

General Conditions

ExpatPlus 2008



IMPORTANT INFORMATION

The 'General Policy Provisions' as set out in Chapter I, are only valid insofar as they are not contradicted by or in conflict with the provisions proper to the different types of cover as set out in Chapter II. In case of contradiction or conflict, the latter take precedence over the former. With respect to the 'Emergency Medical Evacuation and Repatriation Cover', the provisions of Chapter II take precedence over the General Policy Provisions of Chapter I.

Moreover, the Special Conditions will always take precedence over the ExpatPlus General Conditions.

1. Cooling-Off Period

If you are not satisfied with this agreement for whatever reason, you may return it to us within **fifteen (15) days** from the date of delivery. We will cancel the Policy and refund to you all premiums paid.

2. Change of Address

Notify us immediately of any change of your address (including e-mail address) so that we can keep you informed of important information or to facilitate payment of claims.

3. The Financial Mediation Bureau

If you are not satisfied with the rejection or offer of settlement of a claim you may appeal to our Senior Management. If you are still not satisfied with the decision of our Senior Management, you may then refer the case to the Financial Mediation Bureau within six (6) months from the decisions of our Senior Management. The address of the Bureau is as follows:

Belgian Center for Arbitration and Mediation
Stuiversstraat 8
1000 Brussel
Belgium
Tel. + 32 2 515 08 35
Fax + 32 3 515 08 75
info@cepina-cepina.be

4. Medical claims center

For any enquiries or complaints pertaining to any medical insurance related matter on this Policy you may refer to our Contact Center at the following address:

Vanbreda International
P.O. Box 69
2140 Antwerpen
Belgium
Tel. + 32 3 217 69 72 (24/24)
Fax + 32 3 235 83 51
claims@expatplus.com

5. Inquiry on your Policy

If you have any further queries, kindly contact us at:

Vanbreda International
P.O. Box 69
2140 Antwerpen
Belgium
Fax + 32 3 663 73 14
info@expatplus.com

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Chapter I:

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1. Order of Precedence & Purpose of the Insurance

1.1. Order of Precedence

The 'General Policy Provisions' as set out in Chapter I, are only valid insofar as they are not contradicted by or in conflict with the provisions proper to the different types of cover as set out in Chapter II.

In case of contradiction or conflict, the latter take precedence over the former. With respect to the 'Emergency Medical Evacuation and Repatriation Cover', the provisions of Chapter II take precedence over the General Policy Provisions of Chapter I.

Moreover, the Special Conditions will always take precedence over the ExpatPlus General Conditions.

1.2. Purpose of the Insurance

The ExpatPlus insurance programme consists of several insurance plans, intended to offer social protection to expatriated persons, living and working outside their home country:

A. CORE PLAN

1. Medical Insurance Plan

The Medical Insurance Plan reimburses - up to the limits defined in the ExpatPlus General Conditions - reasonable and customary expenses for outpatient as well as for inpatient medical services, provided these expenses have been incurred because of illness, accident or maternity.

2. Emergency Medical Evacuation and Repatriation

Emergency medical evacuation and repatriation services are included within the core plan.

3. Personal Liability

The personal liability of the insured for claims of a third party is insured under the core plan.

B. OPTIONAL EXTENSIONS

Persons insured under the Medical Insurance Plan can also apply for the following additional voluntary insurance cover:

1. Dental Insurance

The dental Plan can be taken out by the persons who are accepted into the Medical Insurance Plan.

2. Personal Accident Insurance (Accidental Death & Dismemberment cover)

This insurance can be taken out as an additional cover to the Medical Insurance Plan, and guarantees the payment of a lump sum in case of accidental death or in case of permanent invalidity caused by an accident.

3. Temporary Incapacity Cover (Loss of Income Protection)

This insurance can be taken out as an additional cover on top of the Medical Insurance Plan, and guarantees payment of a monthly allowance in case the insured is totally unable to perform his/her professional activities because of illness or accident.

4. Permanent Disability Cover (Permanent Invalidity caused by an Illness or accident)

This insurance can be taken out only as a supplement to the Temporary Incapacity Cover and guarantees the payment of an invalidity allowance to the Insured who is affected by a permanent disability, caused by an illness or accident.

2. Definitions, in alphabetical order

'**Accident**' shall mean a sudden, unexpected event, the cause of which is situated outside the victim's body, that results in bodily injury. Following events are also considered to be accidents:

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

'**Assistance Provider**' shall mean Emergency Medical Evacuation and Assistance Services Provider, Mondial Assistance.

'**Claims Handler and Plan Administrator**' is VANBREDIA INTERNATIONAL NV, Plantin en Moretuslei 299, 2140 Antwerpen, Belgium
Postal Address: Vanbredia International, P.O. Box 69, 2140 Antwerpen, Belgium.

'**Complementary Medicine Practitioner**' shall mean an acupuncturist, chiropractor, homeopath or osteopath who is legally qualified and allowed to practise complementary medicine by the authorities in the country in which the treatment is received.

‘Co-payment (co-insurance)’ shall mean the percentage of the (eligible medical) expenses to be paid by the Insured himself/herself, not reimbursed by the insurance plan.

‘Chronic conditions’ is defined as a sickness, illness, disease or injury which has one or more of the following characteristics:

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

‘Day-care treatment’ shall mean the treatment in a hospital or medical day-care centre, for which the patient does not have to stay overnight.

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

‘Deductible’ shall mean the (first) part of the (eligible) medical expenses, not reimbursed by the insurer and deducted from the amount (of eligible medical expenses) on which the reimbursement is calculated.

‘Dentist (or Dental Surgeon)’ shall mean a person officially qualified and licensed to practise dentistry in the country where the treatment is received.

‘Dependant’ shall mean the legal spouse (or legal partner) and/or unmarried children, until the thirty first (31st) of December of the year of the twenty eighth (28th) birthday, of the Insured, who are financially dependent on the Insured.

‘Disability’ means a Sickness, Disease, Illness or the entire Injuries arising out of a single or continuous series of causes.

‘Doctor (or Physician)’ means a person who graduated from a recognised medical school as listed in the WHO Directory of Medical Schools and who is licensed to practise medicine in the country where the treatment is received.
Family Doctor or GP (General Practitioner): a Doctor providing medical treatment not requiring a Specialist’s training.

Specialist Doctor: a Doctor having a specialised qualification in the field of, or expertise in, the

treatment of the illness or injury being treated.

‘Eligible medical expenses’ shall mean Medically Necessary expenses incurred due to a covered illness, accident or maternity but not exceeding the limits in the Schedule

‘Fertility treatment’ shall mean fertility treatment refers not only to the treatment of infertility (surgical or by using IVF procedures) but also includes all investigative procedures necessary to establish the cause(s) of infertility (e.g. hysterosalpingography, laparoscopy, hysteroscopy).

‘Home country’ is the country of which the Insured has the nationality and is holding a passport.

‘Host country’ is the country where the Insured is expatriated to, as declared in the application form.

‘Injury’ shall mean bodily injury caused solely by Accident.

‘Illness (or Sickness)’ shall mean a deterioration of health confirmed by a Doctor (see definition of ‘Doctor’ above).

‘Inpatient’ shall mean inpatient care or treatment is treatment for which, for medical reasons, the patient has to stay in hospital overnight.

‘Insurance year’ shall mean a twelve months’ period, starting on the effective date of coverage of the Insured.

‘Insured’ shall mean the person(s) covered by the ExpatPlus insurance plan or parts thereof and whose names are mentioned in the Special Conditions.

‘Insurer’ is the insurance company underwriting the risks covered by the insurance plan, Justitia N.V., Plantin en Moretuslei 301, 2140 Antwerpen, Belgium.

‘Intensive care unit’ shall mean a section within a Hospital which is designated as an Intensive Care Unit by a Hospital, and which is maintained on a **twenty-four (24)** hours basis solely for treatment of patients in critical conditions and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.

‘Maximum annual reimbursement’ shall mean benefits payable in respect of expenses incurred for treatment provided to the Insured during the period of insurance shall be limited to Overall Annual Limits as stated in the Schedule of Benefits irrespective of a type/types of disability. In the event the Overall Annual Limit has been exhausted, no further payments shall be made for the remaining period of the insurance year.

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

‘Medically necessary’ shall mean a medical service which is:

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

‘Outpatient’ shall mean outpatient care or treatment is medical treatment for which the patient does not have to stay overnight in a hospital.

‘Physician’ See definition of ‘Doctor’.

‘Plan Administrator and Claims Handler’ is Vanbreda International NV, Plantin en Moretuslei 299, 2140 Antwerpen, Belgium.
Postal Address: Vanbreda International, P.O. Box 69, 2140 Antwerpen, Belgium.

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

‘Pre-existing conditions’ are medical conditions or any related conditions, for which symptom(s) have been shown at some point during the 5 years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

‘Prescription drugs’ shall mean drugs/medicines which are necessary to treat a confirmed medical diagnosis or medical condition, and which are not available without prescription by a Doctor (excluding OTC-drugs).

‘Reasonable and Customary’ shall mean medical expenses will be considered ‘reasonable and customary’ if they correspond to the charge usually made by the health care provider for a similar service or supply and do not exceed the normal charge made under the best prevailing conditions for such a service or supply in the locality where the service or supply is received. If usual and prevailing charges cannot be determined because of the unusual nature of the service or supply, the Claims Handler will on behalf of the Insurer determine to what extent the charge is reasonable, taking into account:

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

‘Sickness, disease or illness’ shall mean a condition marked by a pathological deviation from the normal healthy state confirmed by a doctor.

‘Special Conditions’ is a document issued with each insurance policy, stating:

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

‘Standard private room’ shall mean a private room is a room with one bed. A ‘standard’ private room is the lowest rate (regular) private room in a hospital.

‘Surgery’ shall mean any of the following medical procedures:

- To incise, excise or electro cauterize any organ or body part, except for dental services.

- To repair, revise, or reconstruct any organ or body part both invasive and non-invasive.
- To reduce by manipulation a fracture or dislocation.
- Use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or urethra.

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

3. Eligibility and acceptance into the insurance

3.1. Eligibility

3.1.1. Individual expatriates

The ExpatPlus plan is open to individual expatriates (private persons) and their dependants whose home country or host country is located within the European Economic Area.

3.1.2. Expatriate employees sent on assignment abroad by their employer

The ExpatPlus plan is open to employers located in the European Economic Area to cover their expatriated employees (and their dependants)⁽¹⁾ on foreign assignment outside their home country or usual place of residence.

3.2. Acceptance into the insurance

3.2.1. Individual expatriates (‘individual cover’)

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

3.2.2. Expatriated employees (‘group cover’)

In case of compulsory affiliation by the employer, and the number of enrolled staff amounting to less than five (5) employees:

A medical questionnaire has to be completed by each employee and for each dependant and has to be submitted by the candidate-insured(s) to the medical consultant (physician) of the Insurer through the Plan Administrator. The medical consultant can define partial or total exclusion of cover, or, at his discretion, propose an additional premium to waive exclusions.

In case of compulsory affiliation by the employer of a group of five (5) or more employees: No health declaration(s) will be required for the medical insurance plan, meaning that there will be immediate and full acceptance into the medical insurance of both employees and dependants. For the other insurance plans (the additional voluntary insurance cover: Personal Accident Cover/Temporary Incapacity Cover/Permanent Disability Cover) however, the Medical consultant can still define partial or total exclusion of cover, or, at his discretion, propose additional premium to waive exclusions.

3.3. Addition of new dependants into the insurance

Addition of a spouse/legal partner is possible, provided that the application (according to the same procedure and conditions of acceptance, as described in article 3.2.) for these family members is made within one month following the date of marriage/legal partnership. Addition of a new-born or adopted child is possible, provided that the application is made within two months following the date of birth or adoption.

A medical questionnaire has to be completed when the baby is 2 months old and has to be sent to the medical consultant of the Insurer through the Plan Administrator. The Medical Consultant can propose an additional premium of up to 150% to waive exclusions.

