, political or other conditions such as to make such Services impossible or reasonably impracticable.

## 3.5. Benefits

The Assistance Provider shall, subject to the terms and conditions as defined hereunder, and within the Limits of Indemnity as stipulated in article 3.5, provide the following Services and information to a User calling the alarm centre of the Assistance Provider. When the Assistance Provider has the information immediately available, the Assistance Provider shall provide the information or Services, as appropriate, to the User while the User is on the telephone. In all other cases, the Assistance Provider will provide the information to the User by the quickest possible means.

### 3.5.1. Emergency Medical Evacuation

The Assistance Provider will arrange for the air and/or surface transportation and communication for moving the User when in a Serious Medical Condition to the nearest hospital where appropriate medical care is available. The Assistance Provider retains the absolute right to decide whether the User's medical condition is sufficiently serious to warrant emergency medical evacuation. The Assistance Provider further reserves the right to decide the place to which the User shall be evacuated and the means or method by which such evacuation will be carried out having regard to all the assessed facts.

### 3.5.2. Emergency Medical Repatriation

The Assistance Provider will arrange for the return of the User to the Home Country or Usual Country of Residence by air and/or surface transportation following an emergency medical evacuation where the User is evacuated to a place outside the Home Country or Usual Country of Residence for in-hospital treatment. The Assistance Provider reserves the right to decide the means or method by which such repatriation will be carried out in regard to all the assessed facts and circumstances of which the Assistance Provider is aware at the relevant time.

### 3.5.3. Transportation of mortal remains or burial at the place of death

The Assistance Provider will arrange for transporting the User's mortal remains from the place of death to the Home Country or Usual Country of Residence, or alternatively pay the cost of burial at the place of death as approved by the Assistance Provider.

### 3.5.4. Compassionate Visit

Upon request from the User, the Assistance Provider will arrange and pay for one economy class return airfare for a relative or a friend of the User to join the User who is hospitalised outside the Home Country or Usual Country of Residence for a period in excess of 5 consecutive days, subject to the Assistance Provider's prior approval and only when judged necessary by the Assistance Provider on medical and compassionate grounds.

### 3.5.5. Return of minor children

Upon request from the User, the Assistance Provider will arrange and pay for a one-way airfare per child for the return of minor children (not yet 19 years old, unmarried and in school) to the Home Country or Usual Country of Residence if they are left unattended as a result of the accompanying User's illness, accident or emergency medical evacuation. An escort will be provided when required.

### 3.5.6. Early return of the User

Upon request from the User, the Assistance Provider will arrange and pay for an economy class return airfare for the User to return to the country of burial or funeral of the following family member(s), in the event this family member has deceased outside the User's usual country of assignment: Domestic Partner or Legal Partner, father, mother, child, brother or sister.

### 3.5.7. Colleague replacing the evacuated or repatriated User

The Assistance Provider will arrange and pay for an economy class return airfare to the location where the User is stationed to send a replacement employee in the event the User has been evacuated or repatriated, provided the said replacement is sent within one month from the date of the User's emergency medical evacuation or repatriation.

### 3.5.8. Additional Services

**3.5.8.1.** Accommodation for compassionate (see article 3.5.4.)

Accommodation for compassionate visit by a relative accompanying the Insured up to an amount as specified in the table of Benefits.

**3.5.8.2.** Telephone medical advice

The Assistance Provider will arrange for the provision of medical advice to the User over the telephone.

**3.5.8.3.** Medical service provider referral

The Assistance Provider shall provide to the User, upon request, the name, address, telephone number and, if available, office hours of Physicians, hospitals, clinics, Dentists and dental clinics (collectively 'Medical Service Providers'). The Assistance Provider shall not be responsible for providing medical diagnosis or Treatment. Although the Assistance Provider shall make such referrals, it cannot guarantee the quality of the Medical Service Providers and the final selection of a Medical Service Provider shall be the decision of the User. The Assistance Provider, however, will exercise reasonable care and diligence in selecting the Medical Service Providers.

**3.5.8.4.** Arrangement of hospital admission

If the medical condition of the User is of such gravity as to require hospitalisation, the Assistance Provider will assist such User in the hospital admission.

**3.5.8.5.** Monitoring of medical condition during and after hospitalisation

The Assistance Provider will monitor the User's medical condition during and after hospitalisation, subject to any and all obligations in respect of confidentiality and relevant authorisation.

**3.5.8.6.** Medical translation service

The Assistance Provider will arrange for the provision of medical translation to the User over the telephone. Where the Assistance Provider uses an external service provider to provide the translation service, the quality of the translator cannot be guaranteed.
The Assistance Provider will however exercise reasonable care and diligence in selecting such service providers.

