Henner
INDIVIDUAL

AXA 安盛

Policy Terms & Conditions

Care & Health

Hong Kong

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POLICY TERMS & CONDITIONS

Introduction

Please read this Care & Health Policy ("Policy") carefully and ensure that the terms and conditions are understood based on the insurance coverage that has been selected. This Policy should be kept in a safe place as it is a contractual document setting out the rights of the Insured Person under the Policy.

Henner SAS is the designer of this Policy and its wholly owned subsidiary GMC Services Asia Pacific Pte Ltd ("Plan Administrator") is the Plan Administrator chosen by AXA GENERAL INSURANCE HONG KONG LTD to administer the Policy. AXA GENERAL INSURANCE HONG KONG LTD ("Insurer") is the insurer under this Policy.

If the Insured Person has any questions after reading the Policy, please feel free to contact the Plan Administrator, GMC Services Asia Pacific Pte Ltd.

If there are any material changes that may affect the insurance provided, including, but not limited to, change of marital status, change of Country of Usual Residence, changes in occupation/ business or health affecting any of the Insured Persons, etc., please notify the Plan Administrator immediately.

Important notice

1. Before the Insurer can provide insurance cover, the Insured Person must have made full and frank disclosure of all material facts and circumstances that the Insured Person knows (or can reasonably be expected to know) that is relevant to the Insurer's decision to provide the Insured Person coverage under the Policy. Otherwise, the Insured Person may receive no benefits from the Policy.
2. The insurance cover under this Policy is based on the information submitted by the Insured Person to the Insurer. The details are set out in the Application document submitted inclusive of the Medical Questionnaire. Please read all the documents carefully. If they contain any information that is incorrect, please notify the Insurer immediately. Otherwise the Insured Person may receive no benefits in the event of a claim. If the information, which the Insured Person subsequently provides the Insurer, differs materially from the information that was initially provided to the Insurer, the Insurer may offer cover on different terms or decline cover altogether.
3. The Main Insured will be given a period of 14 calendar days from the date this Policy is received to review the Policy ("Free Look Period"). In the event the Main Insured decides to cancel the Policy during the Free Look Period, the Main Insured may return the Policy to us for cancellation and a full refund, provided no claims have been made during the Free Look Period. Please note that cancellation of the Policy during the Free Look Period must be done in accordance with the procedure set in the termination clause.
4. If the Insurer does not hear from the Main Insured during the Free Look Period, the Insurer will deem the information, as set out in the Policy and its accompanying documents, as true, complete and accurate, and the Main Insured will be deemed to have agreed to all the benefits, terms and conditions as set out in this Policy.

The Contract

This Policy is a contract between the Main Insured and AXA General Insurance Hong Kong Ltd, and consists of the following:

- Policy Schedule
- These Policy Terms & Conditions
- Table of Benefits
- Application Documents
- Certificate of Insurance (COI)
- Medical Questionnaire and any other information provided with it

The Policy, conditions, exclusions, endorsements and memoranda, if any, shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part shall bear the same meaning wherever it appears.

This Policy shall become effective on the date specified in the Certificate of Insurance and shall be valid for the Period of Cover (12 months' period from effective date of the Policy) specified therein.

Having received and accepted the Insured Person's first premium payment, and any subsequent premiums required, the Insurer will provide the cover shown in the relevant sections of the Policy, up to the sums insured or limits of indemnity stated in the Table of Benefits.

Currency of the Policy

The currency of this Policy is the US Dollar (USD).

Health & Assistance benefits

Table of Benefits

Henner INDIVIDUAL

Care & Health
Hong Kong

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Table of Benefits

BASE PLAN	Primary	Vitality	Serenity	Prestige
Maximum annual limit Benefits are per insured and per policy year unless stated otherwise	USD 4 500 000			
Chronic Conditions	Covered under applicable policy limits			
OUT OF AREA EMERGENCY COVER				
Emergency Inpatient Treatment	Covered under inpatient benefits			
Emergency Outpatient Treatment	-	Covered under outpatient benefits		
Out of area emergency cover includes short-term medical coverage when you are visiting a location outside of your selected area of coverage during temporary business or holiday trips. Coverage is limited to a maximum of 90 consecutive days per trip only if directly caused by an accident, sudden illness or injury.				
INPATIENT BENEFITS				
Direct billing within the Henner medical providers network	Yes			
Inpatient treatment charges Treatments provided when admitted to hospital for one or more nights: • Specialist, • Surgeon & anesthetist fees, • Drugs & dressings, • General nursing, • Intensive care unit, • Medical appliances & surgical implants, • Operating theatre, • Ancillary services (laboratory, radiology, imaging, etc.), • Purchase or rental of mobility aids, • Physiotherapy & complementary therapies (if prescribed by a specialist as part of the insured's hospital stay but are not the primary treatment which they are in hospital to receive).	Fully covered			
Outpatient Surgery This covers expenses for procedures or treatments by incisions, shockwaves or lasers, including endoscopic procedures requiring the professional services of a Medical Practitioner and does not require an overnight hospital stay.	Fully covered			
Hospital Accommodation This covers up to Standard private room with standard patient meals. Extra costs of a superior, deluxe, executive or VIP suite are not covered. The total eligible hospital expenses (excluding Hospital Accommodation) will be subjected to a co-insurance of 20%, should a higher category room be selected.	Fully covered			
Parent Hospital Accommodation This covers the cost of one parent staying in hospital overnight with a child under 18 years of age if the child is eligible to receive medical treatment under the plan.	Up to 30 days	Up to 30 days	Up to 45 days	Up to 45 days
Reconstructive Surgery Reconstructive surgery is covered when it aims to restore natural function/appearance after an accident or cancer surgery, providing the accident or surgery occurred during the period of cover. We do not cover cosmetic treatments to enhance appearance.	Fully covered			
Daily Cash Benefit A cash payment is given to the insured if they receive inpatient treatment for an eligible medical condition in hospital and stay in a hospital overnight, at no cost for accommodation and treatment.	USD 350 / day Up to 30 days			
Palliative Care If the insured is given a Terminal Diagnosis, and there is no available treatment which will be effective in aiding recovery, we pay for hospital or hospice care and accommodation, nursing care, prescribed medicines, and physical and psychological care	Up to USD 25 000 Lifetime limit	Up to USD 50 000 Lifetime limit	Up to USD 100 000 Lifetime limit	Up to USD 200 000 Lifetime limit
Land Ambulance This is covered when it is medically necessary to transport the insured from their home to a hospital; when transporting the insured from the scene of an accident or injury to a hospital; or when transporting the insured from one hospital to another.	Fully covered			
Treatment for Alcohol or Substance Abuse 24 This is covered if it is provided at recognised treatment facilities for the condition, and if that treatment is medically necessary and prescribed by a Medical Practitioner	-	-	-	Up to USD 50 000 Lifetime limit
Inpatient Psychiatric Treatment Inpatient treatment received in a recognised psychiatric unit of a hospital. All treatment must be administered under the direct control of a registered psychiatrist.	-	-	Up to USD 10 000	Up to USD 15 000
Emergency Dental Work Emergency treatment provided during a hospitalisation as a result of an accidental external traumatic injury to the mouth. Any tooth injury sustained while eating or chewing is not considered external trauma and repair of the tooth is not covered. Follow up outpatient dental treatment after discharge from the hospital is covered under Post-hospitalisation Benefit. This benefit excludes Dental Prostheses	Fully covered			