Premiums for the new-born baby are to be paid as from the first month of affiliation.

3.4. Age limits for enrolment

- For individuals, the minimum and maximum ages for enrolment are eighteen (18) years and sixty (60) years.
- For expatriated employees, enrolled on a compulsory basis by their employer, there is

⁽¹⁾ For definition of ‘dependants’ see article 2 of the General Conditions; the Medical Insurance (including the Emergency Evacuation and Repatriation Cover) as well as the Dental Plan is open to the insured expat’s dependants, but the ‘Temporary Incapacity Cover’ and the ‘Permanent Disability Cover’ are not open to the dependants. The ‘Personal Accident Cover’ however can be taken out for the spouse (or legal partner) and dependent adult (i.e. as from age 18) children of the employee or the individual expat, insofar as these persons are also covered by the Medical Insurance Plan.

no specific age limit set for enrolment into the medical insurance plan. For the other additional insurance plans, reference is made to the conditions applying to each of these insurance plans.

3.5. Change of level of cover

Downgrading and upgrading is possible, but only on the annual renewal date. In case of upgrading, the medical questionnaire has to be filled out again (if applicable).

Changing the geographical scope (territoriality) of the cover is always possible in function of the country of expatriation. However, it is not possible to change to zone A just for one quarter (with the objective to get treatment in the USA or Canada).

3.6. Individual continuation

If an expatriated employee, who was insured for at least six (6) months under an ExpatPlus group cover, decides to continue on an individual basis, and applies for cover before expiration of his/her cover under the group cover, no medical questionnaire has to be filled out and no waiting periods are applicable. However, articles 3.4 (age limit) and 3.5 (Medical questionnaire in case of upgrade) are still applicable.

4. Effective date of coverage

The insurance cover takes effect on the day immediately following the acceptance by the Insurer or Plan Administrator of:

- the completed application form;

And

- the acceptance of the candidate-insured by the Medical consultant into the insurance, whenever such medical acceptance is required in accordance with the specific eligibility and acceptance rules of each insurance cover, as described in the different chapters of these General Conditions.

However, coverage cannot take effect before the initial premium has been duly received by the Insurer or the Plan Administrator on behalf of the Insurer.

New dependants have to be declared – by means of a duly filled out application form and medical questionnaire - within one month following the date of marriage, start of legal partnership, birth or legal adoption. The insurance cover takes effect on the day immediately following the acceptance into the insurance by the Medical consultant, whenever such medical acceptance is

required (in accordance with the specific eligibility and acceptance rules of each insurance cover, as described in the different chapters of these General Conditions).

However, coverage cannot take effect before the initial premiums have been duly received by the Insurer or the Plan Administrator (on behalf of the Insurer).

5. Cooling-off period

If this Policy shall have been issued and for any reason whatsoever the Insured shall decide not to take up the Policy, the Insured may return the Policy to the Insurer for cancellation provided such request for cancellation is delivered by the Insured to the Insurer within **fifteen (15)** days from the date of delivery of the Policy. The Insured is entitled to the return of the full premium paid.

6. Duration and cancellation of policy

6.1. Period of cover and renewal

The duration of the insurance policy is fixed at three months, starting from the effective date of coverage as stipulated in article 4 above, unless otherwise agreed upon by the parties (Policyholder and Insurer). At the end of the three months' period, the policy will be automatically renewed by tacit agreement for successive periods of 3 months each, unless otherwise agreed by the parties.

6.2. Cancellation of the policy

The policy can be terminated by the Policyholder through notification by registered letter, delivered to the Insurer at least one month before the renewal date of the policy. Termination of the Personal Accident Cover and/or the Temporary Incapacity Cover (and/or the Permanent Disability Cover, will not automatically lead to termination of the Core Plan, unless otherwise agreed upon by the parties (Policyholder and Insurer).

6.3. Aggravation of the Risk

With respect to the Medical Insurance Cover: Except for changes in the state of health of the Insured incurred after acceptance into the insurance, the Insured is obliged to inform the Insurer (through the Plan Administrator) of any change in circumstances or conditions that may increase the risk to illness or accident (e.g. dangerous professional activity). The Insurer may then propose new insurance conditions (within a period of one month after having received

notification of the aggravation of the risk) or cancel the insurance cover (within one month) retro-actively as from the moment of the start of the aggravation of the risk.

With respect to the other Insurance Covers (Personal Accident Cover/Temporary Incapacity Cover/Permanent Disability Cover/Emergency Medical Evacuation and Repatriation): the Insured is also obliged to inform the Insurer (through the Plan Administrator) of any change in circumstances or conditions that may increase the risk to illness or accident (e.g. dangerous professional activity). The Insurer may then propose new insurance conditions (within a period of one month after having received notification of the aggravation of the risk) or cancel the insurance cover (within one month) retro-actively as from the moment of the start of the aggravation of the risk.

7. Termination of cover

For the Insured, the insurance under this Policy shall **automatically** terminate:

- if any premium on this Policy is not paid on the due date or within the grace period; or
- if the Insured is a dependant child, on the thirtyfirst (31st) of December of the year when the Insured dependent child is attaining **twenty eight (28th)** years old or when they are **no longer considered to be dependent children** or upon the date of **marriage**;
- if the dependant is the spouse or legal partner, upon the date of divorce or legal separation from the Insured, or as from the end of the legal partnership;
- upon the death of the Insured.

7.1. Suspension of cover and cancellation of the insurance because of non-payment of premium

In case of failure by the Policyholder to pay the premium on the due date, the Insurer has the right to suspend or cancel the insurance policy. The Insurer will first notify the Policyholder by means of a registered letter, reminding the Policyholder of the amount of the premium that has to be paid, and informing him of the consequences of non-payment. If the premium shall then not have been paid within 15 days following service or posting of the registered letter, the insurance cover will be suspended automatically. Payment by the Policyholder of the premiums due, together with interest, if any, shall terminate suspension. The Insurer may cancel the policy during the period of suspension. In this case, cancellation shall

take effect on the expiry of the period of 15 days, starting from the first day of suspension. Claims incurred during the period of suspension are not covered.

8. Premium & Premium increase

8.1. Amount and payment of the premium

The amount of the insurance premium is mentioned in the Special Conditions. The premium is payable by the Policyholder to the Insurer (through the Plan Administrator) on a quarterly basis in advance. Taxes and charges as established by the applicable laws will be added to the amount of the premium, and have to be paid in full by the Policyholder.

8.2. Premium Increase

In case the Insurer increases the premium rate, he will notify the Policyholder, in writing, of said increase and of the date as from which the new premium will become effective. This notification will be sent to the Policyholder, in writing, at the latest on November **fifteen (15)** of the expiring calendar year. The new premium rates will become effective as of the next renewal date, starting on or after January 1 of the next calendar year.

If the Policyholder does not agree with the new premium conditions, he can terminate the policy through notification of cancellation to the Insurer by registered letter, delivered to the Insurer or the Plan Administrator at least 15 days before the renewal date of his policy.

9. Return to the home country

When the Insured returns to live and/or to work in his/her home country, thereby ending the period of expatriation abroad, the Insured or the Policyholder have to notify the Insurer (through the Plan Administrator) in writing of the exact date of relocation to the home country. The insurance will remain in force until the end of the quarter of return to the home country, at which date it will be automatically terminate. The Policyholder can nevertheless request - in writing and before the termination date - cover for one additional three months' period (without interruption of cover), at the conditions prevailing on the first day of this additional three months' period. During this period the Insured (or the Policyholder) can apply for affiliation to a local social security scheme or look for another private insurance.

Failure to notify the Insurer of the relocation to the home country, shall result in the Insurer not providing cover for the duration of the Insured's return to the home country.

10. Currency

The ExpatPlus plan can be taken out in € (EURO), £ (GBP) or in \$ (USD). The choice of currency has to be made (by the Policyholder) before the coverage takes effect, and can only be changed at the annual renewal date. Premiums and claims shall be payable in €, £ or in \$, according to the currency in which the policy has been concluded.

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

11. General Exclusions

The coverage described in this policy does not extend to:

1. consequences of a voluntary or intentional act committed by the Insured person or his/her beneficiary; or consequences of hazardous competitions;
2. consequences of insurrections or riots if by taking part the Insured or his/her beneficiary has broken the applicable laws;
3. consequences of brawls, fights and all kinds of disturbances and measures taken to combat them, except in case of self-defence;
4. consequences of the preparation of or participation in crimes or misdemeanours;
5. consequences of drug-addiction and alcoholism;
6. direct or indirect consequences of any action relating to what is commonly designated as 'Nuclear risk'. This exclusion is not applicable to medical radiations required by covered medical treatment;
7. events related to bets or challenges;
8. expenses resulting from any kind of competition with motor vehicles;
9. flight risk: the insurance covers the use, as a passenger, of all planes, hydro-planes or helicopters duly authorised to transport persons, as long as the Insured is not a member

of the crew and does not exercise in the course of the flight a professional or other activity, in relation with the plane or the flight. However, this exclusion is not applicable to the medical and dental cover;

10. Consequences of war or acts of war, and terrorism to the extent mentioned in article 12 hereafter. However, this exclusion is not applicable to the medical and dental cover.

Important remark

For the additional specific exclusions relating to each separate insurance cover of the ExpatPlus insurance programme, reference is explicitly made to the provisions proper to the different types of cover (see chapter II).

12. War and terrorism

War and terrorism are defined as follows:

12.1. War

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

12.2. Terrorism

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

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

With respect to the risks and consequences of war and terrorism, all consequences of active participation of the Insured (and/or his/her covered dependants) in operations of war and terrorism are explicitly excluded from coverage.

In case the Insured is victim of activities of war and terrorism without any active involvement on behalf of the Insured or his/her beneficiaries in these activities, the insured are covered within the limits and the ceilings of the coverage.

However, the Insurance cover is not valid when the Insured (or covered dependants) was travelling to or from or residing in a country or a region within a country publicly known to be in state of war or civil war at the time damages (bodily injury, or death) to Insured or his/her covered dependants happened. In case of dispute concerning the fact whether a given country is known to be in state of war or civil war, the list of countries (or parts of countries) for which it is the UK Foreign and Commonwealth Office's (FCO) advice not to travel to ('against all travel'), as published on their official website (www.fco.gov.uk), will be decisive.

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

13. Dispute Settlement

13.1. Non-medical disputes

13.1.1. Settlement in good faith / alternative dispute resolution

Before resorting to arbitration, the parties shall attempt to settle in good faith all disputes or differences which arise between them out of or in connection with this Insurance Policy, by negotiation between them in good faith, and, in the event of failure of such negotiations, the parties may, if they so agree, attempt to resolve any such dispute or difference by the use of a procedure known as Alternative Dispute Resolution (i.e. mediation, conciliation, expert

determination or mini-trial).

13.1.2. Arbitration

All disputes arising out of or in relation with this insurance policy, which parties are unable to settle by mutual agreement within a reasonable time or according to the stipulations of above paragraph, can be finally settled under the CEPANI (Belgian Centre for Arbitration and Mediation) Rules of Arbitration by one or more arbitrators appointed in accordance with those Rules. The seat of arbitration shall be Antwerp (Belgium). The law governing the contract shall be the law of Belgium.

The arbitration procedure shall be initiated by registered letter addressed by the claimant to the other party. This letter shall indicate the subject of the dispute; include all relevant documentation and supporting evidence to substantiate the claim. Within thirty (30) days of receipt of the said letter or such longer period as the parties may agree, the dispute shall be submitted for arbitration to CEPANI. The costs of arbitration shall be borne jointly by the parties, each having to pay fifty per cent of total costs. The costs of arbitration do not comprise the costs of each party's counsellor or defence, which remains at the charge of each party.

