healthcare

your personal handbook and membership agreement

January 2010

InternationalExclusive

offers you comprehensive coverage whether you are home or abroad

redefining / standards

AXA

contents

introduction

This handbook has been designed to set out all the features and benefits of the AXA **International**Exclusive plan. On the next few pages you will find details of your cover followed by the membership agreement which includes definitions relevant to your plan. If there is anything you do not understand please do not hesitate to call our Health Service Team on: (852) 2867 8680 which is also shown on the reverse of your membership card.

Take a few moments to refresh your memory about your AXA **International**Exclusive plan then relax and look forward to the highest standards of service from AXA. You can rest assured that, whatever the coming year brings, we'll be there to support you.

What your healthcare insurance cover is designed to do

As with all insurance policies your AXA **International**Exclusive plan is there to cover you for costs arising from an unforeseen event. For healthcare insurance this means the cost of eligible treatment resulting from an unexpected illness or accident.

You must take care of your own health and not only rely totally on medical practitioners to do this for you. When something unfortunate does affect your health we will do our best to help you but we must always act within the limits of your policy.

A personal service

At AXA we are always aware that behind every claim there is a person who needs help and assistance.

What our service team is there to do

It is the role of our Health Service Team to assist you, wherever possible, within the terms and limits of your AXA **International**Exclusive plan. You will find the number of our Health Service Team on the reverse of your membership card. Please also see page 28 of this handbook for details of your AXA office.

Please do not use the Emergency Control Centre number shown below for general & claims enquiries that can be dealt with by our Health Service Team.

Please take a note of this and keep your membership card in a safe place where you can find it easily. Please have your membership card with you whenever you call our Health Service Team. The information on your card will help them to deal with your enquiry as quickly as possible.

International Emergency Medical Assistance

You have access to International Emergency Medical Assistance. This is a worldwide, 24 hours a day, 365 days a year emergency service providing evacuation or repatriation services. If you need immediate emergency in-patient treatment, where local facilities are unavailable or inadequate, a phone call to the Emergency Control Centre on: (852) 2863 5514 will alert the International Emergency Medical Assistance service. Please see the separate booklet for full details. Please note that, for your own protection, calls may be recorded in case of subsequent query.

Please note that entitlement to the evacuation service does not mean that the member's treatment following evacuation or repatriation will be eligible for benefit. Any such treatment will be subject to the terms and conditions of the member's plan.

Decisions about your treatment

We do not decide whether the treatment you receive is given on an in-patient, daycare or out-patient basis. This is decided by the attending medical practitioner. We will not usually question this unless, in the opinion of our medical team, it would have been more appropriate for treatment to have been given differently. In the unlikely event of this happening we will ask for an explanation of why the particular method of treatment was chosen. We recognize that there may have been a valid reason for the choice made by the medical practitioner. Our intention in questioning such matters is to be able to fairly and accurately assess any claim.

In the event of any differences in opinion between our medical team and the attending medical practitioner, our medical teams' opinion shall prevail.

Persons eligible

Members eligible to be covered under this policy must be aged eighty (80) years or less at the time of application.

Our philosophy is to continue offering renewal beyond age 80 so that members can enjoy the peace of mind of continuing their cover for as long as possible subject to you paying the applicable premium.

This policy may provide cover for members residing outside of Hong Kong, however, in most cases we cannot cover you if you are a national of your resident country (other than Hong Kong). In addition, country specific regulations may impact your eligibility.

what you're covered for

In applying deductibles and co-insurance (the percentage of eligible benefits payable by the **member**) **we** will subtract the deductible first and then apply the co-insurance to the balance of eligible benefit remaining.

Please refer to the **benefits table** on pages 26-27 for further information on the benefit levels of your **plan**.