BASE PLAN	Primary	Vitality	Serenity	Prestige
Organ transplant (i) Medical treatment costs incurred for the transplantation of organ, such as bone marrow, cornea, intestines, kidney, pancreas, liver, heart or lungs. (ii) Direct cost of surgery to remove the organ for transplantation from donor up to USD 20 000 We do not cover costs associated with the research and acquisition of an organ.	(i) Fully covered (ii) Up to USD 20 000			
Kidney dialysis This covers inpatient and outpatient charges for kidney dialysis, peritoneal or hemodialysis-related procedures. This does not cover travel and accommodation costs incurred with such treatments.	Fully covered			
Cancer treatment This covers inpatient and outpatient treatments, including chemotherapy, radiotherapy, oncology, immunotherapy, consultations, diagnostic tests and drugs. Medicines and drugs prescribed to prevent a recurrence of cancer and related specialist consultations are covered.	Fully covered			
HIV/AIDS 12 This covers treatments arising from or related to Human Immunodeficiency Virus (HIV) and/or HIV-related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC), for a maximum period of 6 years from the date of the first diagnosis. Diagnosis and treatment are covered on an inpatient or outpatient basis	Up to USD 20 000	Up to USD 40 000	Up to USD 60 000	Up to USD 80 000
Complications of Pregnancy 12 This covers inpatient treatment of an eligible medical condition which arises during antenatal stages of pregnancy or child birth but exclude delivery expenses, conditions include but are not limited to: • Ectopic pregnancy, • Medically prescribed abortion, • Hydatidiform mole, • Retained placenta, • Placenta praevia, • Eclampsia, • Pre-eclampsia, • Diabetes during pregnancy, • Post-partum hemorrhage, • Any costs for investigations and/or treatments, relating to or arising from complications of maternity, that threaten the life of the insured mother. False labour, morning sickness and similar conditions associated with the management of a difficult pregnancy is deemed as covered under Maternity Coverage where applicable	Fully covered			
PRE & POST HOSPITALISATION BENEFITS				
Pre-hospitalisation treatment This covers: • Medical Practitioners' and specialists' fees, • prescribed drugs and dressings, • MRI, • PET and CT scans, • X-rays and • other diagnostic tests and procedures 90 days prior to a scheduled Hospitalisation or Outpatient Surgery related to the same medical condition.	Up to 90 days prior to covered hospitalisation			
Post-hospitalisation treatment This covers: • Medical Practitioners' and specialists' fees, • prescribed drugs and dressings, • physiotherapy, • speech therapy, • occupational therapy • MRI, • PET and CT scans, • X-rays after a Hospitalisation or Outpatient Surgery related to the same medical condition..	Up to 90 days after covered hospitalisation			
Rehabilitation This covers rehabilitation treatment you receive as an inpatient, carried out under the control and supervision of a Medical Practitioner in a recognised rehabilitation hospital or unit following your treatment in hospital for a condition which is covered by your plan. This benefit is payable only when the admission is prescribed by your attending Medical Practitioner	Up to USD 2 000	Up to USD 3 000	Up to USD 4 000	Up to USD 5 000
Home Nursing This is covered if it is in lieu of an extended hospital stay, prescribed by a Medical Practitioner following a hospitalisation covered by this policy, and if it starts immediately after you leave the hospital. We will only pay for home nursing if it is provided in your home by a qualified nurse and it comprises medically necessary care that would normally be provided in a hospital. We will not pay for home nursing that only provides non-medical care or personal assistance	Up to 30 days	Up to 30 days	Up to 60 days	Up to 60 days

BASE PLAN	Primary	Vitality	Serenity	Prestige
OUTPATIENT SERVICES				
Annual Limit	-	Up to USD 6 000	Up to max. annual limit	Up to max. annual limit
Direct billing within the Henner medical provider network	No	Yes	Yes	Yes
General Practitioner Fees This covers consultation by the Medical Practitioner and other services rendered during the visit	-	Fully covered	Fully covered	Fully covered
Specialist Fees This covers consultation by the Medical Practitioner and other services rendered during the visit	-	Fully covered	Fully covered	Fully covered
Telemedicine by mydoc This covers Telemedicine expenses by a General Medical Practitioner for general medical advice, common cough & cold, allergies etc (i) Video Consultation (ii) Prescribed medications	(i) Fully covered (ii) Excluded	(i) Fully covered (ii) Up to the applicable limit under **Prescribed Medicines and Mandatory Vaccines** benefit		
Prescribed Medicines and Mandatory Vaccines	-	Fully covered		
Prescribed Health Supplement (e.g. Vitamins)	-	-	-	Up to USD 300 No Direct billing
Prescribed Diagnostic Radiology and Laboratory Tests This covers • blood and urine tests, • X-rays, • ultrasound scans, • electrocardiograms (ECG), • MRI and CAT (CT) scans, and • PET scans, where they are medically necessary and prescribed by a Medical Practitione	-	Fully covered		
Prescribed Physiotherapy, Speech Therapy and Occupational Therapy Referral letter from a Medical Practitioner is required. This covers outpatient physiotherapy and occupational therapy that are deemed medically necessary and restorative to help you to carry out the normal activities of daily living. We also pay for speech therapy if it is medically necessary to restore impaired speech function and prescribed immediately following a treatment that is covered under this policy. We do not cover speech therapy that is educational in nature, or help to improve speech skills that are not fully developed.	-	Up to USD 80 / session Max 10 sessions	Up to USD 150 / session Max 15 sessions	Up to USD 180 / session Max 20 sessions
Psychiatric Consultation With A Registered Psychiatrist	-	-	Up to USD 100 / visit Max 5 visits	Up to USD 250 / visit Max 10 visits
Psychologist Consultation With A Registered Psychologist Referral letter from a Medical Practitioner is required.	-	-	-	Up to USD 150 / visit Max 10 visits
Hormone Replacement Therapy This covers hormone replacement therapy when prescribed by a Medical Practitioner following a diagnosis of premature ovarian failure or as a consequence of a hysterectomy. This excludes vitamins and supplements. For the purpose of this benefit, premature ovarian failure shall mean where initial onset takes place in a woman under the age of 40.	-	Fully covered		
Complementary Therapies and Medicines This covers a combined maximum number of visits to • orthoptists, • chiropractors, • osteopaths, • homeopaths, • podiatrists and • practitioners of Traditional Chinese Medicine and medication prescribed. The treatment must be carried out by a qualified practitioner who holds the appropriate license to practice in the country where the treatment is received.	-	-	Up to USD 150 / session Max 10 sessions	Up to USD 180 / session Max 20 sessions
MEDICAL PROSTHESES, ORTHOPAEDIC & MOBILITY AIDS				
Annual Limit	-	Up to USD 1 000	Up to USD 3 000	Up to USD 4 500
Prescribed Medical prostheses, Orthopaedic and Mobility Aids 6 These benefits cover the purchase or rental of crutches, braces or wheelchairs; durable medical equipment like glucometers; orthopaedic sole, orthoses, orthopaedic and non-orthopaedic prostheses. This does not cover the maintenance of the item; modification or fitting of furniture, or any modification to your personal or work environment.	-	Up to annual limit	Up to annual limit	Up to annual limit
Prescribed Assistive Hearing Devices 6	-	Up to USD 600 per device	Up to USD 900 per device	Up to USD 1 200 per device

Emergency Assistance, Evacuation & Repatriation

EMERGENCY ASSISTANCE, EVACUATION & REPATRIATION	
Emergency medical evacuation	Unlimited
Emergency medical repatriation	Unlimited
Round-trip economy airfare for your spouse or next of kin in the event of hospitalisation	Unlimited for hospitalisation lasting 7 consecutive days
One-way economy airfare to the assignment country after recovery (i) Return ticket (ii) Accommodation costs	Unlimited (i) Limited to one ticket (ii) During 10 days, up to USD 150 per day
Repatriation of mortal remains & related expenses	Unlimited Casket up to USD 4 000
Compassionate visit - Round-trip economy airfare in the event of the death of a Member.	Unlimited
Dispatch of medicines unavailable locally	Unlimited no. of requests. Cost of medicines & related charges to be borne by Member.
Legal assistance: (i) Legal Fees (ii) Bail (by way of advance only)	(i) up to USD 1 500 (ii) up to USD 10 000
Transmission of urgent messages to the family	Unlimited
Second medical opinion	Up to 2 requests / member/ year. Limit to different medical condition per request.

Maternity Options

	Serenity	Prestige
Pre and Post-Natal Care 12 ⏱ Pre and post-natal expenses including but not limited to: • Routine obstetricians' and midwives' fees, • routine ultrasounds and examinations, • prescribed medicines, • drugs and dressings, • pre-natal blood tests, if required, • amniocentesis procedure (also referred to asamniotic fluid test or AFT) or chorionic villous sampling (also referred to as CVS), • noninvasive pre-natal testing (NIPT) for high risk individuals, • any fees as a result of post-natalcare required immediately following routine childbirth, • antenatal classes, • Pre-natal vitamins and supplements prescribed by a Medical Practitioner. The limits shown for this benefit apply to each pregnancy, regardless of the number of children born. It covers the main insured or a spouse covered under the policy. This benefit does not cover surrogacy or its related treatments.	Up to USD 6 000 per pregnancy	Within the delivery limits stated below
Natural Delivery, Elective Caesarean, Non-Elective Caesarean 12 ⏱ 🖬 This covers inpatient treatment relating to natural, elective and non-elective caesarean delivery. Home birth and assisted water birth by the attending doctor or doula are also covered. The limits shown for this benefit apply to each pregnancy, regardless of the number of children born. It covers the main insured or a spouse covered under the policy. This benefit does not cover surrogacy or its related treatments. Deductible if selected, is applicable to this benefit.	-	Up to USD 15 000 per pregnancy
Emergency Caesarean 12 ⏱ This covers inpatient treatment relating to emergency caesarean. The limits shown for this benefit apply to each pregnancy, regardless of the number of children born. It covers the main insured or a spouse covered under the policy. This benefit does not cover surrogacy or its related treatments. Deductible if selected, is applicable to this benefit.	-	Up to USD 25 000 per pregnancy
Infertility treatment 12 ⏱ 🖬 This covers infertility treatment for female Insured Persons under 40 years of age, including investigative procedures necessary to establish the cause for infertility, in-vitro fertilisation (IVF), and artificial insemination (AI). One cycle includes all imaging biological and genetic investigations, hospital expenses (in and outpatient), and medical fees in relation to AI and IVF. One cycle starts with all medical care related to the covered fertility treatment and ends with an insemination or embryo transfer. The coverage is limited to 3 cycles per lifetime.	-	Up to USD 3 000 per cycle max. 3 cycles