13.2. Medical disputes

In case the Insured does not agree with decisions of the medical consultant of the Insurer, he/she can call upon his/her own treating doctor to assist him/her, and both the doctors of the Insurer and the Doctor of the Insured will try to reach agreement on the issue. If both Doctors fail to reach an agreement, they can jointly appoint a third Doctor to settle the dispute. If the two Doctors cannot agree on the choice of a third Doctor, he/she will be appointed by the President of the 'Ordre des Médecins /Conseil Provincial d'Anvers' ('Orde van Geneesheren /Provinciale Raad van Antwerpen') in Belgium. Each party has to pay the fees of their own Doctor, the fees of the third Doctor to be paid half by each of the parties.

14. Data Protection

The insurance policy is subject to compliance with the Belgian Data Protection Act of 1992. This Act applies in relation to any personal data processed in connection with this insurance policy. The Insurer, Claims Handler & Plan Administrator will provide sufficient guarantees in respect of the technical and organisational measures governing the data processing to be carried out; and will

therefore operate technical and organisational measures to protect against unauthorised or unlawful processing of such data and against accidental loss or destruction of or damage to such data. They shall comply with the following obligations:

- process the personal data solely for the execution of the present insurance policy and for the purposes for which they have been transferred to the Insurer or the Claims Handler & Plan Administrator;
- take care that the access to the data and possibilities of processing for the persons who are acting under their authority, are limited to what is necessary for the fulfilment of their duties and for the requirements of the service that is the subject of the present insurance policy
- only disclose personal data to third parties to the extent that such disclosure is necessary for the purposes of providing the services covered by the insurance policy

This insurance policy is issued under and governed by the laws of Belgium.

15. Subrogation

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

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

16. Defence

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

17. Complaints Procedure

If an Insured has any complaint regarding the standard of service received under this insurance policy, the following procedure is available to restore the situation:

- in first instance, the Insured should write to: the Head of the Claims Unit, Vanbreda International, P.O. Box 69, 2140 Antwerpen, Belgium.
- if still not satisfied, the Insured can write to: the Managing Director, Vanbreda International, P.O. Box 69, 2140 Antwerpen, Belgium.

18. Governing Law

Chapter II:

BENEFITS AND PROVISIONS PROPER TO THE DIFFERENT TYPES OF COVER

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ExpatPlus Benefits table

In the tables below we have summarised the benefits applicable for each product option. Please refer to the wording of these general conditions for full benefit details and definitions. All benefits shown are per insured person, per insurance year (unless specifically stated).

	GLOBE	ORBIT	UNIVERSE
Maximum annual reimbursement per insured	€ 1.000.000 £ 650.000 \$ 1.250.000	€ 1.500.000 £ 1.000.000 \$ 1.875.000	€ 3.000.000 £ 2.000.000 \$ 3.750.000
Territorial scope of cover	Zone A: Worldwide		
	Zone B: Worldwide excluding USA & Canada (but 90 days cover in USA & Canada in case of accident and emergency treatment)		
Deductible options for outpatient care, per insured and per year	€ 0 - £ 0 - \$ 0 € 100 - £ 65 - \$ 125 € 300 - £ 200 - \$ 375	€ 0 - £ 0 - \$ 0 € 100 - £ 65 - \$ 125 € 300 - £ 200 - \$ 375	€ 0 - £ 0 - \$ 0

Hospitalisation inpatient treatment (day-patient and with overnight stay in hospital)

	GLOBE	ORBIT	UNIVERSE
Hospital room & board (pre-certification required)	100% of semi-private or 80% of standard private room	100% of standard private room	100% of standard private room
Doctor's fees (surgeon, anaesthetist)	100%	100%	100%
Other medical expenses (medical imaging, drugs and dressings, use of operating room, etc.)	100%	100%	100%
Hospital accommodation in intensive care unit (ICU)	100%	100%	100%
Rehabilitation and convalescence rest/care (when the admission immediately follows hospitalisation)	Not covered	Not covered	100% (max. 28 days)
Parent accommodation of one parent for child < 16	100% up to € 1.500 100% up to £ 1.000 100% up to \$ 1.875	100% up to € 1.500 100% up to £ 1.000 100% up to \$ 1.875	100% up to € 1.500 100% up to £ 1.000 100% up to \$ 1.875

Outpatient treatment

	GLOBE	ORBIT	UNIVERSE
Doctor's fees (generalist, specialist)	80%	90%	100%
Diagnostic tests, lab tests, medical imaging (x-ray, MRI- and CT-scans)	80%	90%	100%
Prescribed drugs	80%	90%	100%
Physiotherapy	80% up to € 1.000 80% up to £ 650 80% up to \$ 1.250	90% up to € 2.000 90% up to £ 1.300 90% up to \$ 2.500	100% up to € 3.000 100% up to £ 2.000 100% up to \$ 3.750
Preventive care & well-being benefit <ul style="list-style-type: none"> • Check-up • Eye test • Mammogram • Pap-smear test • PSA-test • Vaccinations 	100% up to € 600 100% up to £ 400 100% up to \$ 750	100% up to € 800 100% up to £ 535 100% up to \$ 1.000	100% up to € 1.000 100% up to £ 650 100% up to \$ 1.250

Outpatient treatment (continued)

	GLOBE	ORBIT	UNIVERSE
Alternative medicines such as homeopathy, acupuncture, chiropraxy and osteopathy	80% up to € 1.000 80% up to £ 650 80% up to \$ 1.250	90% up to € 2.000 90% up to £ 1.300 90% up to \$ 2.500	100% up to € 3.000 100% up to £ 2.000 100% up to \$ 3.750
Therapy <ul style="list-style-type: none"> Ergotherapy Logopaedics and/or Speech therapy Psychiatric outpatient care 	Not covered	50% up to € 1.000 50% up to £ 650 50% up to \$ 1.250	50% up to € 2.000 50% up to £ 1.300 50% up to \$ 2.500

Other medical treatment

	GLOBE	ORBIT	UNIVERSE
Maternity (waiting period of 10 months applies) ¹ <ul style="list-style-type: none"> Pregnancy Fertility treatment and sterilisation (IVF, ICSI, AI and all similar treatments) Childbirth 	reimbursement according to type of outpatient treatment Not covered 80% up to € 5.000 80% up to £ 3.250 80% up to \$ 6.250 (100% if home confinement)	reimbursement according to type of outpatient treatment Not covered 100% up to € 7.500 100% up to £ 5.000 100% up to \$ 9.375	reimbursement according to type of outpatient treatment 100% up to max. € 9.000 / £ 6.000 / \$ 11.250 (3 x € 3.000 / £ 2.000 / \$ 3.750) 100% up to € 10.000 100% up to £ 6.500 100% up to \$ 12.500
Cancer treatment (excluding experimental treatments) (hospitalisation and outpatient treatment)	100%	100%	100%
Chronic and pre-existing conditions ²	Covered	Covered	Covered
AIDS / HIV Treatment <ul style="list-style-type: none"> Inpatient Outpatient 	100% 80%	100% 90%	100% 100%
Nursing at home	80% up to € 160 per day £ 110 per day \$ 200 per day (maximum 60 days)	90% up to € 180 per day £ 120 per day \$ 225 per day (maximum 60 days)	100% up to € 200 per day £ 135 per day \$ 250 per day (maximum 100 days)
Organ transplant (excluding costs for donor – prior approval required)	100% up to € 100.000 £ 65.000 \$ 125.000	100% up to € 125.000 £ 83.500 \$ 156.250	100% up to € 150.000 £ 100.000 \$ 187.500
Kidney dialysis (excluding experimental treatments)	100%	100%	100%
Local ambulance (to nearest hospital)	100% up to € 500 100% up to £ 325 100% up to \$ 625	100% up to € 1.000 100% up to £ 650 100% up to \$ 1.250	100% up to € 1.500 100% up to £ 1.000 100% up to \$ 1.875
Dental treatment following accident	100% up to € 750 / £ 500 / \$ 937,50 + dental surgery up to € 2.000 / £ 1.300 / \$ 2.500	100% up to € 1.000 / £ 650 / \$ 1.250 + dental surgery up to € 2.500 / £ 1.625 / \$ 3.125	100% up to € 1.250 / £ 850 / \$ 1.562,50 + dental surgery up to € 3.000 / £ 2.000 / \$ 3.750
Psychiatric care <ul style="list-style-type: none"> Inpatient Outpatient 	Not covered see Therapies	90% up to € 10.000 90% up to £ 6.500 90% up to \$ 12.500 see Therapies	100% up to € 20.000 100% up to £ 13.500 100% up to \$ 25.000 see Therapies

Other medical treatment (continued)

	GLOBE	ORBIT	UNIVERSE
Vision care (glasses, frames, contact lenses)	80% up to € 100 80% up to £ 65 80% up to \$ 125	90% up to € 200 90% up to £ 135 90% up to \$ 250	100% up to € 300 100% up to £ 200 100% up to \$ 375
Medical aids (e.g. hearing aids and orthopaedic appliances)	80% up to € 1.500 80% up to £ 1.000 80% up to \$ 1.875	90% up to € 2.500 90% up to £ 1.650 90% up to \$ 3.125	100% up to € 3.000 100% up to £ 2.000 100% up to \$ 3.750

¹ Unless waived in the special conditions.

² Acceptance of your application is subject to a medical questionnaire and approval by the medical consultant. Unless waived in the special conditions. Pre-existing and chronic conditions are covered within the limits of your plan if accepted by the medical consultant at the time of your enrolment.

A. CORE PLAN

1. MEDICAL INSURANCE

1.1. Purpose of the Medical Insurance Plan

The Medical Insurance Plan reimburses - up to the limits defined in the present general conditions - reasonable and customary expenses for outpatient as well as for inpatient medical services, provided these expenses have been incurred because of illness, accident or maternity.

1.2. Eligibility and acceptance into the Medical Insurance Plan

With respect to eligibility and acceptance into the insurance, reference is made to conditions as set out in article 3, Chapter I of the General Policy Provisions.

1.3. Levels of Medical Cover

With respect to Medical Insurance Plan, there are three different levels of cover:

Level 1 = 'Globe'

Level 2 = 'Orbit'

Level 3 = 'Universe'

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

1.4. Territorial scope of the insurance

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

a. Worldwide cover

b. Worldwide cover with exception of medical expenses incurred in the United States of America (USA) and in Canada.

However, during business trips or holidays, not exceeding (in total) 90 days per Insurance year, medical expenses incurred in the USA or Canada as a direct consequence of an accident or a medical emergency (for definition of 'accident' and 'emergency' please see article 2) are covered up to the limits of the policy. If the medical condition concerned already existed prior to the travel to the USA or Canada and was the objective of the travel, the medical expenses are not covered. Expenses related to pregnancy (and complications thereof) and/or childbirth will not be considered to be accident or emergency expenses, and will therefore not be covered.

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

1.5. Benefits

1.5.1. Definitions

We refer to article 2 of Chapter I.

1.5.2. Description of benefits

Eligible medical expenses, subject to the exclusions, limits and ceilings mentioned in this policy, are listed in the benefits table above. The Medical Insurance Plan reimburses eligible 'reasonable and customary expenses' for outpatient as well as for inpatient medical services, provided these expenses have been incurred because of illness, accident or maternity. Moreover, to qualify for reimbursement, treatments and procedures have to be medically necessary and appropriate (consistent with the diagnosis as established by a Doctor). They have to be prescribed by a Doctor, and performed by a Doctor or by a legally qualified and duly licensed

medical practitioner.

The reimbursement ceilings (i.e. the maximum amount of reimbursement) for certain types of medical services are - unless indicated otherwise in the benefits table - always applicable per Insured and per insurance year. This means that each ceiling is applicable for a 12 months period of uninterrupted coverage, starting on the effective date of coverage of the Insured.

1.5.2.1. Inpatient treatment

Pre-certification as stated in 1.6. below is always required except in case of emergency. Failure to comply with the pre-certification requirement will lead to a reduction of the reimbursement with 25%.

1.5.2.1.1. Hospital Room and Board

Reimbursement of the Reasonable and Customary Charges Medically Necessary for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured's confinement, but in no event shall the benefit exceed, for any **one (1)** day, the rate of standard private room.