Benefits	Clarifications
Yearly maximum	**We** will pay up to the maximum shown for each **member** each **policy year**. All benefits paid during the **policy** period will count against the yearly maximum. Cover does not extend beyond the **area** shown for your **plan** unless **you** are eligible for 'outside **area of cover**' benefit.
Outside **area of cover**	This is to cover emergency **treatment**, or **treatment** of a **medical condition** which arises suddenly whilst outside the **member's area of cover**. **We** will, in consultation with the treating practitioner, retain the right to determine what constitutes 'emergency' **treatment**. This benefit does not provide cover for **treatment** for any condition if **you** have travelled outside your **area of cover** to get **treatment** (whether or not that was the only reason) or for any **treatment** which was, or may have reasonably been known about, before travel commenced. Under no circumstance will benefit be payable for any aspect of pregnancy or childbirth.
Level of reimbursement	Reasonable and customary (R&C) in the country/**area** of **treatment**

In-patient and daycare treatment – general information

By in-patient **treatment**, **we** mean **treatment** at a **hospital** where the **member** has to stay in a **hospital** bed for one or more nights. By daycare **treatment**, **we** mean **treatment** at a **hospital**, daycare unit, or out-patient clinic where the **member** requires a procedure, eligible for benefit, necessitating admission to a **hospital** bed but not requiring an overnight stay.

Subject to the limits shown for your **plan you** are covered for **hospital** charges incurred for eligible **treatment** given between admission and discharge such as:

- charges for accommodation
- diagnostic procedures
- operating theatre charges
- nursing care, drugs and dressings
- surgical appliances used by the **medical practitioner** during surgery except external prosthesis or appliances
- surgeons' and anaesthetists' charges including pre- and post- operative consultations
- intensive care unit charges
- consultations and physiotherapy while admitted for **treatment** of a **medical condition** and when such **treatment** directly relates to it
- radiotherapy and chemotherapy
- computerized tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques
- special nursing in **hospital** and/or nursing at home, after discharge, when agreed in writing beforehand that it is medically necessary and appropriate

Please note: all non-emergency admissions require our written pre-authorization before admission.

The approval **we** give to the provider will indicate the amount which is reasonable and customary (R&C) for the proposed **treatment**. Please refer to section 'claims procedure' on page 11 of this handbook.

Please refer to the **benefits table** on pages 26-27 for further information on the benefit levels of your **plan**.

Benefits	Clarifications
Daily accommodation charges	By 'accommodation' **we** mean a lowest cost available 'single en-suite' room.
Parent accommodation	**We** will pay when the child **member** is under 18 years old and **treatment** is received within your **area of cover**. This is paid from the child's benefit.
Cash benefit	This is payable for eligible in-patient **treatment** only when the **member** receives **treatment**, within the **area of cover**, provided no cost is borne by **us**. No other benefit will be payable in respect of the period for which the cash benefit has been claimed.
In-patient direct billing	**We** will pay up to the reasonable and customary (R&C) cost of **treatment** within **our** international **directory of hospitals**.

In-patient and direct billing

All non-emergency in-patient **treatment** must be approved by **us**, in writing, prior to admission. **You** can take advantage of direct billing facilities for eligible in-patient care within **our** international **directory of hospitals**.

Please note: prior to admission or receiving **treatment you** must identify yourself and your eligibility for discounts by showing your membership card together with a recognized official form of identification (such as a passport) to any network provider as evidence that **you** are an insured **member** of an AXA **International**Exclusive **policy**. Failure to ensure that the network provider recognizes your entitlement to **our** discounted services may result in the **member** being required to pay any difference between the invoice value and **our** negotiated price.

Please note that AXA reserves the right to recover from the **member** any ineligible expenses it has incurred on behalf of that insured **member** under this **policy**.