Wellness Options

	Serenity	Prestige
Annual Limit	Up to USD 1 000	Up to USD 1 300
Routine Health Checkup 12 ⏱ This includes but is not limited to:. • urine analysis, • blood samples (diabetes, cholesterol, etc.), • hearing tests, • biometric assessments (size, weight, BMI measurement), • sight tests, • electrocardiogram at rest, • memory tests, • lung capacity measurements, • cancer screenings, • hemoccul tests and • HIV tests	Up to USD 750	Up to USD 1 000
Non Mandatory Vaccinations This covers the cost of all immunisations and booster injections that are not mandatory in your Country of Usual Residence and country you are travelling to.	Up to USD 400	Up to USD 600

Dental Options

	Vitality	Serenity	Prestige
DENTAL			
Routine Dental Treatment 6 ⏱ This covers • dental check-ups, • X-rays/bitewing/single view/ Orthopantomogram (OPG), • gum shields/mouth guards, • fillings, • root canal treatment, • tooth extraction, • tooth cleaning, • non-surgical periodontal treatment, • anaesthetic.	80% Up to USD 300	Up to USD 500	Up to USD 1 000
Major Restorative Dental Treatment 6 ⏱ 🖹 This covers • dentures (acrylic/synthetic, metal and metal/acrylic), • crowns, • inlays and onlays, • dental implants, • new or repair bridge work, • removal of solid odontomes, • apicetomy, • orthodontic work for children up to 16 years old, with treatment period limited to 3 consecutive years.	80% Up to USD 700	Up to USD 1 200	Up to USD 2 000
Adult Orthodontic Work 24 ⏱ This covers orthodontic treatment for adults aged above 16 years old, with treatment period limited to 3 consecutive years.	-	-	Up to USD 1 200 max 3 years
Teeth Whitening Procedure Performed At A Dental Clinic 24 ⏱	-	-	Up to USD 900 every 3 years

Vision Options (can only be chosen if Dental has been selected)

	Serenity	Prestige
Spectacle Lenses (excluding sunglasses), Frames and Contact Lenses 6⏱ This covers an eye examination carried out by an optician or optometrist as well as corrective lenses or glasses. A copy of a prescription or corresponding invoice indicating the corrective value for each eye is needed as supporting document for claims purposes.	Up to USD 500	Up to USD 800
Lasik Surgery and Lens Implants 12⏱🖫 This covers lasik or laser eye surgery to treat myopia, hyperopia, and astigmatism.	-	Within the USD 800 Vision limit above

🖫 These benefits are subject to prior agreement.Failure to apply for prior agreement (when necessary) may result in the possibility of claim denial or partial refund. ⏱ Applicable waiting period (corresponding number denotes length of waiting period in months)

Options to reduce costs

Annual inpatient deductible	USD 2 500, USD 5 000 or USD 10 000 annual inpatient deductible options are available. The option chosen is the total amount that you will have to pay per policy year for any inpatient related claims including day patient, maternity option (if selected) and pre and post hospitalization claims that would otherwise be covered under your plan. The annual deductible applies separately to each person covered. Depending on the design of your plan the discount can go up to 40%.
Semi- Private room restriction Available with Area 1 cover only	This covers inpatient and day patient treatment up to a semi-private room and corresponding rates. Selecting this option means that any hospital rooms stay will be restricted to ward or semi-private room. Should a higher room category be selected the difference in accommodation costs between the actual room selected and the semi-private room will be at the charge of the member and all other eligible hospital expenses will be subjected to a co-insurance of 20%. This option is applicable to all benefits.
Outpatient co-insurance	Unless co-insurance is specifically stated in the Table of Benefits, a 10% or 20% co-insurance option is available for the following benefits: Outpatient Services and Medical prostheses, Orthopaedic and Mobility Aids, Wellness, Maternity & Vision. The same level of co-insurance selected will apply to these benefits. The total amount payable for an eligible claim will be either 100%, 90% or 80% of the benefit limit shown under your plan, depending on the co-insurance you have selected. The coinsurance will not apply to treatment regarding renal dialysis, cancer and HIV. This option is not available for Primary plan.
Restricted Providers **(Tier-1 Providers restriction)** Available with Area 1 cover only	Network hospitals are grouped into 2 benefit tiers, based on costs. Expenses incurred from Tier-1 Providers shall be rejected. *Tier-1 providers list - Singapore: I) Mount Elizabeth Novena and Orchard Hospital, II) Gleneagles Hospital, III) Parkway East Hospital// Hong Kong: I) Hong Kong Sanatorium & Hospital, II) Matilda International Hospital, III) Hong Kong Adventist Hospital// China: I) Shanghai United Family Hospital, II) Beijing United Family Hospital & Clinic, III) Parkway Health Group of Hospitals.*
Areas of coverage	Area 1 - Worldwide excluding the USA Area 2 - ASEAN excluding Singapore Area 2 includes Indonesia, Malaysia, Philippines, Thailand, Brunei, Vietnam, Laos,Myanmar and Cambodia. The benefits under the plan can be claimed • in the area where your country of residence is located as well as the lower areas • worldwide in case of accident and unexpected illness during temporary trips of less than 90 consecutive days outside your area of cover

The benefits stated are per beneficiary and per policy year (12 months after the inception of the policy), unless stated otherwise in the benefit table. Stated age restrictions refer to age attained on the 1st day of the policy period. Refer to the Membership Guide and Policy Terms and Conditions for detailed terms of application, waiting periods and exclusions.

Any persons and/or their eligible dependents, who at the point of application, is employed or seeking employment in the following occupations are not eligible for coverage under the plan: *Airplane Pilots or Co-Pilot, Boiler Operator, Chemical Plant and System Operator, Embalmer, Flight Attendants, Flight Engineer, Metal-Refining Furnace Operator, Nuclear Medicine Technologist, Nuclear Power Plant Worker, Professional Athlete, Radiologist, Stationary Engineer, Water and Wastewater Treatment Plant and System Operator.*

Health Coverage

Health coverage is described in the Table of Benefits above.

Emergency Assistance, Repatriation and Evacuation Coverage

Emergency assistance, repatriation and evacuation coverage is described in the Table of Benefits. The organisation of this coverage has been delegated to an assistance company by the Insurer.

The assistance company will, subject to the terms and conditions defined hereunder, and within the limits of indemnity, provide the following services and information to a Member calling the alarm centre. When the assistance company has the information available, they will provide the information or services, as appropriate, to the Member while the Member is on the telephone. In all other cases, the assistance company will provide the information to the Member by the quickest possible means.

Emergency medical transport

The assistance company will arrange and pay for the emergency evacuation by air and /or surface evacuation of the Member when in a serious medical condition to the nearest hospital where appropriate medical care is available. It is clear that the primary emergency is taken in charge by the local emergency services from whom the assistance company cannot substitute.

The assistance company will pay for the ordinary and necessary expenses related to the transportation, medical care during transportation, communications and all usual and customary ancillary charges incurred in moving and transporting a Member. The emergency medical transport is subject to agreement between the treating doctor and relevant medical authorities.

The assistance company retains the absolute right to decide whether the Member's medical condition is sufficiently serious to warrant emergency medical evacuation.

The assistance company further reserves the right to decide the place to which the Member shall be evacuated and the means or method by which such evacuation will be carried out given all the assessed facts and circumstances of which the assistance company is aware at the time of the event.

The assistance company further reserves the right to use all transport tickets or vouchers initially available to the Member.

Transfer or repatriation following evacuation

The assistance company will arrange and pay for the transfer of the Member suffering from a serious medical condition by aircraft or land vehicles to a medical structure for a hospitalisation or in returning the Member to their Home Country following an Emergency Medical Evacuation for subsequent in-hospital treatment or rehabilitative treatment. The assistance company reserves the right to decide the means or method by which such repatriation will be carried out having regard to all the assessed facts and circumstances of which the assistance company is aware at the relevant time.

Round-trip airfare for next of kin with a hospitalised Member

If the medical condition of a Member does not require repatriation to their Home Country and if the hospitalisation is expected to last more than seven (7) consecutive days, the assistance company shall provide a family member or next of kin with a round-trip economy class plane ticket or 1st class train ticket for them to travel to their bedside.

This service only applies if there is no adult family member already with the Member.

Return to the Country of Assignment after repatriation

Following a Member's medical evacuation or repatriation in his/her Home Country, and with the assistance company prior written approval, the assistance company will arrange and pay for the reasonable and necessary cost for airfare to return to his/her Country of Assignment. The assistance company will also arrange and pay for the cost of an ordinary room accommodation in any reasonable hotel up to the daily amount stipulated in Table of Benefits for a maximum of ten (10) consecutive days.

The assistance company further reserves the right to use all transport tickets or vouchers initially available to the Member.

Transportation of mortal remains

The assistance company will arrange the transportation of the mortal remains from the place of death to the place of burial in the Home Country and pay for all the reasonably and unavoidably expenses incurred.

This service will also apply upon request from the family and with the approval of the assistance company in case the body has been temporarily buried as per the local practices in order to be buried or incinerated in the Home Country.

The cost of the coffin necessary for the transportation is covered up to USD 4000. Cost of the ceremony and embalmment, except if obligatory because of the local law, are not covered by the program.