1.5.2.1.2. Intensive Care Unit

Reimbursement of the Reasonable and Customary Charges Medically Necessary for actual room and board incurred during confinement as an inpatient in the Intensive Care Unit of the Hospital. This benefit shall be payable equal to the actual charges made by the Hospital.

No Hospital Room and Board Benefits shall be paid for the same confinement period where the Daily Intensive Care Unit Benefit is payable.

1.5.2.1.3. Doctors' Fees

1.5.2.1.3.1. Surgical Fees

Reimbursement of the Reasonable and Customary Charges for a Medically Necessary surgery by the Specialists, but within the maximum indicated in the Schedule of Benefits. If more than one (1) surgery is performed for Any One Disability, the total payments for all the surgeries performed shall not exceed the maximum stated in the Schedule of Benefits.

1.5.2.1.3.2. Anaesthetist Fee

Reimbursement of the Reasonable and Customary Charges by the Anaesthetist for the Medically Necessary administration of anaesthesia not exceeding the limits as set forth in the Schedule of Benefits.

1.5.2.1.4. Other medical expenses

1.5.2.1.4.1. Operating Theatre

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

1.5.2.1.4.2. Hospital Supplies and Services

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

1.5.2.1.5. Parent accommodation

Reimburses up to stipulated limits stated in the Schedule of Benefits the expenses for meals and lodging to accompany a dependant child who is the Insured (aged below **sixteen (16)** years) in the hospital.

1.5.2.1.6. Hospital cash benefit

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

1.5.2.1.7. Convalescence and Rehabilitation

Convalescence and rehabilitation rest/care (in a recognised centre and when the admission is medically motivated) is covered when the admission immediately follows (within 5 days) an hospitalization for illness or surgery and with a max. of 28 days.

1.5.2.2. Outpatient treatment

This benefit provides for the reimbursement of actual expenses incurred for out-patient care subject to the stated sub-limit set forth in the Schedule of Benefits.

1.5.2.2.1. Doctor's Fees

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

1.5.2.2.2. Diagnostic tests

Reimbursement of the Reasonable and Customary Charges for Medically Necessary tests (ECG, x-ray, laboratory tests etc.) which are performed for diagnostic purposes on account of an injury or illness when in connection with a Disability within the amount as set forth in the Schedule of Benefits in a Hospital and which are recommended by a qualified Medical Practitioner.

1.5.2.3.3. Prescription medicines/drugs

Only drugs that are prescribed by a Doctor and that are not available without prescription can be reimbursed. OTC ('over-the-counter') medicines do not qualify for reimbursement, nor do lifestyle products, dietary products, vitamins, food supplements etc. For vaccines, the special provisions of 1.5.2.3.4. apply.

1.5.2.3.4. Preventive care and wellness benefits

- well baby care;
- vaccinations (adults and children);
- one adult physical examination per Insurance year;
- one routine eye test per Insurance year;
- one (bilateral) mammogram per Insurance year [for Insured females as of age **thirty-five (35)** years];
- one pap-smear test per Insurance year [for Insured females as of age **thirty-five (35)** years];
- one PSA-test per Insurance year [for Insured males as of age **fifty (50)** years].

1.5.2.3.5. Physiotherapy

Physiotherapy prescribed by a Doctor, including mensendieck physiotherapy, is covered on the condition that the medical prescription clearly mentions the need for this specific form of physiotherapy AND if the care provider is a certified physiotherapist.

1.5.2.3.6. Treatments performed by Complementary Medical Practitioners

- Chiropractor
- Osteopath
- Acupuncturist
- Homeopath

These treatments have to be prescribed by a Doctor.

1.5.2.3. Other medical treatment

These benefits provide for the reimbursement of actual expenses incurred subject to the stated sub-limit of the overall annual limit per Insured per Policy year for:

1.5.2.3.1. Maternity care

1.5.2.3.1.1. Pregnancy

Cost are reimbursed according to type of outpatient treatment

1.5.2.3.1.2. Childbirth

The covered amount includes reimbursement for doctors' fees, hospital accommodation, other related medical expenses incurred during hospital stay.

Elective caesarean surgery is excluded from cover.

1.5.2.3.1.3. Fertility treatment

1.5.2.3.1.3.1. Diagnosis infertility

Investigative procedures necessary to establish the cause for infertility.

1.5.2.3.1.3.2. Infertility treatment

The expenses related to infertility treatment are covered as out-patient or in-patient expenses, subject to the following conditions:

- i. it has to concern a primary infertility;
- ii. maximum 3 attempts per female plan member are covered;
- iii. maximum € 3.000 per attempt;
- iv. maximum age of the female plan member of 40 years;
- v. the expenses related to the sperm/egg donation are not covered;
- vi. the expenses related to a surrogate mother are not covered.

1.5.2.3.1.3.3. Expenses related to sterilisation

One sterilisation per insured and per lifetime.

1.5.2.3.1.3.4. Ceiling

For the expenses related to artificial insemination (AI) and other similar treatments, there is no maximum number of attempts.

For all expenses related to the above (1.5.2.3.1.3.), there is an overall limit of € 9.000 / £ 6,000 / \$ 11.250.

1.5.2.3.1.4. Waiting period

There is a ten (10) months waiting period for all medical expenses related to maternity care article 1.5.2.3.1. , meaning that only expenses incurred as from the eleventh (11th) month after acceptance into the insurance can be eligible for reimbursement. This waiting period can be waived for the Insured if at the time of converting to this cover; the Insured had been enjoying similar cover. Such waiver is only valid if explicitly mentioned in the Special Conditions attached to this Policy.

1.5.2.3.2. Cancer treatment

If an Insured is diagnosed with Cancer as defined below, the Insurer will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of cancer performed at a legally registered cancer treatment centre subject to the limit of this disability as specified in the Schedule of Benefits. Such treatment (e.g. radiotherapy or chemotherapy excluding experimental treatment, consultation, examination tests, take home drugs) must be received as an inpatient or as an outpatient at a Hospital or a registered cancer treatment centre

immediately following discharge from Hospital confinement or surgery.

Cancer is defined as the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist treatment or surgery (excluding endoscopic procedures alone) is considered necessary. The cancer must be confirmed by histological evidence of malignancy.

1.5.2.3.3. Organ transplant

Reimburses Reasonable and Customary Charges incurred on transplantation surgery for the Insured being the recipient of the transplant of an organ. Payment for this Benefit is applicable whilst the Policy is in force and shall be subject to the limit as set forth in the Schedule of Benefit. The covered amount includes doctor's fees, hospital accommodation (standard private room) and other related medical expenses during hospital stay. Prior approval of the insurer's medical consultant is always required.

Following expenses are excluded from cover:

- costs related to the search for a donor;
- costs for acquisition of the organ (in case a price is charged for the organ);
- costs incurred for removal of organ from the donor.

1.5.2.3.4. Kidney Dialysis

If an Insured is diagnosed with Kidney Failure as defined below, the Insurer will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of kidney dialysis performed at a Hospital or at a legally registered dialysis centre subject to the limit of this disability as specified in the Schedule of Benefits.

Such treatment (dialysis excluding consultation, examination tests, take home drugs) must be received as an inpatient or outpatient.

Kidney failure means end stage renal failure presenting as chronic, irreversible failure of both kidneys to function as a result of which renal dialysis is initiated.

These benefits exclude all experimental treatments.

1.5.2.3.5. Medical aids

ExpatPlus reimburses expenses for hearing aids orthopaedic appliances & stockings, artificial limbs, wheelchair, etc.

1.5.2.3.6. Local ambulance to the nearest hospital

Reimbursement of the Reasonable and Customary Charges incurred for necessary domestic ambulance services (inclusive of attendant) to and/or from the Hospital of confinement. Payment will not be made if the Insured is not hospitalised and subject to the maximum limit set forth in the Schedule of Benefits.

1.5.2.3.7. Psychiatric care

Outpatient psychiatric care reimburses only care prescribed by or performed by a Doctor. The covered amount includes fees of Doctor and/or (treatment fees of) Medical Practitioner, but does not include drugs. Drugs are covered according to the provisions of Prescribed drugs.

1.5.2.3.8. Dental treatment following accident

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

1.6. Pre-certification requirement

All in-patient medical treatments (except emergency hospital admissions), as well as day surgery and day care treatment are subject to pre-certification. This means that in case of non-emergency hospitalisation, day surgery or day care treatment, for which the diagnosis of the medical condition has been established more than **five (5)** days before actual admission into hospital (or before the start of the day care treatment or day surgery), Insurer has to be informed - in writing - at the latest **five (5)** days before the treatment will be performed (in case of childbirth, **five (5)** days before the delivery will take place). The following information is required:

- diagnosis;
- description of the required medical treatment;
- name and address of the hospital where the treatment will be given;
- expected length of stay in the hospital;
- estimated cost of the treatment.

In case of an emergency hospitalization, the Insurer has to be informed as soon as possible (normally within **forty-eight (48)** hours) and at the latest before discharge from the hospital.

In case of failure to comply with the pre-certification requirement, a penalty of **twenty-five (25)** percent will be applied by the Insurer, meaning that the reimbursement of the eligible expenses will be reduced to **seventy-five (75)** percent of the amount the Insured would normally be entitled to if he/she had duly fulfilled the said requirements.

1.7. Restrictions and Exclusions

In addition to the exclusions mentioned in article 11 of chapter I (General Policy Provisions), the following items or services are excluded from cover:

- treatment that is considered experimental/ investigative according to accepted professional medical standards and treatment that is not medically indicated;
- non prescribed medical treatments;
- complementary (and or alternative) medical treatments other than those explicitly mentioned in the table of medical benefits;
- rejuvenation- and spa-cures, cosmetic treatments and convalescent rest;
- facilities for the aged, primarily giving custodial, educational and rehabilitatory care;
- expenses resulting from maternity and childbirth during the first ten (10) months after the individual inception date of cover; unless explicitly waived in the Special conditions;
- non prescribed drugs;
- OTC ('over-the-counter') medicines; lifestyle products, dietary products, vitamins, food supplements and food products, baby food, mineral waters, tonics, cosmetic products etc.;
- expenses related to sterilisation, unless explicitly mentioned in the schedule of benefits;
- contraceptive and birth control drugs, even if prescribed by a physician;
- costs related to abortion except in case of absolute medical necessity;
- cosmetic/aesthetic treatment except restorative treatment following accident;
- surgical procedures costs related to corrective eye surgery (keratectomy and keratotomy, including LASIK- and LASEK-procedures) are excluded from coverage, except in case of refractive illness of the cornea in which case they are covered as any other surgical expenses;
- remedial teaching;
- elective caesarean delivery expenses;
- sex change operations and related treatment expenses;
- sunglasses and orthoptic treatment.

1.8. Claims Procedure / Co-ordination of Benefits - Other Insurance / Claims Payment

1.8.1. Claims procedure

Each claim has to be submitted to the Claims Handler, in writing - using the special claim forms made available by the Claims Handler (e.g. through the dedicated website) - as soon as

possible after the event giving rise to the claim has occurred. The claim has to be accompanied by the original supporting documentation including all relevant invoices, and proof of payment whenever requested by the Insurer.

Moreover, in case of accident, the Insured has to provide following additional information:

- date and detailed description of circumstances and place of the accident;
- identity of persons involved, as well as of witnesses and persons possibly liable;
- official report from local authorities (police or other).

1.8.2. Coordination of Benefits - Other Insurance

If the Insured is entitled to a reimbursement by another insurer or social security system, the amount reimbursed by the other insurance will be deducted from the amount of reimbursement as determined in accordance with the provisions of article 1.5. ('Benefits'). In that case the Insured has to attach (to his/her claim) copies of the pertaining medical bills and the original settlement notes (with details of the amount reimbursed) provided by the other insurer or the social security system concerned.

Total reimbursement for any given claim will never exceed the total amount of expenses actually incurred by the Insured.

1.8.3. Payment of Claim

The Claims Handler shall effect reimbursement of the covered reasonable and customary medical expenses (max. the limits defined in these General Conditions) following the receipt of the claim form and the relevant and complete written evidence of the medical expenses (original invoices of medical providers etc.).