**3.5.8.7.** Delivery of essential medicine

Upon request from the User, the Assistance Provider will arrange to deliver to the User essential medicine, drugs and medical supplies that are necessary for a User's care and/or treatment but which are not available at the User's location. The delivery of such medicine, drugs and medical supplies will be subject to the laws and regulations applicable locally. The Assistance Provider will not pay for the costs of such medicine, drugs or medical supplies and any delivery costs thereof.

**3.5.8.8.** Travel assistance

The following Services [item (i) to (v)] are purely on referral or arrangement basis. The Assistance Provider shall not be responsible for any third party expenses, which shall be solely the User's responsibility.

I. Inoculation and visa requirement information

Upon request from the User, the Assistance Provider shall provide information concerning visa and inoculation requirements for foreign countries, as those requirements are specified from time to time in the most current edition of World Health Organization Publication 'Vaccination Certificates Requirements and Health Advice for International Travel' (for inoculations) and the 'ABC Guide to International Travel Information' (for visas). This information will be provided to the User at any time, whether or not the User is travelling or an emergency has occurred.

II. Lost passport assistance

The Assistance Provider will assist the User who has lost his/her passport while travelling outside the Home Country or Usual Country of Residence by referring the User to the appropriate authorities involved.

III. Emergency travelling service assistance

The Assistance Provider shall assist the User in making reservations for air ticket or hotel accommodation on an emergency basis when travelling overseas.

IV. Embassy referral

The Assistance Provider shall provide the address, telephone number and hours of opening of the nearest appropriate consulate and embassy worldwide.

V. Emergency document delivery

The Assistance Provider shall assist the User to arrange for emergency document(s) to be delivered to the User's friend, relative or business associate, upon the User's request to do so.

## 3.6. Exclusions

The following Treatment, items, conditions, activities and their related or consequential expenses are excluded. They will only be performed in exceptional cases, after the User has explicitly, in writing, requested the performance of these services to the Insurer (through the Third-party Administrator). Only after consent of the Insurer and of the Assistance Provider, the services will be delivered. And in such case the User will have to pay all the expenses related to the performance of the services concerned:

1. costs incurred without the prior agreement of Assistance Provider;

2. the consequences of:
- an Illness under Treatment and not stabilised for which the Insured is in convalescence;
- Illnesses occurring during a trip undertaken for diagnostic purposes;
- Illness occurring during a trip undertaken for Treatment purposes;

3. the eventual sequelae (control, additional Treatment, recurrences) of an illness having already resulted in two previous repatriations;

4. the consequences of Illnesses or benign lesions that can be treated on the spot;

5. pregnancy, other than any clear, unforeseeable complications and, in all cases, voluntary termination of pregnancy, childbirth, IVF and their consequences;

6. evacuation / repatriation as a consequence of psychiatric conditions;

7. the consequences:
- of situations with risks of infection in an epidemic context;
- of exposure to infectious Biological Agents;
- of exposure to combat gas type Chemical Agents;
- of exposure to incapacitating agents;
- of exposure to neurotoxics or agents with remanent neurotoxic effects; which are subject to quarantine or preventive measures or specific monitoring on the part of the local and/or national health authorities in the country where the Insured is staying, except for a sudden occurrence after the Insured's arrival in the area of contamination.

8. the Insured's participation in any sport as professional or under contract providing for remuneration, as well as any preparatory training;

9. the Insured’s failure to comply with official prohibitions, as well as failure to observe official safety regulations linked to the practice of a sport;

10. 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;

11. costs not explicitly indicated as giving rise to reimbursement, as well as catering costs, and any expense for which the Insured is not able to provide documentary evidence.

### 3.7. Authorisation

As a condition precedent to the Assistance Provider's obligation to make payment for any of the Services, the User will, upon request, execute an agreement to empower the Assistance Provider to obtain relevant information, to collect due proceeds from insurance or other sources, and undertake to reimburse the Assistance Provider's expenses incurred on the User’s behalf that are not covered under the present insurance plan.

### 3.8. Examinations

The Assistance Provider shall have the right and opportunity through its medical representative to examine the User whenever and as often as may reasonably be required.

### 3.9. Fraud

If fraudulent means or devices are used by the User and/or anyone acting on their behalf, the Insurer and the Assistance Provider shall have the automatic right to terminate Services for such User and/or all benefits for such User will be forfeited.

### 3.10. Negligence in obtaining medical treatment

Medical Treatment shall be sought and followed promptly on the occurrence of an injury or illness and the Insurer or the Assistance Provider shall not be liable for that part of any claim which in the opinion of a Medical Practitioner arises from the unreasonable or wilful neglect or failure by the User to seek and remain under the care of a qualified Medical Practitioner.