Compassionate Visit

In the event of the death of a Member due to accident or sickness during a trip, the assistance company will arrange and pay for an economy class round-trip on scheduled flight for a Member of the family or next of kin to assist in the final arrangement at the destination of the deceased Member. The assistance company further reserves the right to use all transport tickets or vouchers initially available to the family member.

Dispatch of medication unavailable locally

The assistance company will, when possible and legally permissible, arrange for delivery of essential medicine and drugs required for the Member and if such medicines and drugs are not available locally.

This service shall be provided for one-off requirements. Under no circumstances shall it be provided for long-term treatments that may require regular delivery of medication, or for vaccination requests.

The Member remains responsible for covering the cost of such prescription medication and undertakes to reimburse the amount spent, plus any customs clearance charges incurred, within 30 days following the date of dispatch.

Legal assistance

In the event of an accident occurring in a private life situation, the assistance company will:

(a) Provide for the defence of the Member in legal proceedings against him/her for civil liability to the Civil Laws in force in the country, and

(b) Conduct proceedings in order to obtain an indemnity from an identified third party for the Member following personal injury and/ or damages to his/her personal belongings if such damages are estimated to be in excess of USD 500, whichever is applicable.

(c) The assistance company covers the expense of lawyer's fees to a total not exceeding the amount stipulated in the Table of Benefits per event.

Bail bond

If, in the event of an involuntary offence against the legislation of the country in which they are located, the Member is obliged by the authorities to pay a bail, the assistance company shall advance a sum of up to the amount stipulated in the Table of Benefits.

The assistance company shall give the Member a period of six months from the date of the advance to repay this sum. If this bail is repaid to the Member before this period by the authorities of the country, it must be returned immediately to the assistance company.

If a Member summoned before a Court fails to appear, the assistance company shall immediately demand repayment of the bail which the Member has not been able to recover due to their failure to appear.

Legal actions may be instigated if the bail is not repaid within the deadline stipulated above.

Transmission of urgent messages

If it is materially impossible for the Member to send an urgent message and if he or she makes the request, the assistance company will deal with sending free of charge, by the most expedient means, any messages or news from the Member to family members, close relatives or employer.

Message content will be entirely the responsibility of the author who must be identifiable and who shall remain solely responsible for any liability arising from the same. The assistance company shall act as intermediary for their transmission only. The assistance company can also serve as intermediary in the opposite direction.

Second Medical Opinion (SMO)

In case the Member is diagnosed an eligible Medical Condition, the Member may activate SMO services.

The SMO service ensures the transfer of the Member's data and medical files regarding the medical condition and/or diagnosis on which the Member wishes to seek an additional medical opinion, to an expert physician specializing in the medical condition in question in order to obtain his/her opinion on the diagnosis and/or treatment first recommended by the Member's attending physician, and the communication of such opinion to the Member along with medical files provided by the Member for the completion of such service.

As the case may be, the SMO service will have one of the following results:

- Confirm the diagnosis and/or treatment prescription provided by the attending physician;
- Provide additional insight to the initial diagnosis and/or prescription;
- Suggest a diagnosis and/or treatment prescription different from the initial one and provide with a recommendation

List of eligible medical conditions for SMO services: Cancer, Stroke, Kidney Failure, Motor Neuron Disease, Alzheimer's Disease, Parkinson's Disease, Total Permanent Disability, AIDS, Hepatitis, Cardiomyopathies, Infectious disease of the Intestines, Major Organ Failure (End Stage Disease), Coronary Artery, Surgery/Angioplasty, Brain Tumour, Deafness, Loss of Speech, Complex Gynaecological Disorders (Including Fertility or IVF; In Vitro Fertilization), Myelodysplastic Disease, Orthopaedics (Joint Replacement; Complex Surgical Hand Conditions; Rotator), Cuff Injuries, Carotid Artery Endarterectomy, Spinal Cord Tumours and Diseases Requiring Operative/Procedural Intervention, Eye Conditions requiring Procedural/Operative Intervention (excluding Simple Cataracts/ And Refractive Corrective Surgery), Major Organ Transplant, Multiple Sclerosis, Coma, Loss of Limbs, Major Burns, Valvular Heart Disease / Heart Valve Replacement or Repair, Paediatric Neurosurgical Conditions, Paediatric Cardiac Conditions, Paediatric Malformations, Congenital Heart Defects in Adults, Epilepsy Surgery, Creutzfeld-Jacob Disease, Elephantiasis, Necrotizing Fasciitis, Primary Pulmonary Arterial Hypertension, Progressive Muscular Atrophy, Asthma (Severe), Rheumatoid Arthritis (Severe).

The SMO service is only provided in English Meetings with the Member. Medical files taken into account, and the outcome of the consultation with the expert physician shall be in English. The organisation and provision of the SMO service is limited to 2 requests per Member per year, each request is catered for a different medical condition.

Exclusions

Unless stipulated in the Certificate of Insurance or Table of Benefits as being covered, the following is excluded:

General Exclusions

- Consequences directly or indirectly arising from taking an active part in a war or warlike operations or in an act of terrorism, invasion, act of a foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power or taking part in civil commotion, popular uprisings or riot of any kind except in an effort to save a human life.
- Consequences of events arising from either:
    - ionising radiations from or contamination by radioactivity from any nuclear fuel, from any nuclear waste, or from the combustion of nuclear fuel; or
    - the radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component thereof; or
    - any weapon of War and/or machine employing atomic or nuclear fission and/or fusion, or other similar reaction or radioactive force or matter; or
    - the radioactive, toxic, explosive or other hazardous or contaminating properties of any radioactive matter.
    - People living in areas with pre-existing high Nuclear, Biological or Chemical contamination.
- Expenses from self-inflicted injuries or injuries caused intentionally and damage resulting from the participation even as an accomplice in any illegal activity or crime, offence or brawl, suicide or attempted suicide, except in self-defence.
- 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 of 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 sanctions, laws or regulations of the European Union, United Kingdom or United States of America. Please note that International Sanctioned countries may be updated from time to time without prior notice.
- Expenses incurred outside the Period of Cover or for which the premium due has not been fully settled.

Health Exclusions

- Care that presents no direct Medical Necessity for the treatment of Illness, including elective/voluntary and/or plastic/aesthetic surgery and its consequences
- Treatment costs incurred outside the Period of Cover and/or selected Area of Coverage
- Expenses related to any Pre-Existing Conditions which existed before the cover start date, unless the Insurer explicitly agrees

- Expenses incurred for non-authorised practitioners or those not exercising their profession in accordance with applicable regulations by the World Health Organisation (WHO)
- Expenses in excess of Reasonable and Customary Charges
- Procedures requiring Prior Approval and for which Prior Approval was not requested or granted
- All forms of experimental treatment or uncontrolled treatment that do not follow commonly accepted, customary or traditional medical practice, unless the Insurer explicitly agrees
- Alternative medicine such as chiropractic treatments, homeopathy, osteopathy, traditional ayurvedic medicine and traditional Chinese medicine
- Preventive treatments, health check-ups and screening examinations
- Personal and comfort items expenses such as earwax removing solutions, dental and oral hygiene products, essential oils, sunglasses, telephone charges, TV, alcoholic beverages and visitor's meal in the event of Hospitalisation or Outpatient Surgery
- Health comfort items or generally available medical equipment for the home, such as blood pressure measuring devices, thermometers, inhalators, sun lamps, massage devices, heating pads, cold pads, software programs, bedding and learning aids
- Non-prescribed drugs and/or non-medical common products, such as antiseptics, artificial tears, cleansers, conditioners, contact lenses solutions, creams, dressings, herbal lozenges, lotions, moisturisers and nasal wash/rinse
- Dietary supplements such as formula milk, enzymes, hormones, minerals, pre- and probiotics, proteins and vitamins
- Smoking cessation treatments and products
- Verifications, studies, treatments, consultations and complications related to sterility, sterilisation, sexual disorders, contraception including the fitting and removal of contraceptive devices and abortion, except in the case of a Medically Necessary abortion in accordance with local legislation
- Beauty consultations and treatments, youth cures, slimming cures and its consequences
- Consultations, treatments and complications related to the loss or the implanting of hair
- Spa treatments inclusive of any transport and accommodation expenses
- Medical Expenses related to a stay in a thalassotherapy centre or fitness centre, even if the stay is medically prescribed
- Medical Expenses related to a stay in a Convalescent Home or Rehabilitation Facility, unless the stay immediately follows Hospitalisation or major surgery as assessed by the Insurer's Medical Practitioner
- Stays in geriatric facilities or under partial/permanent supervision
- Treatment for mental disorders except consultations with and prescribed drugs by an authorised psychiatrist