Reimbursements shall be made to the Insured, but if the Insured has deceased, payment shall be made in the sole discretion of the Insurers, or to any person submitting satisfactory evidence that he/she is entitled to such payment.

Benefits may be assigned to hospitals directly.

1.9. Medical Information and Examination

Whenever required for the smooth settlement of the claims related to the insurance cover provided by the insurance policy, and in accordance with Belgian legislation concerning the protection of personal data, the Insured is obliged to provide (directly or through his/her Doctor) all the necessary medical information requested by the Insurer through the Claims Handler. Confidential information may be forwarded under sealed envelope to the Insurer's Medical consultant. Whenever deemed necessary for the assessment

of a claim, the Insurer is allowed to request a medical examination of the Insured, performed by a Doctor appointed by the insurer, at the Insurer's expense. The Insured can ask for his/her own Doctor to be present at this examination, the costs for the own Doctor to be borne by the Insured himself/herself.

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

1.10. Time limitation

Claims should be reported to the Claims Handler as soon as possible after their occurrence.

For some treatments, pre-certification is required (article 1.6. of Chapter II A I , 'Pre-certification requirement').

In any case, claims have to be received by the Insurer (through the Claims Handler) no later than 3 years after the event giving rise to the claim occurred. Beyond this maximum term of 3 years, no claim will qualify for payment by the Insurer.

ExpatPlus Benefits table

Evacuation and repatriation

	GLOBE	ORBIT	UNIVERSE
Repatriation assistance			
Repatriation / Evacuation	100%	100%	100%
• Emergency medical evacuation to the nearest hospital or emergency medical repatriation			
• Accommodation expenses patient and one other insured person	€ 100 / day £ 65 / day \$ 125 / day (max. 7 days)	€ 100 / day £ 65 / day \$ 125 / day (max. 7 days)	€ 100 / day £ 65 / day \$ 125 / day (max. 7 days)
• Transport costs of one accompanying insured person and/or minor children if left alone	100% one-way	100% one-way	100% one-way
Hospitalisation on the spot (> 5 days for adults; > 2 days for children)			
• Transport costs family member	100%	100%	100%
• Accommodation expenses	€ 100 / day £ 65 / day \$ 125 / day (max. 7 days)	€ 100 / day £ 65 / day \$ 125 / day (max. 7 days)	€ 100 / day £ 65 / day \$ 125 / day (max. 7 days)
Early return			
• Transport costs in case of emergency hospitalisation of spouse or child (life-threatening situation)	100%	100%	100%
• Transport costs because of death of first degree family member			
Temporary replacement colleague (transport costs)	100%	100%	100%
Delivery of essential medicines	100%	100%	100%
Rescue costs	€ 750 £ 500 \$ 937,50	€ 750 £ 500 \$ 937,50	€ 750 £ 500 \$ 937,50
Psychological support	2 telephone consultations / insured	2 telephone consultations / insured	2 telephone consultations / insured
Cash advance in case of theft papers, travel documents etc.	€ 400 £ 260 \$ 500	€ 400 £ 260 \$ 500	€ 400 £ 260 \$ 500
Assistance death			
• Repatriation of mortal remains	100%	100%	100%
• Transport costs of all insured family members	100%	100%	100%

Personal Liability

	GLOBE	ORBIT	UNIVERSE
Maximum combined reimbursement / event	max. € 4.500.000 max. £ 3.000.000 max. \$ 5.625.000	max. € 4.500.000 max. £ 3.000.000 max. \$ 5.625.000	max. € 4.500.000 max. £ 3.000.000 max. \$ 5.625.000
• Bodily injury and resulting financial loss / claim	max. € 4.500.000 max. £ 3.000.000 max. \$ 5.625.000	max. € 4.500.000 max. £ 3.000.000 max. \$ 5.625.000	max. € 4.500.000 max. £ 3.000.000 max. \$ 5.625.000
• Property damage and resulting financial loss / claim	max. € 450.000 max. £ 300.000 max. \$ 562.500	max. € 450.000 max. £ 300.000 max. \$ 562.500	max. € 450.000 max. £ 300.000 max. \$ 562.500

2. EVACUATION AND REPATRIATION

2.1. Purpose and eligibility

The purpose of the cover is to provide to the Insured the services mentioned in article 2.3.2. ('Benefits'), in particular the worldwide medical evacuation and repatriation services.

Every person who is accepted into the ExpatPlus medical insurance can automatically enjoy these services.

Newborn children however can only be covered under the emergency medical evacuation and repatriation cover after the 31st day from the date of birth.

The present contract may be taken out by:

*contract taken out by a natural person:
- aged under 75,
- with an expatriate status.

*contract taken out by a corporate entity:
- whose insured employee is under 75 years of age. The present contract cannot be renewed if the insured or any one of the beneficiaries is over 75 years of age.

2.2. Guarantee of Service Delivery

The Insurer guarantees the Insured the delivery of the emergency medical evacuation and repatriation services as described in these General Conditions. To this end, the Insurer has contracted the services out to a worldwide specialised medical assistance services provider (hereafter referred to as the Assistance Provider), 'Mondial Assistance', which will deliver the services concerned on behalf of the Insurer.

In its capacity as the underwriting insurer of the ExpatPlus insurance policy and in particular of the 'emergency medical evacuation and repatriation' cover, the Insurer remains committed to provide to the Insured the services to the extent mentioned in the present Chapter II of the General Conditions, and consequently, will endeavour to fulfil - by its own means or through contracting out to another third party - the contractual obligations and the continuity thereof (e.g. in case of unexpected dissolution or winding up of the operations of Mondial Assistance).

2.3. Benefits

2.3.1. Definitions

'**Accident**': any sudden and unforeseen event, the cause of which is situated outside the victim's

body or the damaged object, which is the cause of the damage.

'**Baggage**': the personal belongings of the insured (purchased or carried personally).

'**Date of effect**': date as from which the Mondial Assistance services are available to the insured.

'**Deductible**': the first part of the eligible expenses left to your account in the settlement of a claim. Deductible amounts pertaining to each benefit are specified in the table of benefits and deductible amounts.

'**Family**': parents, grandparents, descendants, and dependant children aged under 28.

'**Funeral costs**': initial conservation and handling costs, placing in a coffin, specific arrangements for transportation, conservation made compulsory by legislation, packaging and simplest coffin required for transportation and complying with local legislation, excluding burial, embalming and ceremony costs.

'**Jewellery and valuables**': items in gold, silver or other precious metals or semi-precious stones, curios, works of art, photographic, computer and telephone equipment and their accessories.

'**Premium**': the amount to be paid by the person taking out the insurance.

'**Regular flight**': a scheduled flight made by a commercial aircraft the precise times and frequencies of which are in compliance with those published in the Official Airlines Guide.

'**Us - We**': Mondial Assistance France.

'**You**': the holder of the assistance insurance and/or the beneficiary/beneficiaries.

2.3.2. Description of benefits

For specific amounts and limits of the benefits, please refer to the benefits table.

2.3.2.1. Assistance for repatriation, illness or unforeseen events.

2.3.2.1.1. Repatriation assistance

Should your condition require your repatriation, we assist you as follows:

- We organise and cover your return or your transportation to a hospital.

We organise and cover your return to your home, either in your country of origin or in the country in which you are staying or your transportation to the hospital closest to your home and/or best equipped to provide the care your condition requires.

In the latter case, if you so wish, we can, as soon as your condition allows it, subsequently organise and cover the return to the country in which you are staying.

- We organise and cover the return of an insured accompanying person and of minor children. After agreement from our medical service, we organise and also cover the trip of an insured person with you on the spot to enable that person to accompany you and/or the return to their home of minor children travelling with you if no adult member of your family is present on the spot with them and if your repatriation take place more than 24 hours before their initial date of return.

- Reimbursement of your costs of accommodation and of those incurred by the insured members of your family or of an insured person accompanying you.

Upon presentation of the necessary proof and within the limits shown in the table of benefits, we reimburse you for your additional accommodation costs and those incurred by the insured members of your family or of an insured person accompanying you from the date of your immobilisation up to the date of your repatriation to your country of origin.

All the medical costs (costs of hospitalisation, medical visits, payment of guarantees and reimbursements) will be managed and paid by Vanbreda International.

Mondial Assistance will be responsible for implementing the services related to medical emergencies such as hospitalisation and repatriation. Any urgent hospitalisation shall be notified to Vanbreda International which will issue the guarantees of payment and be responsible for the smooth processing of the file. Hospitalisation, whether it is urgent or otherwise, but which does not necessitate repatriation will be managed directly by Vanbreda International.

IMPORTANT

Decisions are made on the basis of your medical condition only.

Our doctors will contact the medical organisations on the spot, and, if necessary, your usual general practitioner, in order to collect all the information enabling them to take the decisions best suited to

your state of health.

Your repatriation will be decided upon and managed by medical staff holding a legally recognised degree in the country in which the said medical staff has its usual place of business. Should you refuse to comply with the decisions made by our medical department, you release us from any liability with respect to the consequences such as an initiative, and will lose any and all rights to compensation and damages from us.

Moreover, we cannot under any circumstances replace local emergency rescue services, or cover the costs thus incurred.

2.3.2.1.2. Hospitalisation on the spot

We cover the costs enabling a member of your family to come to your bedside.

If you are hospitalised for more than 5 days or more than 48 hours if you are a minor or disabled and if no adult member of your family was accompanying you during your stay:

we cover the return ticket for a member of your family to enable him/her to come to your bedside; provided that proof of expenditure is submitted, and within the limits indicated in the table of benefits, we refund the additional accommodation costs incurred by that said person.

This service cannot be combined with the guarantee 'Organisation and coverage of the return of an insured accompanying person and minor children'.

2.3.2.1.3. Search and/or rescue costs

We refund the costs of search at sea or in the mountains and/or the rescue costs incurred up to the limit of the ceiling shown in the table of benefits.

2.3.2.1.4. Assistance for an early return

Insofar as the means initially scheduled for your return to your country of origin cannot be used, we organise and cover the costs of the return trip of one of the insured persons under the present contract.

You can benefit from this service in the following cases:

- in the event of illness or accident resulting in emergency hospitalisation, starting during the period of your stay and involving a life threatening situation in the opinion of our medical staff, of your de jure or de facto spouse, of any one of your minor or disabled descendants not taking part in the trip and living in the country of origin of the insured;

- to attend the funeral, following the death of your de jure or de facto spouse, of any one of your forbears, descendants, brothers, sisters, your legal guardian, of the person under your guardianship, not taking part in the trip and living in the country of origin of the insured and less than 80 years old.

2.3.2.1.5. Assistance in the event of an interruption in your professional assignment

In the event of your professional assignment being interrupted subsequent to a covered event, we cover the transportation costs incurred by your company to enable a colleague to replace you and continue the interrupted assignment.

2.3.2.1.6. Sending of medication on the spot

Should you be staying in a foreign country and require medicine which is not available on the spot:

- subject to the approval of your prescribing general practitioner, we will cover the cost of sending medicine which is not available on the spot, provided that such medicine be indispensable for a current medical treatment, that no equivalent medicine can be prescribed to you on the spot, and that national or international health and customs regulations do not prohibit the sending of such medicine;
- we will send you such medicine in the shortest possible time. We cannot, however, be held liable for the time taken by the transport companies used or for any unavailability of the medicine.

You undertake to refund the said medicine within a period of three months following receipt thereof, failing which we will be entitled to claim legal interest and expenses, above and beyond the cost of the medicine.

2.3.2.1.7. Assistance for unforeseen events

- Communication with your family or firm
If you can no longer communicate with your family or company, we will forward your urgent messages to them if you succeed in communicating with us.
- Theft of your identity papers, credit card, transport tickets or professional documents:

If your identity documents, credit cards and/or travel tickets are stolen:

- we can give you advice as to the steps to be taken;
- we can contact financial institutions with a view to stopping payment, insofar as you fax us a written proxy to do so;
- if you no longer have any means of payment, we

grant you an advance of money to an amount not exceeding the ceiling shown in the table of benefits.