- Consultations, therapies and/or treatments by a psychologist
- Treatments related to drug addiction, alcohol and substance abuse
- Adult Orthodontic treatment
- Treatments to modify the refraction of an eye or eyes (laser eye correction), including refractive keratotomy (RK) and photo-refractive keratotomy (PRK)
- Competitive sports other than those in which the Insured Person participates purely as an amateur
- Expenses incurred for treatment undertaken on a foetus while it is in the mother's womb.
- Expenses incurred due to surrogacy
- Maternity expenses incurred by Dependant child(ren)
- Expenses related to complications or conditions arising from excluded conditions, treatments and elective caesarean sections
- Expenses incurred for health education programmes and services, including but not limited to, parenting, teaching or antenatal classes
- Consultations, treatments and complications related to sleep disorders, developmental and learning disorders
- Expenses incurred for Occupational Rehabilitation
- Expenses incurred when acquiring an organ, harvesting an organ, locating a replacement organ or transporting an organ
- All operations or treatment related to gender reassignment
- Reimbursements for Medical Expenses that have been paid by another insurance company, person, organisation, or public health programme. This Policy will only reimburse eligible Medical Expenses that are not paid by a third party. If another insurance company, person, organisation or public health programme is responsible to pay for the cost of the treatment, the Insurer reserves the right to seek restitution of any costs that have been paid/reimbursed
- Expenses paid with vouchers issued by shopping malls or other commercial entities
- Document fees charged by a medical provider such as for referral letter, medical report, etc.
- Transportation costs including the cost of delivery of medications (if any).
- Expenses incurred for treatment or consultations performed, or referrals made by, an authorised Medical Practitioner who is the Insured Person's spouse, partner, child, parent or sibling, and self-prescribed treatment or self-referral if the Insured Person is an authorised Medical Practitioner

Emergency Assistance, Repatriation and Evacuation Exclusions

The following treatment, items, conditions, activities and their related or consequential expenses will not be borne by the assistance company unless approval has been sought and obtained in writing from the assistance company and subject to additional fees.

However, the assistance company will undertake to assist the Member on a fee-for service basis, subject to prior written approval by an Authorized Person or provisions of appropriate financial guarantees by the Member.

- Any expense incurred for more than one emergency evacuation and/or repatriation for any single serious medical condition of a Member during the term of the Service Program and in the case where the Member wouldn't have taken all the necessary disposals to avoid impairment of the serious medical condition.
- Any cost or expense following an emergency medical evacuation / repatriation or medical transportation not expressly approved in advance and in writing by the assistance company and/or not arranged by the assistance company. This exception shall not apply to Emergency Medical Evacuation from remote or primitive areas when the assistance company cannot be contacted in advance and delay might reasonably be expected in loss of life or harm to the Member.
- Any expense related to an evacuation and/or repatriation in the Home Country.
- Any expense for an evacuation or repatriation incurred by the Member contrary to the advice of a medical practitioner, related to non-urgent treatment, or for treatments that where known in advance.
- Any expense for medical evacuation or repatriation if the Member is not suffering from a Serious Medical Condition, and/or in the opinion of the assistance company physician, the Member can be adequately treated locally, or treatment can be reasonably delayed until the Member returns to his/her Home Country or Country of Assignment.
- Any expense for medical evacuation or repatriation where the Member, in the opinion of the assistance company physician, can travel as an ordinary passenger on a commercial carrier without a medical escort.
- Any treatment or expense related to childbirth, miscarriage or pregnancy. This exception shall not apply to any abnormal pregnancy or vital complication of pregnancy which endangers the life of the mother and/or unborn child during the first twenty-eight (28) weeks of pregnancy.
- Any expenses incurred while the Member is practicing dangerous sports: air sport (including parachuting, free-fall, bungee jumping, 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, automobile rally's and 4-wheel drive accidents, all sports engaged in on professional or sponsored bases or during competition.
- Any expense incurred during a practice of high risk sports, such as caving, mountaineering or climbing necessitating the use of ropes, rock-climbing, air-ballooning, paragliding, martial arts, racing of all kinds other than foot. This exclusion shall not apply when the Member is accompanied by a monitor or a professional guide which is recognized by an international federation, or when the it is practiced by an amateur who has certified qualifications which allow him to practice and is practicing this activity in an independent way in the measure that they are practiced on a regular and reasonable way.

- Any expenses incurred for psychological disorders except those in relation of Psychological Support benefits as detailed in Table of Benefits.
- Any expenses incurred for psychiatric illness/diseases and nervous breakdowns. This exclusion shall not apply for first manifestation of disorder of this nature requiring immediate hospitalization in a specialized facility.
- Any expenses related to consequences of a chronic illness not consolidated and to consecutive illness. This exclusion shall not apply for first manifestation of symptoms of this nature or during a sudden and unexpected aggravation putting in danger the vital prognosis at a short term and requiring an immediate hospitalization in a specialized facility.
- Any expenses incurred consecutively to a serious and intentional act, contrary to the basic elements of safety, health and security or resulting from the non-compliance to the medical recommendations or treatment, in which case it constitutes a self-inflicted injury dangers situation.
- Any expense incurred as a result of a self-inflicted injury, suicide, drug addiction or abuse, alcohol abuse.
- Any expense related to the Member engaging in any form of aerial flight except as a passenger on a scheduled airline flight or licensed charter aircraft declared.
- Any expense incurred as a result of an illegal act, in regards to the laws of the country of occurrence.
- Any expense related to treatment performed or ordered by a non-registered practitioner or not in accordance with the standard occidental medical practice.
- Any expense incurred as a result of the Member voluntarily participation in a war, riot, public insurrection or any illegal act, including those that can lead to imprisonment, or any event that occurred during active service in a police or military unit.
- Any expense, regardless of any contributory cause(s), involving the use of or selling or the threat thereof of any nuclear weapon or device or bacteriological or chemical agent, whatever the cause, and notably, all expenses incurred in case of war or terrorist act.
- All expenses incurred for the Member's transportation from a ship, plat-form, off-shore oil drilling rig towards land after an accident that occurred off-shore.
- All expenses incurred in any action initiated and organized at state level, or between states, by any governmental or non-governmental authority or organism.
- The following are excluded from the scope of the SMO services:
    - Any request for a SMO regarding cases that did not have an initial diagnosis or were not the object of thorough examination that could have resulted in questioning the diagnosis rendered by a competent local medical authority.
    - Pathologies of urgent nature: any circumstance that initiates or suggests, by its occurrence of discovery, a functional or vital risk if a medical intervention does not occur immediately.
    - Any request for a SMO regarding a medical condition that was the object of intervention by the assistance company within 2 years prior to the request.

Extenuating circumstances

The assistance company may not be held liable for failure to fulfil its obligations under this Policy if it is prevented by force majeure or events such as strikes, riots, popular uprisings, reprisals, restrictions placed on free circulation, sabotage, terrorism, civil or foreign war, radioactivity, any heat release, irradiation or blasts resulting from atomic fusion or fission, natural disasters, epidemics, or any other unforeseen occurrence that renders performance of this Policy impossible.

Eligibility

Terms of eligibility for Insured Persons:

- From Age 18 and up to Age 60 at Policy inception or or on day 1 of the Period of Cover
- Spouse or common-law partner of the Main Insured from Age 18 and up to Age 60, if not divorced or separated by a final court ruling. Only one person shall be considered as a Dependant/s spouse in respect of the above.
- The children of the Main Insured and those of his/her common-law partner on condition that they are unmarried, unemployed and:
    - Up to Age 18 on day 1 of the Period of Cover, or
    - Between Age 19 and Age 28 inclusive on day 1 of the Period of Cover, if studying on a full-time basis (a certificate proving school/university enrolment is required annually)

All the Insured Persons must reside in the same Area of Coverage.

Addition of eligible Dependants must be done at Policy inception or within 30 days following a lifestyle event, such as marriage or birth of a newborn child. Coverage will start from the date of marriage or birth. If eligible Dependant is not added within 30 days following a lifestyle event, subject to the policy terms & conditions and acceptance by the Insurer, the effective date of coverage shall be no earlier than the date of written notification received by the Plan Administrator.

Maternity coverage is only available to female main insured or spouse from Age 18 to 45 provided if her spouse is enrolled in Vitality, Serenity or Prestige plan.

Eligible Dependants are allowed to choose their own base plans. However, plan Options are subjected to the following conditions:

- Dependant/s may purchase optional benefits (Dental or Vision) coverage only if the Main Insured has opted for the same optional benefit coverage
- Dependant/s may select a different Co-Insurance and Deductible level than the Main Insured. If the Main Insured has selected a Restricted Network (Tier-1 Providers restriction) or Semi-Private room restriction, the Dependant/s will have to follow suit as well

Medical Underwriting

All new applicants are subject to full medical underwriting at application.

For existing Insured Persons who wish to make a Modification to Coverage:

- Full medical underwriting is required if the Insured Person upgrades his/her coverage plan including Area of Coverage (e.g.: upgrade from Primary to Vitality or from Area 2 to Area 1)
- Simplified medical underwriting is required if the Insured Person upgrades to a lower or nil Co-Insurance or Deductible plan.

Medical Underwriting may be waived for newborn child who is added within 30 days from birth if the mother has maternity benefits and had fulfilled the 12-month waiting period.

Medical Assessment

The doctors and experts designated by the Insurer have free access to the Insured Person for the purpose of any medical examination required or necessary under the Policy. The Insurer may refuse, suspend or reduce the right to benefits, based on the conclusions of its doctors and experts and regardless of decisions taken and payments paid by the social security or equivalent bodies, or of any other organisation on which the Insured Person depends. The Insured Person shall provide all supporting documents and accept all expert assessments or examinations requested by the Insurer, for themselves. Failure to do so may result in suspension of benefits. Decisions made by the Insurer based on the conclusions of the Plan Administrator's Medical Advisory Board's doctor are notified to the Insured Person by email.

Enrolment

Commencement of coverage under this Policy is effective on the date indicated on the Certificate of Insurance, and, at the earliest, on the day after the Plan Administrator receives the duly filled and signed Application Form and Medical Questionnaire, along with all requested additional information. Commencement of coverage is also subjected to approval by the Plan Administrator's Medical Advisory Board and payment of first premium. The coverage is purchased for a Period of Cover of 12 months and is renewable every year on the anniversary of its date of effect, unless termination is requested under the terms stated on page 31 of this Policy. For individuals / families, the Main Insured undertakes to sign the individual Application Form and the Medical Questionnaire on behalf of their Dependants. Depending on the Medical Questionnaire provided, the Plan Administrator's Medical Advisory Board may request additional medical information. The Plan Administrator reserves the right to limit the coverage, review the premium or decline Policy enrolment based on the above documents and information. After examining the Application Form and the additional information that may have been requested, the Plan Administrator notifies acceptance by issuing a Certificate of Insurance on which are mentioned the selected coverage types corresponding to the chosen Area of Coverage, the coverage effective date and the list of Dependants covered by the Policy. The Insured Person shall keep a copy of their Policy Terms and Conditions, Certificate of Insurance and signed Application Form.

Area of Coverage

In order to be covered by this Policy, the **Medical Expenses** of the **Insured Person** must be incurred in the selected **Area of Coverage**. The selected **Area of Coverage** must include at least the **Country of Usual Residence** of the **Insured Persons**.

The **Area of Coverage** must be selected from one of the following areas:

Area of Coverage 1: Worldwide excluding the USA

Area of Coverage 2: ASEAN excluding Singapore

(Area of Coverage 2 includes Indonesia, Malaysia, Philippines, Thailand, Brunei, Vietnam, Laos, Myanmar, and Cambodia)

Nevertheless, coverage is provided for temporary stays outside the **Area of Coverage** up to 90 consecutive days per trip, on the condition that the expenses incurred are due to an **Accident**, an **Unexpected Illness** or an **Emergency**. The coverage is no longer effective after stays of over 90 consecutive days per trip outside the **Area of Coverage**.

Modification of the Area of Coverage

The **Area of Coverage** may only be changed on the Policy renewal date upon Insurer's approval.

Change of the Country of Usual Residence

The **Insured Person** must inform the Plan Administrator immediately when there is a change of address and the **Country of Usual Residence**.

- If the new **Country of Usual Residence** belongs to the same **Area of Coverage** as the initial **Country of Usual Residence**, the change is made upon Insurer's approval.
- If the new **Country of Usual Residence** belongs to a different **Area of Coverage** of the initial **Country of Usual Residence**, the change is made upon Insurer's approval and the new premium will apply.

Waiting Periods

The following waiting periods correspond to the **Period of Cover** during which the **Insured Persons** cannot claim under the Policy.

The applicable waiting periods as follows:

- **6 months: Medical Prostheses, Orthopaedic and Mobility Aids**, Routine Dental Treatment, Major Restorative Dental Treatment, Spectacles Lenses, Frames and Contact Lenses.
- **12 months:** Maternity (including maternity related expenses and Complications of Pregnancy), Infertility Treatment, Routine Health Check-up, HIV/AIDS treatment, Lasik Surgery and Lens Implant.

- 24 months: Adult Orthodontic Work, Teeth Whitening Procedure Performed at A Dental Clinic, and Treatment for Alcohol or Substance Abuse.

Waiting periods are applicable to all Insured Persons:

- At Policy enrolment
- When increasing coverage
- When switching to a higher Area of Coverage (without changing the Country of Usual Residence)
- When adding a new option (Maternity, Dental, Vision, Wellness), and
- When reducing the Deductible or Co-Insurance limits

The 6-month waiting period for Medical Prostheses, Orthopaedic and Mobility Aids, Routine Dental Treatment, Major Restorative Dental Treatment, Spectacles Lenses, Frames and Contact Lenses and the 12-month waiting period for Routine Health Check-up may be waived if the Insured Person can prove that they had equivalent health coverage during application, by providing a Certificate of Insurance of the Insured Person's previous health insurance with the expiry of cover of less than a month, proving the continuity of insurance cover:

General Conditions

14-day Free Look Period

If the Main Insured wishes to cancel the Policy during the Free Look Period, the Main Insured must write to the Plan Administrator via mail with acknowledgement of receipt and return all Policy documents within the 14 days Free Look Period. The address for notification and return is:

GMC Services Asia Pacific Pte Ltd.
137 Telok Ayer Street #07-01/02/03
Singapore 068602

The termination of cover will take effect on the start date of the Policy. For the avoidance of doubt, the Main Insured will not be allowed to cancel the Policy during the Free Look Period if any claim made by the Insured Persons has been submitted to and reimbursed by the Insurer.

Alteration

The Insurer reserves the right to amend the terms and provisions of this Policy, provided that such amendments apply to all Insured Persons under the Policy. The Insurer will inform the Main Insured of the intended amendment at least thirty (30) days prior to the renewal. Unless specifically mentioned, such amendment shall not affect any special conditions or endorsements applicable at the time of commencement of cover.

No alteration to this Policy shall be valid unless reflected in an endorsement and signed by an authorised representative of the Insurer. No broker or agent has the authority to amend or to waive any of the terms and conditions of this Policy.

Claims

Claim submission period

Requests for claims must be presented to the Plan Administrator within 6 months of the date the medical care is incurred. If the coverage is terminated, this period is reduced to 3 months from the Insured Person's coverage termination date. After this period, submission of claim will no longer be accepted.

Limitation to Actual Costs

The benefits due under the Policy are always limited to actual costs that are Reasonable and Customary Charges. Medical Expenses will be considered Reasonable and Customary Charges if they correspond to the charge usually made for a similar service.

The Reasonable and Customary Charges is assessed depending on current medical practices in the country in which the care is provided (type of treatment, quality of care and equipment, geographical area and country) and is subject to the coding and pricing standards for acts and treatments referenced or part of nomenclatures in each country. An unreasonable and uncustomary nature can therefore lead to a refusal to cover or a limitation of the reimbursed amount.

Reimbursements cannot exceed the amount of the Medical Expenses incurred by the Insured Person. This is inclusive but not limited to any reimbursement the Insured Person is entitled to. If the Insured Person is entitled to reimbursement from any other source including but not limited to insurance policy providing cover for the same loss, damage or liability under the Policy, the Insurer shall not be liable to pay for any such loss, damage or liability under the Policy except for any excess beyond the amount that is or would have been payable under those policies (including local social security or equivalent bodies). For the application of the above terms, the limitation to the amount of the remaining expenses for the Insured Person is determined by the Insurer for each act or item of expense. For avoidance of doubt, the amount the Insurer will pay will be such that the actual reimbursement will not be more than the expenses actually incurred.

Payment of Benefits

Any benefits payable under this Policy shall be paid to the Insured Person. The receipt of any benefit payable under this Policy by the Insured Person shall in all cases be deemed a final and complete discharge of all our liability.

Clerical Error

A clerical error by the Insurer or the Plan Administrator shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force.

Conditions Precedent to Liability

The Insurer will have no liability to pay any benefits under this Policy if any of the Insured Person:

- fail to fully and truthfully disclose to us all material information known (or which could reasonably be expected to be known) before inception of this Policy and upon each renewal;
- fail to properly observe and fulfil the terms and conditions of this Policy;
- make any untrue statement;
- omit, suppress or incorrectly state any material information affecting the risk;
- make any claim that is fraudulent or exaggerated, or make any false declaration or statement in support of a claim.

The due observance and fulfilment of the terms of this Policy insofar as they relate to anything to be done or not to be done by the Insured Person (as the case may be) shall be conditions precedent to any liability of the Insurer to make any payment under this Policy.

Data Protection

AXA General Insurance Hong Kong Limited (referred to hereinafter as the "Company") 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 Company is accurate. The Company 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 Company to collect your personal data (including credit information and claims history) 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 Company, other companies of the AXA 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 Company 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 Company and/or our affiliates, including investigation of claims;
5. detecting and preventing fraud (whether or not relating to the products/services provided by the Company and/or our affiliates);
6. evaluating your financial needs;

7. designing products/services for customers;
8. conducting market research for statistical or other purposes;
9. matching any data held which relates to you from time to time for any of the purposes listed herein;
10. 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;
11. conducting identity and/or credit checks and/or debt collection;
12. complying with the laws of any applicable jurisdiction;
13. carrying out other services in connection with the operation of the Company's business; and
14. 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 Company, 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 Company and/or our affiliates;
3. any agent, contractor or third party who provides administrative, technology or other services (including direct marketing services) to the Company 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;
6. any government department or other appropriate governmental or regulatory authority in Hong Kong or elsewhere; and.
7. the following persons who may collect and use the data only as reasonably necessary to carry out any of the purposes described in paragraphs nos. 2, 3, 4 and 5 of the Purposes specified above: insurance adjusters, agents and brokers, employers, health care professionals, hospitals, accountants, financial advisors, solicitors, organisations that consolidate claims and underwriting information for the insurance industry, fraud prevention organisations, other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check data provided against existing data.