In that case, you benefit from a period of three months, as from the date on which the funds were made available, to refund the said advance or the costs incurred by us on your behalf.

Upon the expiry of that period, we shall be entitled to claim in addition the legal costs and interest.

2.3.2.1.8. Psychological support

We place at your disposal our service of telephone reception and support within the limits shown in the table of benefits and deductibles in the event of any major trauma following an illness or covered accident.

2.3.2.2. Assistance in the case of death

Assistance in the event of the death of an insured person

In the event of the death of an insured person, we organise and cover:

- the transport of the body from where it is placed in the coffin to its place of burial in the country of origin or burial on the spot;
- the funeral costs required for transport, within the limit of the ceiling shown in the table of benefits;
- the additional costs for the transport of the insured members of the family of the deceased accompanying the deceased insofar as the means initially planned for their return to the country of origin can no longer be used as a result of the death.

2.3.2.3. Additional 'Maf Expat' assistance

You benefit from a dedicated Web site enabling you to consult the health and geopolitical information concerning the geographic area of your country of expatriation with in particular the list of health establishments and of medical practitioners, and all the necessary practical information (translation of medical terms, list of embassies, etc.), with links to service providers (e.g. car rental firms), plans of airports, city maps, and a guide to behaviour (customs of the country concerned).

2.3.3. Benefits exclusions

In addition to the exclusions common to all the benefits (2.4.), the following are also excluded: Under all the 'Repatriation, illness and unforeseen events' assistance and under 'Assistance in the case of death':

1. costs incurred without the prior agreement of our Assistance service;
2. the consequences:
 - of an illness under treatment and not stabilised for which you are in convalescence;
 - illnesses occurring during a trip undertaken for diagnostic purposes;
 - illness occurring during a trip undertaken for treatment purposes;
3. the eventual sequelae (control, additional treatment, recurrences) of an illness having already resulted in two previous repatriations;
4. the consequences of illnesses or benign lesions that can be treated on the spot;
5. pregnancy, other than any clear, unforeseeable complications and, in all cases, voluntary termination of pregnancy, childbirth, in vitro fertilisation and their consequences;
6. psychiatry;
7. the consequences:
 - of situations with risks of infection in an epidemic context;
 - of exposure to infectious biological agents;
 - of exposure to combat gas type chemical agents;
 - of exposure to incapacitating agents;
 - of exposure to neurotoxics or agents with remanent neurotoxic effects;
 which are subject to quarantine or preventive measures or specific monitoring on the part of the local and/or national health authorities in the country where you are staying, except for a sudden occurrence after your arrival in the area of contamination.
8. your participation in any sport as a professional or under contract providing for remuneration, as well as any preparatory training;
9. your failure to comply with official prohibitions, as well as failure to observe official safety regulations linked to the practice of a sport;
10. the consequences of an accident during your participation in an air sport (including hang gliding, paragliding, gliding) or in any of the following sports: skeleton, bobsleigh, ski-jumping, mountain-climbing with roping, rock-climbing, skin diving with self-contained apparatus, spelunking, bungee-jumping, skydiving;
11. costs not explicitly indicated as giving rise to reimbursement, as well as catering costs, and any expense for which you are not able to provide documentary evidence.

2.4. Exclusions common to all the benefits

In addition to the specific exclusions indicated for each benefit, we never insure the consequences of

the following circumstances and events:

- civil or foreign war, riots, demonstrations, strikes, hostage-taking, handling of weapons;
 - your voluntary participation in bets, crimes or brawls, except in the case of self-defence;
 - any and all effects of nuclear origin, or caused by any source of ionising radiation;
 - your intentional acts and faults, including suicide and suicide attempts;
 - your consumption of alcohol, drugs or any other narcotic mentioned in the Public Health Code, not covered by a doctor's prescription;
 - events for which liability may be incumbent either upon the organiser of your trip, by application of chapters VI and VII of the French law no. 92-645 of July 13, 1992 laying down the conditions for carrying on the business of organising and selling stays, or upon the carrier, in particular for reasons of air safety and/of over-booking;
 - your refusal to embark on the flight initially scheduled by the authorised agency.
- The guarantees of the present contract shall end without further consideration or enquiry upon the seventy fifth (75th) birthday on the insured and his/her beneficiaries

2.5. Financial commitment of Mondial Assistance

The organisation by the beneficiary or by those with him/her can give entitlement to reimbursement of one of the cases of assistance set out above only if Mondial Assistance has been previously advised thereof and given its explicit agreement, in particular concerning the means to be used, by sending the information by fax, e-mail, telegram or telex, with a file number. The costs incurred will then be reimbursed upon production of the relevant evidence, within the limits committed by Mondial Assistance to organise the service.

2.6. Subrogation

Mondial Assistance is subrogated, up to the compensation paid and the services provided thereby, in the rights and actions of the policy holder against any person responsible for the facts having caused its intervention.

When the services provided in performance of the contract are covered, totally or partly, by a Social Security Fund or by any other institution, Mondial Assistance shall be subrogated in the rights and actions of the insured against the said fund or institution.

2.7. Time limitation

Any action resulting from the 'ExpatPlus - Assistance' cover is time-lapsed after a period of 2 years as from the event of the causal event.

2.8. What to do in the event of a claim

For any request for assistance

You must contact us, or have a third party contact us, as soon as your situation leads you to presume that you will require an early return or expenses falling within the scope of our cover.

Our services are available 24 hours a day and 7 days a week:

by telephone on no. + 32 3 217 69 78

You will immediately be given a file number, and we will ask you to:

- specify your contract number no. 241 676,
- provide an address and telephone number where you can be contacted, as well as the contact information for the people taking care of you,
- allow our doctors to have access to any and all medical information concerning you or the person for whom our intervention is required.

For any demand for reimbursement

In order to benefit from a refund of the expenses paid by you with our approval, you will be required to submit all the documents serving as grounds for your claim.

Services which were not applied for beforehand and that were not organised by our department do not entitle you to any refund or compensation.

For the coverage of transport costs

When we organise and cover transportation falling within the scope of our guarantees, such transportation will be undertaken by train, 1st class, and/or by air, economy class, or by taxi, depending on the decision of our Assistance department. In such cases, we become the owners of the initial tickets and you undertake to return them to us or to refund the amount reimbursed to you by the body having issued the said travel tickets.

2.9. Framework of our assistance interventions

Our interventions are undertaken within the framework of national and international laws and regulations and our services are provided subject to obtaining the required permission from the authorities entertaining jurisdiction.

Moreover, we cannot be held liable for delayed performance or failure to provide the services

agreed upon in any case of force majeure or of occurrences such as strikes, riots, demonstrations, restrictions on free circulation, sabotage, terrorism, civil or foreign war, consequences of the effects of a source of radioactivity or any other fortuitous event.

3. PRIVATE LIFE THIRD PARTY LIABILITY (PERSONAL LIABILITY)

3.1. Scope

We guarantee the financial consequences of any private liability incurred by you under the application of the legislation or case law of the country in which you are, resulting from:

- bodily injuries;
- damage to property;
- consequential immaterial damage resulting from guaranteed bodily injuries or damage to property, following an accident in the course of your private life and affecting a third party;
- caused by you;
- caused by people for whom you are responsible;
- caused by objects or animals in your charge.

3.2. Subsidiarity

You benefit from the cover during your stay abroad only in those countries where you do not benefit from any other private liability insurance taken out elsewhere.

3.3. Amount of the benefit

The cover is granted up to the limit of the ceilings shown in the table of benefits, it being understood that:

- the limit per event shown in the table of benefits is the maximum amount guaranteed for one and the same event, inclusive of all forms of bodily injury, damage to property and direct consequential damages;
- in all cases, a deductible per claim of 75 € / 50 £ / 100 \$ remains for your account.

3.4. Benefits exclusions

In addition to the exclusions common to all the guarantees (2.4.), the following are also excluded:

1. the consequences of damage caused to members of your family, your agents, whether or not they are salaried, in the exercise of their functions or any other person listed as insured under the present contract;
2. the consequences of damage caused to animals or objects belonging to you or that have been loaned, lent or entrusted to you;
3. the consequences of damage caused by:
 - any overland motor vehicle corresponding to the definition of Article L 211-1 of the Insurance Code;
 - any overland vehicle designed to be towed by an overland motor vehicle;

- any air, maritime or river navigation apparatus;
- 4. the consequences of damage resulting from the practice of shooting, mechanical sports (car, motorcycle and more generally any overland motor vehicle) and all aerial sports;
- 5. the consequences of damage caused to third parties and resulting from the organisation of, preparation of or participation in a competition organised under the aegis of a sports federation, subject to administrative authorisation or to an obligation of legal insurance;
- 6. the consequences of damage caused in the course of your professional activity or during your participation in an activity organised by any non profit making association, institution or community;
- 7. the consequences of your contractual responsibility;
- 8. the consequences of any liability you may have relating to a fire, explosion or water damage.

Furthermore, no fines or pecuniary sentences handed down as punishment and not forming the direct redress of any bodily injury or damage to property are ever guaranteed.

3.5. Application procedures in time

The operation of the cover is stipulated in the Law no. 2003- 706 of August 1, 2003.

The benefit triggered by the damage-causing event covers the insured against the pecuniary consequences of his liability when the damage-causing event occurs between the initial coming into effect of the benefit and the date of its termination or expiry, irrespective of the date of any other elements involved in the claim.

3.6. What to do in the event of a claim

- You must neither accept any acknowledgement of liability nor any transaction without our agreement. Nevertheless, the admittance of a material fact or the performance of a simple duty of assistance does not constitute an acknowledgement of liability. You must send us a declaration of the claim, in writing, within the five working days following your knowledge thereof, except for fortuitous cases and any case of force majeure.
Upon expiry of that period, if we suffer any prejudice as the result of a late declaration, you will lose all your rights to compensation.
- In the event of any proceedings being taken against you, you give us full powers to handle the suit and to use any recourse in the civil courts or to ensure your defence and use any recourse

in civil interests before the criminal courts. You must forward to us upon receipt any summons, writ, extrajudicial instrument or procedural exhibit sent to or served upon you. In the event of delay in forwarding such documents, we are entitled to claim from you compensation in proportion to the prejudice suffered by us (Article L 113-11 of the Insurance Code).

If you fail to meet your obligations after the claim, we compensate the injured third parties and their beneficiaries, but we can take proceedings against you to recover the amounts paid.

3.7. Provisions in the event of an annuity being granted to a victim by a legal decision

Should a security be ordered for the payment of an annuity, we constitute the guarantee up to the amount of our coverage.

If no cover is organized, the value of the annuity is calculated according to the rules applicable for the calculation of the mathematical reserve of the annuity. If that value is less than the amount of our guarantee, the annuity is entirely for our account. If it is higher, only the part of the annuity corresponding in capital to the amount of our guarantee is for our account.

B. OPTIONAL EXTENSIONS

1. OPTIONAL DENTAL INSURANCE

1.1. Eligibility

The optional dental insurance is only open to persons who are accepted into the medical insurance plan.

The choice for taking out the dental insurance has to be made on a family level in that sense that all members of the same family, i.e. the Insured and his/her dependants who are accepted into the medical insurance, have to

- a) take out the dental insurance or not (i.e. all family members or none);
- b) opt for the same dental plan (Basic or Comprehensive).

If the dental plan has been subscribed, it has to be maintained for at least one year (unless the contract is terminated).

1.2. Territorial scope of the insurance

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

- a. Worldwide cover
- b. Worldwide cover with exception of medical expenses incurred in the United States of America (USA) and in Canada.

However, during business trips or holidays, not exceeding (in total) ninety (90) days per Insurance year, medical expenses incurred in the USA or Canada as a direct consequence of an accident or a medical emergency (for definition of 'accident' and 'emergency' please see article 2) are covered up to the limits of the policy. If the medical condition concerned already existed prior to the travel to the USA or Canada and was the objective of the travel, the medical expenses are not covered. Expenses related to pregnancy (and complications thereof) and/or childbirth will not be considered to be accident or emergency expenses, and will therefore not be covered.