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 Company 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 Company 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 Company, 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 Company and/or:
   a) any of our affiliates;
   b) third party financial institutions;
   c) the business partners or co-branding partners of the Company and/or affiliates providing the products and services set out in (2) above;
   d) third party reward, loyalty or privileges programme providers supporting the Company or any of the above listed entities
4. in addition to marketing the above products and services, the Company 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 Company 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 Company 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 Company 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 Company holds your personal data, to obtain a copy of the data, and to correct any data that is inaccurate. You may also request the Company 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 Company should be addressed in writing to: Data Privacy Officer of AXA General Insurance Hong Kong Limited, 10 - 11/F, Vertical Square, 28 Heung Yip Road, Wong Chuk Hang, Hong Kong. A reasonable fee may be charged to offset the Company's administrative and actual costs incurred in complying with your data access requests.

Declarations and Communications

Declarations and communications are only effective if they have reached the Plan Administrator in writing or by email.

- Insured Persons have a duty to inform the Plan Administrator in writing of any change in the Country of Usual Residence of the Insured Persons.
- In the absence of a notice of change, all communications shall be validly sent to the last address known by the Plan Administrator.
- Any attempt to defraud the Insurer or misrepresentation (whether innocent, negligent or fraudulent) made by the Insured Person to the Insurer on the causes, circumstances, consequences or the amount of a claim shall cause the loss of all entitlements under this Policy.

Modification to Coverage

Any modification to coverage can only take effect from the next Period of Cover. This may impact the level of premiums and waiting period may apply. The Insurer reserves the right to refuse modifications to coverage.

Non-Assignment

This Policy is not assignable by the Insured Person to any third parties. The Insurer shall not be affected by notice of any trust, charge, lien, assignment or other dealing with this Policy.

Premiums

Premiums due are listed on the invoice and payable in advance. The premiums are calculated based on the attained Age of each Insured Person on day 1 of the Period of Cover. The Main Insured is solely responsible for the payment of the premiums to the Insurer.

Revision of premiums

Premiums are revised as at day 1 of each Period of Cover and charged per Insured Person based on their Age.

Policy Renewal

This Policy may be renewed by paying the premium applicable at the time of renewal. The premium rates will be determined at each renewal based on the profile of all Insured Persons under the Policy.

Misstatement of Age

If the Age of any Insured Person has been misstated and the premium paid as a result is insufficient, any difference in premium that has not been paid as a result of the misstatement of Age shall be paid by the

Insured Person to the Insurer immediately. Any excess premium that may have been paid as a result of any misstatement of Age shall be refunded without interest. If at the correct Age an Insured Person would not have been eligible for cover under this Policy, no benefit shall be payable, and our liability shall be limited to the refund of the premium paid without interest, less any benefit that was paid due to the misstatement of Age.

Rights of Recovery

If the Insurer pays, guarantees, or authorizes payment of expenses to an Insured Person or non-network provider, or if the Insured Person obtains treatment through the direct billing network, and the Insurer later determines that the Insured Person was not entitled to that payment for any reason, the Insurer reserves the right to recover the payment back from the Insured Person.

Rights of Third Parties

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.

Subrogation

The Insurer shall have the rights of subrogation in respect of the Insured Person and may initiate recourse proceedings against any liable third party.

Subscription

Subscription to this plan does not exempt the Insured Persons from being affiliated to any compulsory schemes in the country in which they are residing.

Termination

Termination by the Insurer

Cover under this Policy for any particular Insured Person shall be terminated on the earliest happening of the following events:

- False declarations or omissions by the Insured Person may result in the Policy being null and void, in which case all premiums paid shall be forfeited and all monies paid out by the Insurer shall be recovered from the payee(s)
- On the termination date of this Policy
- In the event of a change of Country of Usual Residence, unless such requests have been informed and approved by the Plan Administrator. This is subject to compliance with local legislation of the Country of Usual Residence

- The United States, Japan or Switzerland becomes the Country of Usual Residence of the Insured Person
- On permanent return to the Country of Nationality of the Insured Person (unless approved by the Insurer)
- On the death of such Insured Person
- On day 1 of the Period of Cover on which the Insured Person reaches the maximum Age of eligibility specified in this Policy for all benefits. However, if the Main Insured and spouse has reached the maximum Age of eligibility and can prove five continuous years of insurance under this Policy, the coverage may be extended beyond the maximum Age of eligibility subject to Insurer's approval.
- Upon such Insured Person ceasing to satisfy any of the other eligibility requirements set out in this Policy
- Cover for all Dependants will be automatically terminated upon the termination of the Main Insured's Coverage.
- The Insured Person is found to be on contravention of any anti-money laundering laws, regulations or sanctions programmes: or
- The Insured Person is found to be a person or belong to an entity that is on the List of Specially Designated Nationals and Blocked Persons maintained by OFAC, or any list adopted by HKMA & HKIA, the United Nations, the European Union, the United States of America or the United Kingdom.

Non-Payment of Premiums by the Main Insured

All premiums due must be paid to and received by the Insurer within Thirty (30) days from the inception or renewal date of the Policy (whichever is applicable). For unpaid/incomplete premium the termination date would be from inception or renewal date of the Policy whichever is applicable.

Similarly for Insured Person with premium instalment payments, the 2nd and subsequent instalments, if any, must be paid and received in full by the Insurer within 30 days in respect of the billed instalment period. Failing which, the Policy will be terminated automatically on day 1 of the said period. Any prior agreement request and medical expenses incurred during the said 30 days will only be reviewed after the premium has been received by the Insurer.

Termination by the Main Insured

The Main Insured can only terminate the Policy by giving 30 days' written notice prior to the end of the current Period of Cover to the Plan Administrator.

The Main Insured has the right to terminate cover for any Insured Person at renewal by giving at least 30 days' written notice in advance to the Plan Administrator.

There will be no pro-rated refund for any mid-term deletion of cover.

Consequences of Termination

The termination date cannot be retroactive in any circumstances. In the event of termination, any outstanding requests for claims under the Policy must be sent to the Plan Administrator within 3 months from the Insured Person's coverage termination date. Claims lodged after the allowed period will no longer be eligible for benefits.

Dispute Resolution and Applicable law

Dispute Resolution

If there is any disagreement under this Policy, it must be referred for arbitration in Hong Kong according to the prevailing Arbitration Rules of Hong Kong. Such rules are deemed to be incorporated by reference into this clause.

The language of the arbitration will be in English. If the Insurer disclaims liability for any claim and the claim is not referred for arbitration within 12 months from the date of disclaimer, then the claims will be deemed to have been abandoned and the insurer shall not be liable for such claim.

Governing Law and Jurisdiction

In case of disagreement the parties undertake to meet in order to use their best endeavours to reach an out-of-court settlement. In the absence of such a settlement, this Policy shall be governed by the laws of Hong Kong Special Administrative Region of the People's Republic of China.

Glossary of Terms

The terms and expressions specific to each Policy are defined below.

Health Definitions

Accident or Accidental
All bodily injuries not intended by the **Insured Person**, caused by the violent, sudden and unexpected action of an external cause, not including severe or chronic **Illness**

Age
This refers to an **Insured Person**'s attained age on day 1 of the **Period of Cover**

Allied Healthcare Professionals
These include but not limited to dietitians, physiotherapists, podiatrists, speech therapists and psychologists

Area of Coverage
Defines the countries in which the **Insured Person** can be treated

Certificate of Insurance / Letter of Acceptance / Acceptance of Proposal
Document giving details of the **Insured Persons**, their chosen plan, the benefits provided, the allowable reimbursement amounts, any **Co-Insurance** or other adjustments taken

Chronic Condition
A disease, illness or injury that has one or more of the following characteristics:

- It continues indefinitely;
- It has no known cure;
- It comes back or is likely to come back;
- It requires ongoing or long-term monitoring through consultations, examinations and/or tests;
- It requires ongoing or long-term control or relief of symptoms;
- The patient will require rehabilitation or special training to manage it

Co-Insurance
The percentage of the eligible **Medical Expenses** that the **Insured Person** must pay, which is not reimbursed under the Policy

Country of Nationality
The country of issuance of the **Insured Person**'s passport

Country of Usual Residence
The country in which the **Insured Person** resides for at least 6 consecutive months in a year

Congenital Abnormalities
Any genetic or non-genetic abnormality, defects, diseases, disorders, **Illnesses**, malformations, anomalies or injuries present at birth, whether diagnosed or not

Convalescent Home or Rehabilitation Facility
Freestanding or part of a **Hospital** unit, these facilities are primarily designed to provide short-term recovery and rehabilitation therapy to patients who are recovering from an injury, surgery or stroke

Deductible
The amount of eligible **Medical Expenses** which the **Insured Person** must pay before any claims are covered by the plan.

Dependant/s
The legal spouse, common-law spouse or partner of the Main Insured under a legally binding consensual union agreement, and/or any legal unmarried and unemployed child(ren), including adopted and step-child(ren).

Doula
A certified person who is trained to assist women in child birth. This person must also be a registered midwife who holds the appropriate license to practice in the country where the treatment is received.

Emergency
A sudden, serious and unforeseen acute medical condition or injury requiring immediate medical treatment, and that without treatment commencing as soon as possible could result in death or serious impairment of bodily function. Assessing if a condition answers to this definition is at the sole discretion and expertise of the Plan Administrator's Medical Advisory Board in the event of a dispute.

Emergency Dental Work
Emergency treatment provided during a **hospitalisation** as a result of an **accidental** external traumatic injury to the mouth. Any tooth injury sustained while eating or chewing is not considered external trauma and repair of the tooth is not covered. Follow up outpatient dental treatment after discharge from the hospital is covered under Post-hospitalisation Benefit. This benefit excludes Dental Prostheses.

Expatriate
A person whose **Country of Usual Residence** is different from his/her **Country of Nationality.**

Home Nursing
Home visits from a **Qualified Nurse** immediately after **Hospitalisation** at the **Insured Person**'s own home as required by **Medical Necessity**, and for treatments normally provided in a **Hospital**. **Home Nursing** is only covered when the treating **Medical Practitioner** recommends it is **Medically Necessary**, and the Insurer agrees for the **Insured Person** to have nursing at home

Hospital
Any legally authorised establishment having the title of medical or surgical **Hospital** in the country where it is located. The establishment must offer its patients permanent surveillance by a doctor. Rest and care homes, spas, cure and fitness centres are not considered to be **Hospitals.**

Hospital Accommodation
The Hospital Accommodation benefit covers the cost of staying in a standard private or semi-private room, depending on the chosen plan.
If the insured person chooses a higher room category than the one, he/she is entitled to, the plan will only cover up to the cost of the eligible room category, and any additional costs incurred for the higher room category will be the responsibility of the insured person. In addition, a 20% co-insurance will apply to the total eligible hospital expenses (excluding Hospital Accommodation). This means that the insured person will be responsible for paying 20% of the total eligible hospital expenses, while the plan will cover the remaining 80%. If the hospital visited does not have the chosen room category, the Hospital Accommodation costs will not be covered at all by the plan.
However, in case of an emergency as defined in the Glossary of Terms, if the hospital only has a higher room category, the insured person may be placed in that room, and the plan will cover the additional costs.

Hospice / Palliative Treatment
A facility or home for the terminally ill, where care and emotional support related to a life-threatening and incurable condition is provided by an accredited Palliative Care team in a homelike setting

Hospitalisation
A **Medically Necessary** admission into a **Hospital** involving an overnight stay

Illness/es
Discovery of the symptoms of **Illness** or of an abnormal physical condition or medical condition that is already sufficiently manifest to draw the attention of the average ordinary prudent person and lead him/her to seek diagnosis, treatment or care

Insured Person/s
The eligible individuals and their **Dependant/s**, who have been declared to and accepted by the Insurer

Land Ambulance
Local road ambulance for **Medically Necessary, Emergency** transport to or between **Hospitals.** The authorised practitioner of the **Insured Person** will determine if this is **Medically Necessary**. The Insurer reserves the right to ultimately determine whether such transportation was medically appropriate.

Maximum Annual Limit
The maximum annual amount of expenses in excess of which the Insurer no longer has a duty to reimburse the expenses incurred

Medical Expenses
The expenses relating to eligible treatment that are dispensed by a duly authorised **Medical Practitioner** or prescribed by a duly authorised **Medical Practitioner**, and dispensed by a duly authorised pharmacist/**Allied Healthcare Professional**

Medical History Disregard (MHD)
Pre-existing medical conditions are covered in accordance to the benefits, terms and conditions of the plan.

Medically Necessary or Medical Necessity
Services or supplies ordered and provided by a **Hospital**, **Medical Practitioner** or other Providers that the Plan Administrator or the Insurer determines as:

- Appropriate to the diagnosis or Treatment of an **Insured Person**'s **Illness** or Injury
- Consistent with accepted medical or professional standards of practice
- Not primarily for the personal comfort or convenience of an **Insured Person**, his/her family, **Medical Practitioner** or other Provider
- The most appropriate levels of services or supplies that can safely be provided to an **Insured Person**
- In the case of **Hospitalisation** care, not able to be provided safely on an Outpatient basis

The Plan Administrator or the Insurer reserves the right to determine **Medical Necessity**. The fact that a **Hospital**, **Medical Practitioner**, or other Provider has prescribed, recommended or approved a service or supply does not, in itself, make it **Medically Necessary**.

Medical Practitioner
A person who has attained primary degrees in medicine or surgery by attending a medical school recognised by the World Health Organisation, who is registered or licensed to practice medicine under the laws of the country where treatment is given, and not an **Insured Person** under the Policy, or a family member of an **Insured Person** under the Policy

Medical Prostheses, Orthopaedic and Mobility Aids
Including but not limited to hearing aids, phonation appliances (electronic larynx), wheelchairs and personal movement assistance, artificial limbs, stoma products, hernia support, abdominal bandages, elastic compression stockings and orthopaedic soles

Medical Questionnaire
Document tracing the medical history used by the Insurer's Medical Advisory Board to assess the health risk of an applicant or an **Insured Person** requesting for a benefit/plan upgrade. This document must be completed by the applicant or **Insured Person** and is valid for one month prior to the effective date of coverage

Occupational Rehabilitation
Expenses incurred for rehabilitation with the purpose of returning injured workers to a level of work activity that is appropriate to their functional and cognitive capacity

Orthodontic
The use of appliances to correct a malocclusion and to reposition teeth so that they function and are aligned correctly

Outpatient Surgery
Expenses for procedures or treatments by incisions, shockwaves or lasers, including endoscopic procedures requiring the professional services of a **Medical Practitioner** and does not require an overnight **Hospital** stay

Parent Hospital Accommodation
Cost of an additional bed in the same room for a parent during an eligible admission of the **Dependant** child **s**ubject to the stipulated **Age** for this benefit.

Period of Cover
This will be a 12-month period from the Policy effective date or subsequent renewal date as applicable.

Periodontal Treatment
Treatment of bacterial infections that affect and destroy the tissues that surround and support the teeth. The tissues concerned are the gums, the attaching fibres (ligament or periodontal ligaments) and the bone that supports the teeth

Pre-Existing Condition
Any disease, **Illness** or injury and its related conditions for which **Insured Persons** have received medication, advice, treatment, experienced symptoms or could reasonably assume to have been aware of, prior to the commencement date of coverage

Prescribed Medicines
Drugs that are dispensed and/or prescribed by a duly authorised **Medical Practitioner**

Qualified Nurse
A nurse who is licensed and registered according to the laws of the country in which the treatment is given

Reasonable and Customary Charges
Expenses paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service

Semi Private Room
The lowest category of a 2-bedded or more room with shared bathroom. Patient's standard meals are included.

Standard Private Room
The lowest category of a 1-bedded room with a private bathroom. Patient's standard meals are included.

Terminal Diagnosis

The conclusive diagnosis of an Illness that is reasonably expected to result in the death of Insured Person within 12 months, by a Medical Practitioner who specializes in that Illness or condition.

Unexpected Illness

A sudden and unforeseeable Illness confirmed by a doctor or an unexpected aggravation requiring medical care that, if not provided within 24 hours, could result in permanent injury, incapacity or death of the Insured Person

Emergency Assistance, Repatriation and Evacuation Definitions

Country of Assignment

The country of permanent residence where the Member is Expatriated outside of the Home Country.

Emergency Security Situation

Civil and /or military unrest, insurrection, revolution, natural disaster or any other similar situation which in the reasonable opinion of the client's security personnel constitute a breakdown of law and order that significantly impairs the physical safety of the Member.

Expatriated

For any Member, living outside his/her Home Country for periods exceeding 90 (ninety) consecutive day or exceeding 180 (hundred and eighty) non-consecutive days on any period of 12 (twelve) months.

Home Country

The Member's country of citizenship or the country where the Member usually lived prior to his/her expatriation.

Member

An individual or any employee of a company or of any of its subsidiaries for whom the company/subsidiary has subscribed to the Care & Health Program in Asia administered by Henner and any subsequent program which Henner will inform the assistance company about. The individual/employee is a member when he lives or travels outside of his/her home country and is Expatriated alone or with his/her immediate family (spouse/life partner, children up to Age 28 if still studying), for a professional mission in his/her Country of Assignment and for professional or private travels outside of the Country of Assignment.

Serious Medical Condition

A condition which in the opinion of the assistance company, constitutes a serious medical emergency requiring urgent remedial treatment to avoid death or serious impairment to the Member's immediate or long term health prospects. The seriousness of the medical condition will be judged within the context of the Member's geographical location, the nature of the medical emergency and the local availability of appropriate medical care or facilities.

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Administered by:

Henner
Here to care

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Insured by:

AXA 安盛

AXA General Insurance Hong Kong Limited is the insurance underwriter of this policy and is solely responsible for all 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 20/F, Vertical Sq, 28 Heung Yip Road, Wong Chuk Hang, Hong Kong