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

1.3. Benefits

Only expenses that are 'reasonable and customary' can qualify for reimbursement, subject to the limits and ceilings as mentioned in table of benefits on the next page:

1.3.1. Basic dental care

Basic dental care Includes up to 2 periodic check-ups per year, prophylactic treatments, fillings, root canal treatment, extraction, Para dental treatment, treatment of paradontosis, treatment of gums, etc.

1.3.2. Major dentistry

Major dentistry covers bridges, implants, orthodontic treatment and dental prostheses (dentures, crowns, inlays). The amount covered includes the fees of the Dentist (or Dental Surgeon). Dental surgery falls also under major dentistry

1.4. Waiting period and age limit

- A waiting period of twelve (12) months applies for all major dentistry. The waiting period can be waived for groups if at the time of affiliation the members of this group had been benefiting from a similar cover. Such waiver is only valid if explicitly mentioned in the Special Conditions.
- Orthodontic treatment is only covered if started before age fifteen (15).

1.5. Other provisions

Apart from the General Policy Provisions as set out in Chapter I of the General Conditions, the provisions of articles 1.8 up to and including 1.10 of Chapter II ('Provisions proper to the different types of cover') also apply to the Dental Insurance Plan.

Dental care

	BASIC	COMPREHENSIVE
Maximum annual reimbursement per insured	€ 3.000 £ 2.000 \$ 3.750	€ 5.000 £ 3.250 \$ 6.250
Basic dental care (check-ups, basic treatments)	80% up to € 1.500 80% up to £ 1.000 80% up to \$ 1.875	100% up to € 2.500 100% up to £ 1.625 100% up to \$ 3.125
Major dentistry (orthodontic, prostheses, bridges, implants) ³	60% up to € 1.500 60% up to £ 1.000 60% up to \$ 1.875	80% up to € 2.500 80% up to £ 1.625 80% up to \$ 3.125

³ Orthodontic treatment is only covered if started before age 15.
A waiting period of 12 months applies to all major dentistry for individuals.

2. PERSONAL ACCIDENT COVER (Accidental Death & Dismemberment)

2.1. Purpose and eligibility

The purpose of the Personal Accident Cover is to guarantee:

- payment of a lump sum in case of accidental death
- or
- payment of a lump sum in case of permanent invalidity of at least 20%, caused by an accident.

The Personal Accident Cover can be taken out for or by the expatriated person as well as by his/her adult dependants (spouse or legal partner/ children as from age 18) insofar as these persons are also accepted in and covered by the Medical Insurance Cover.

2.2. Definition of Accident

For the definition of Accident, reference is made to article 2 of the General Policy Provisions.

2.3. Time limits for the declaration of the accident, claim assessment and benefits payment

2.3.1. Time limit for the declaration of the accident

Any accident resulting in - or which may result in - permanent invalidity or death of the Insured, has to be declared in writing to the Insurer or the Claims Handler within a fortnight after the accident occurred.

The declaration of the accident should contain detailed information relating to the cause of the accident and the nature of the injuries.

2.3.2. Time limit for claim assessment and benefits payment

In case of accidental death, which has to occur within 12 months after the date of the accident causing the decease, a lump sum payment will be effected to the designated beneficiaries of the deceased Insured as indicated on the 'Designation of Beneficiaries'-form.

In case of permanent invalidity, the invalidity must be medically recognised at the latest 1 year after the date of the accident. However, if the Insured's condition has not entirely stabilised within 2 years after the date of the accident, the degree of permanent invalidity will be assessed on the basis of the Insured's state of health at the end of that 2 years' period.

2.4. Amount of the sum insured

The amount of the sum insured is specified in the Special Conditions. However, the minimum sum insured shall be € 50.000 / £ 32,500 / \$ 62.500 and can be increased up to a maximum sum insured of € 500.000 / £ 325,000 / \$ 625.000. Premiums and benefits (lump sum) are calculated on the basis of the sum insured.

2.5. Insured Benefits

2.5.1. Accidental Death

In case of death of the Insured, caused by an accident, the lump sum payable by the Insurer (to the beneficiaries of the Insured) will be equal to 100% of the sum insured, the amount of which is mentioned in the Special Conditions. In case the Insurer paid a benefit for accidental permanent invalidity, the benefit payable in case of ensuing death (within the time frame as mentioned in article 2.3. of the present chapter) caused by the same accident which led to the invalidity will be reduced by the amount already paid for the invalidity.

2.5.2. Accidental Permanent Invalidity

In case of Permanent Invalidity of the Insured caused by an accident, the lump sum payable by the Insurer (to the Insured) will be equal to the amount of the sum insured (as mentioned in the Special Conditions) multiplied by the degree of invalidity (percentage), the latter being determined in accordance with the 'Table of Invalidity' hereafter. Permanent Invalidity of a degree of less than 20% will not qualify for payment of any benefit.

If the Permanent Invalidity caused by the accident amounts to 20% or more than 20% according to the 'Table of Invalidity' hereafter, the benefit amounts to the corresponding percentage (%) of the sum insured.

2.6. Assessment of the degree of Permanent Invalidity and use of the 'Table of Invalidity'

2.6.1. Table of Invalidity

Following Table of Invalidity will be used to determine the degree of invalidity:

Total paralysis	100%	
Total blindness	100%	
Incurable and total mental disability	100%	
Amputation or the permanent loss of the use of:		
a) both arms or both hands	100%	
b) both legs or both feet	100%	
c) one arm or hand and one leg or foot	100%	
Total loss of sight of one eye with removal of the eye	50%	
Total loss of sight of one eye	45%	
Loss of bone of the skull forming a hole in the skull over:		
a) an area of at least 6 cm ²	40%	
b) an area of 3 to 6 cm ²	20%	
c) an area of less than 3 cm ²	10%	
Incurable total loss of hearing in both ears	100%	
Incurable total loss of hearing in one ear	50%	
Amputation of the lower jaw		
a) total	70%	
b) partial (upright branch plus the whole or half of the up toillary bone)	40%	
Loss of top and bottom teeth and their sockets		
a) impossibility of fitting dental prosthesis	10 to 30%	
b) In the case of possible prosthesis with established functional improvement	1 to 10%	
	Right Left	
Loss of arm or hand	75%	60%
Total paralysis of an upper limb	65%	55%
Total paralysis of the circumflex nerve	20%	15%
Total paralysis of the median nerve	45%	35%
Total paralysis of the cubital nerve at the elbow	30%	25%
Total paralysis of the nerve of the hand	20%	15%
Total paralysis of the radial nerve above the triceps	40%	30%
Complete ankylosis of the shoulder:		
a) with immobilisation of the shoulder-blade	65%	55%
b) with mobility of the shoulder-blade	35%	25%
Non-consolidated fracture of the upper arm: (constitution of pseudo-arthrosis)	30%	25%

Total loss of movement of the elbow:		
a) in an unfavourable position	40%	35%
b) in a favourable position	25%	20%
Non-consolidated fracture of the fore-arm: (constitution of pseudo-arthrosis)		
a) both bones	25%	20%
b) a single bone	10%	8%
Total loss of movement of the wrist		
a) in an unfavourable position (flexion, forced extensions or supination)	40%	30%
b) in a favourable position (straight or prone)	20%	15%
Amputation of a thumb		
a) total	20%	18%
b) partial (ungual phalanx)	10%	8%
Ankylosis of a thumb		
a) total	15%	12%
b) partial (ungual phalanx)	10%	8%
Amputation of index-finger		
a) total	16%	14%
b) two phalanxes	12%	10%
c) one phalanx	6%	5%
Amputation of second finger	12%	10%
Amputation of third finger	10%	8%
Amputation of fourth finger	8%	6%
Total paralysis of a lower limb		60%
Complete paralysis of the internal popliteal sciatic nerve		30%
Complete paralysis of the external popliteal sciatic nerve		30%
Complete paralysis of both popliteal sciatic nerves		40%
Shortening of a lower limb		
a) at least 5 cm		30%
b) from 3 to 5 cm		20%
c) from 1 to 3 cm		10%
Complete ankylosis of the hip:		
a) in a bad position (flexion, adduction or abduction)		60%
b) in a straight position		40%
Amputation of the thigh:		
a) upper half and leg		60%
b) lower half and leg		50%
Non-consolidated fracture of the thigh or both bones of the leg (constitution of pseudo-arthrosis)		50%

Complete ankylosis of the knee:	
a) in flexion (from 130 degrees)	50%
b) straight or almost straight	25%
Chronic gonarthrosis according to the degree of muscular atrophy	3 to 20%
Non-consolidated fracture of the knee-cap with wide separation of the fragments and considerable difficulty in extension of the leg from the thigh	40%
Amputation of a leg	50%
Tibio-tarsian ankylosis	15%
Amputation of a foot:	
a) total (tibio-tarsian disarticulation)	50%
b) sub-astragalian	40%
c) media-tarian	35%
d) tarso-metatarsian	30%
Amputation of all toes	20%
Amputation of big toe	10%
Amputation of a toe other than big toe	3%
Ankylosis of the big toe	3,5%

2.6.2. Permanent nature of the invalidity

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

2.6.3. Pre-existing state of infirmity

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

2.6.4. Maximum degree of invalidity

The degree of permanent invalidity can never exceed 100%.

Under no circumstances the sum payable by the insurer will exceed 100% of the sum insured.

2.6.5. Several injuries affecting the same limb

In case of several injuries or infirmities resulting from the same accident or from successive accidents, each injury or infirmity will be assessed separately, but the sum of injuries or infirmities affecting a limb may not lead to a degree of invalidity exceeding the degree of invalidity corresponding to the full loss of the limb concerned.

2.6.6. Events or infirmities not listed in the Table of Invalidity

For events or infirmities not listed in the 'Table of Invalidity', the degree of invalidity shall be determined by reference to the listed events or infirmities: the 'Table of Invalidity' will be used as a guide to assess the degree of invalidity by analogy with listed items.

The sum payable will in no case be less than the amount payable for any reasonably analogous event or infirmity, listed in the table of invalidity.

2.6.7. Total loss of use of a limb

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

2.6.8. Left-handed persons

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

2.6.9. Aggravating facts

In the case of aggravation of the consequences of an accident as a result of infirmities, sickness or circumstances independent of the accidental cause, the degree of invalidity cannot be superior to the one that would have been determined if the accident had struck a healthy organism.

2.7. Additional exclusions

In addition to the general exclusions mentioned under article 11 and 12 of the General Policy Provisions, following exclusions shall apply to the Personal Accident Cover (Accidental Death & Dismemberment):

- accidents resulting from obviously foolhardy and/or reckless acts by the Insured, or accidents he/she has intentionally caused or provoked;
- he consequences of suicide or of suicide attempts;
- accidents occurring in a state of drunkenness or under the influence of non-prescribed drugs except if it is established by the insured or the beneficiaries that such state was not the cause of the accident;
- accidents provoked by ionising radiations other than the medical radiations required by covered medical treatment;
- invalidity and/or death resulting from an illness.

2.8. Obligations to be fulfilled by the insured

2.8.1. Declaration of accident

Any accident that leads or that could lead to invalidity or death must be declared in writing to the Insurer (through the Claims Handler) within a fortnight after the accident occurred.

The declaration must contain all information relating to the accident, including:

- place, date and detailed circumstances of the accident;
- names and addresses of persons involved;
- names and addresses of witnesses and of persons possibly liable;
- the official report from the local authorities (e.g. police report or other relevant documents).

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

2.8.2. Changes to the extent of the invalidity

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

2.8.3. Medical information

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

2.8.4. Force Major

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

2.9. Payment of the Benefit

At the inception of the policy, the Policyholder has to provide the Claims Handler with the 'Designation of Beneficiaries'-form, duly filled out and signed by the Insured.

In case of death caused by an accident, the Insurer will pay the lump sum insured to the Insured's designated beneficiaries (or the lawful heir(s) in case no beneficiaries have been declared on the said form) within a month of receiving:

- the documents mentioned under article 2.8.1. ('declaration of Accident'), and
- copy of the birth certificate of the deceased or a certificate of civil status, and

- an original death certificate, and
- a medical certificate, established by a Doctor, stating the cause of death.

Before the claim can be paid, the causal link between the accident and death should have been established.

The burden of proof lies with the beneficiaries.

In case of permanent invalidity caused by an accident, the Insurer will pay the lump sum insured to the Policyholder. Following documents have to be provided to the Claims Handler:

- the documents mentioned under article 2.8.1 ('declaration of Accident');
- copy of the birth certificate of the Insured concerned or a certificate of civil status;
- a detailed medical certificate, established by the attending physician, stating the cause of the invalidity, accompanied by all relevant documents needed to accurately assess the invalidity (cf. article 2.6. above).

After all documents have been received by the Claims Handler and the condition of the Insured concerned has sufficiently stabilised to allow the Insurer's Medical consultant to assess degree of invalidity (according to the provisions as set out in article 2.6. 'Assessment of the degree of permanent invalidity'), payment of the insured sum due will be made within one month.

3. TEMPORARY INCAPACITY COVER (Loss of Income)

3.1. Purpose and Eligibility

The purpose of the Temporary Incapacity Cover is to guarantee to the Insured, after the waiting period as defined hereafter, the payment of a monthly allowance during a maximum period of 2 years, in case the Insured is totally unable to perform his/her professional occupation.

The Temporary Incapacity Cover can only be taken out for or by an expatriated employee and is not available to the dependants (spouse or legal partner/children) of the insured employee.

3.2. Medical Acceptance into the Insurance

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

3.3. Temporary Incapacity Benefit

The 'temporary incapacity' insurance provides for a monthly allowance in case the Insured - further to an accident or an illness - is totally unable to perform his/her own professional occupation (i.e. the usual professional occupation at the time the incapacity started).

3.4. Waiting Period

The allowance is payable after a waiting period of 90 days (for which no benefits are due) of uninterrupted total incapacity to perform the own professional occupation.

The waiting period shall commence on the starting date of the incapacity, as determined by the treating physician.

3.5. Assessment of the Incapacity

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

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

3.6. Amount and duration of the Benefit

The amount of the monthly allowance in case of total incapacity of the Insured to perform his/her

own professional occupation is mentioned in the Special Conditions.

The minimum amount to be insured is € 1.000 / £ 650 / \$ 1.250 (monthly allowance). The amount insured cannot exceed 80% of the gross (monthly) salary of the Insured, nor can it exceed an amount of € 10.000 / £ 6,500 / \$ 12.500 per month.

The Policyholder shall submit to the Plan Administrator a copy of the latest salary statement of the Insured.

After the waiting period of 90 days, the allowance will be paid as long as the insured is unable to perform his/her occupation, limited however to a maximum period of 2 years.

3.7. Partial resumption of work

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

In case the incapacity would become less than 30%, the allowance will be discontinued.

3.8. Relapse

In the event of a relapse, the payment of the allowance shall be resumed without application of a new waiting period. By a relapse is meant the incapacity to work, which arises within three months of the end of incapacity covered by this insurance policy, and which is caused by the same illness or the same accident.

Any additional incapacity resulting from another cause shall be subject to a new waiting period of 90 days.

3.9. Benefit payment

The incapacity allowance shall be payable, to the Policyholder, at the end of each month, and for the first time at the end of the month following the expiration of the waiting period. If the incapacity to work comes to an end in the course of a month, the allowance shall be proportional to the number of days lapsed in that month.

Payments shall cease at the event of one of the following occasions:

- when the degree of incapacity becomes less than 30%;

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

3.10. Additional exclusions

In addition to the general exclusions mentioned in article 11 and 12 of the General Policy Provisions, the following exclusions apply to the Temporary Incapacity cover:

3.10.1. Maternity leave and childbirth

Maternity leave and incapacity to work because of childbirth are not covered. They will not be taken into account for the calculation of any waiting period and will not give rise to any benefits.

In case the Insured would however be in receipt of benefits for temporary incapacity for other reasons (than childbirth or maternity leave) during which period the maternity leave would start, the payment of benefits will be suspended to resume only after the end of the maternity leave, and only in case if the Insured is then still unable to resume work.

If on the expiry date of the normal maternity leave of a female Insured, a health condition exists which prevents the Insured from fully resuming her usual professional occupation (total inability to work), the waiting period will start as from that date.

3.10.2. Dangerous sports

- Incapacity resulting from any sport for professional purposes, even as a secondary profession;
- or any remunerated participation in sports competitions;
- or any unremunerated practice of sports reputed to be rash and hazardous, such as :
 - rugby;
 - winter sports competitions and races ;
 - aerial sports (except ballooning);
 - hunting big game (including safari);
 - speleology and cave diving;
 - alpinism, if not on official paths;
 - motor vehicle racing on land and water (except non-competitive recreative Jet Ski, recreative water ski, or tourist rallies for which no time or speed imperatives have been imposed);
 - rafting, canyoning, bungee jumping and similar sports.

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

3.11.1. Notification of incapacity

In case of incapacity to perform the usual professional occupation because of illness or accident, such incapacity has to be notified by the Policyholder to the Claims Handler in writing as soon as possible and at the latest on the ninety first (91st) day of the incapacity. At the same time, a medical report, established by the treating Physician of the incapacitated person, indicating the nature and extent of the incapacity of the Insured as well as the probable duration of the incapacity, has to be forwarded to the Claims Handler, for the attention of the Insurer's Medical consultant.

Furthermore, a proof of income has to be provided.

3.11.2. Changes to the extent of the incapacity

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

3.11.3. Medical information

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

3.11.4. Force Major

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

4. PERMANENT DISABILITY COVER

4.1. Purpose and eligibility

4.1.1. Purpose

The purpose of the Permanent Disability Cover is to guarantee payment of a monthly disability allowance, (maximum up to age of sixty five (65)) to the Insured who is affected by a permanent disability caused by an illness or accident, prohibiting him/her from fully or partially continuing his/her professional occupation, therefore leading to a total or partial loss of income.

The insurance covers permanent disability caused by an illness or accident and amounting to a degree exceeding 33,33%.

Moreover, in case the degree of disability exceeds 66,67%, and if the Insured needs the assistance of a third person to perform the basic activities of daily living, the insurance guarantees an additional lump sum benefit, in accordance with the provisions as set out below.

4.1.2. Eligibility

The Permanent Disability Cover can only be taken out as an additional insurance (supplement) to the Temporary Incapacity Cover. The Permanent Disability Cover can only be taken out for or by an expatriated employee and is not available to the dependants (spouse or legal partner/children) of the insured employee.

4.2. Medical Acceptance into the Insurance

Joining the Permanent Disability Cover is subject to the acceptance of the candidate-insured into the insurance by the Insurer's Medical consultant.

4.3. Definition of Permanent Disability (resulting from an illness or accident)

4.3.1. Disability

An Insured is considered to be disabled because of illness or accident, if:

- his/her ability to work, i.e. the ability to perform his/her normal professional occupation (occupation at the time the disability started) or any other gainful occupation for which he/she is reasonably fitted by training, education or experience,

and

- his/her ability to function in general has been reduced because of the illness or accident concerned. In order to qualify for the insured benefits, it has to be medically determined that the Insured's disability is of a permanent nature

and that the degree of (the combination of both) occupational and functional disability exceeds 33,33% according to the disability table hereafter (article 4.6.).

4.3.2. Permanent

'Permanent' means that continuation of the medical treatment will not lead to any significant improvement of the person's state of health, and that the disability will therefore be definitive and irreversible.

4.4. Waiting period

The Permanent Disability Cover is a supplement to the Temporary Incapacity Cover.

Benefit payment will therefore start at the earliest after the allowances paid by the Insurer within the framework of the Temporary Incapacity Cover have come to an end.

4.5. Assessment of disability

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

4.6. Amount and duration of the benefit

4.6.1. Calculation of the amount of the monthly disability allowance

Insured allowance

The amount of the insured allowance is mentioned in the Special Conditions. In no event, the amount of the insured allowance shall be higher than the monthly allowance of the Temporary Incapacity Cover.

Deductible

No benefits will be due for disabilities of less than 33,33% (=1/3).

Degree of permanent disability between 33,33% (= 1/3) and 66,67% (=2/3)

If the degree of disability, as determined in accordance with the stipulations of articles 4.3. and 4.5. above, is situated between 33,33% and 66,67%, then the amount of the disability allowance will be calculated as follows: $((3 \times n) - 1) \times \text{insured allowance}$, 'n' being the degree of disability (%).

Disability table

Degree of occupational disability	Degree of functional disability								
	20%	30%	40%	50%	60%	70%	80%	90%	100%
10%						36,59	40,00	43,27	46,42
20%				36,94	41,60	46,10	50,40	54,51	58,48
30%			36,54	42,17	47,62	52,78	57,69	62,40	66,94
40%			40,00	46,2	52,42	58,09	63,50	68,68	73,68
50%		35,57	43,09	50,00	56,46	62,57	68,40	73,99	79,37
60%		37,80	45,79	53,13	60,00	66,49	72,69	78,62	84,34
70%		39,79	48,20	55,93	63,16	70,00	76,52	82,79	88,79
80%		41,60	50,40	58,48	66,04	73,19	80,00	86,54	92,83
90%		43,27	52,42	60,82	68,68	76,12	83,20	90,00	96,55
100%	34,20	44,81	54,29	63,00	71,14	78,84	86,18	93,22	100,00

Degree of permanent disability exceeding 66, 67 % (=2/3)

If the degree of disability, as determined in accordance with the stipulations of articles 4.3. and 4.5. above, exceeds 66,67%, then the amount of the disability allowance will be equal to the amount of the insured allowance (100%).

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

If from the start of the disability (i.e. as from the start of the payment of the disability allowance) the degree of permanent disability exceeds 66,67%, and if the Insured, as from the start of the disability, needs the assistance of a third person to be able to perform the following activities of daily living:

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

then the Insurer will pay a once-only additional benefit of € 25.000 / £ 16,250 / \$ 31.250 (single lump sum) to the Insured.

4.6.3. Yearly adjustment of disability allowance (indexation)

The monthly disability allowance shall be subject to an annual increase of 2%.

This adjustment will be applied for the first time at the end of the first month of the first calendar year following the first benefit entitlement.

4.6.4. Duration of benefit

Benefits will be paid at the latest till the end of the month in which the insured person

- reaches the age of 65;
 - deceases;
 - resumes work;
- whichever event occurs first.

4.7. Benefit payment

The disability allowance shall be payable on a monthly basis, at the end of each month. Before any payment can be made, the Claims Handler should have received a copy of the Insured's birth certificate or a certificate of civil status.

4.8. Additional exclusions

In addition to the general exclusions mentioned in article 11 and 12 of the General Policy Provisions, the following exclusion apply to the Permanent Disability Cover:

- disability resulting from any sport for professional purposes, even as a secondary

profession, or any remunerated participation in sports competitions, or any unremunerated practice of sports reputed to be rash and hazardous, such as:

- rugby;
- winter sports competitions and races;
- aerial sports (except ballooning);
- hunting big game (including safari);
- speleology and cave diving;
- alpinism, if not on official paths;
- motor vehicle racing on land and water (except non-competitive recreative Jet Ski, recreative water ski, or tourist rallies without time or speed imperatives);
- rafting, canyoning, bungee jumping and similar sports.

4.9. Obligations to be fulfilled by the insured

4.9.1. Assessment of disability - medical information

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

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

The Insurer's Medical consultant has the right to ask for relevant additional information and/or have the insured person medically examined to assess the incapacity. Furthermore, a proof of income has to be provided.

4.9.2. Changes to the extent of the disability

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

If you need any additional information, please contact us.

ExpatriPlus
Plantin en Moretuslei 299
2140 Antwerpen - Belgium
Tel. + 32 3 217 65 29
info@expatriplus.com
www.expatriplus.com