Out-patient treatment – general information

Out-patient **treatment** is **treatment** given by a **medical practitioner** at an out-patient clinic, a **medical practitioner's** consulting room or in a **hospital** where the **member** is not admitted to a bed. **You** are covered, subject to the limits shown, for:

- **medical practitioner** charges for consultations
- diagnostic procedures
- **prescriptions** (note any prescribed drug or other medication required for more than 30 days must be pre-authorized by **us**)
- physiotherapy received as an out-patient (this is subject to **our** pre-authorization)
- computerized tomography, magnetic resonance imaging, positron emission tomography, x-rays and gait scans received as an out-patient (this is subject to **our** pre-authorization)
- radiotherapy and chemotherapy received as an out-patient (out-patient co-insurance does not apply for this **treatment**)
- **surgical procedures** received as an out-patient

Please refer to the **benefits table** on pages 26-27 for further information on the benefit levels of your **plan**

Benefits	Clarifications
Consultation	A consultation is a **visit** to any **medical practitioner** for the **treatment** of an eligible **medical condition**. Second opinion for the same condition: · pre-authorization is not required for the **International**Exclusive Plus plan · written pre-authorization is required for the **International**Exclusive plan Thereafter subsequent opinions and referrals for the same condition: · written pre-authorization is required for all **plans**
Courses of chiropractic **treatment**, acupuncture, homeopathy, osteopathy and physiotherapy	Such **treatment** must be pre-authorized by **us** in writing and be given by a qualified practitioner who is recognized by **us** and registered to practice this where the **treatment** is given. By 'course' **we** mean a maximum of five sessions within a period of five consecutive weeks. **Treatment** given by a **physiotherapist**, chiropractor, osteopath, homeopath or acupuncturist must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medical practitioner** who has defined a diagnosis. There must be a clear **treatment** plan from the **physiotherapist**, chiropractor, osteopath, homeopath or acupuncturist with an end point and expected outcome. Any further **treatment** needed after the limits of the **treatment** plan have been exceeded can only be allowed for benefits following review and further referral by the supervising **medical practitioner** and approval by **us**. Please also see 2.1(d).
Traditional Chinese medicine	Such **treatment** must be given by a qualified traditional Chinese medical practitioner who is recognized by **us** and registered to practice this where the **treatment** is given. The benefit covers for a maximum of twenty sessions each **year** and up to the limit per **visit** shown for your **plan**. There must be a clear **treatment** plan from the traditional Chinese medical practitioner with an end point and expected outcome. Please also see 2.1(d).
Co-insurance applicable to all out-patient claims	This is the amount of eligible expenses claimed that the **member** will have to bear. This amount will be collected by whoever provides your **treatment** (for direct billing) or deducted from any reimbursement made to **you** by **us**. The amount shown applies to each and every out-patient consultation or **treatment** received as an out-patient. Co-insurance always applies to each **member** even when consultations and **treatment** are received by more than one **member** at the same time.
Out-patient direct billing	In some cases of high cost out-patient **treatment** **we** may be able to make special arrangements for direct settlement. The more notice **you** provide **us**, the more likely it is that **we** will be able to arrange direct billing. Please note that specific limitations apply for eligible pre-existing **medical conditions** (whether **chronic** or not) and for **chronic** conditions. See page 7 and the **benefits table** on pages 26-27 for further details.

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) within **our** network **hospitals**. This assessment will apply even when the treating **medical practitioner** refers **you** for **treatment** outside **our** network if that **treatment** would have been available within **our** network. Reasonable and customary (R&C) will apply in any event. If in doubt please contact **us** before receiving **treatment**.

Other benefits – general information

These are the additional features of your **plan**. Please note that all deductibles, limitations and terms apply to these benefits exactly as for the main in-patient/daycare and out-patient benefits depending on whether **treatment** is received as an out-patient, in-patient or daycare patient.

Please refer to the **benefits table** on pages 26-27 for further information on the benefit levels of your **plan**.

Benefits	Clarifications
Health screen (**International**Exclusive Plus plan only)	Benefit is payable only once in each **year** of membership and is subject to a waiting period of a **year**. By this **we** mean that **you** must have been continuously covered on the **International**Exclusive Plus plan for 12 consecutive months and have effected the annual renewal of that **plan** for the coming **policy year**. This waiting period is calculated initially from your date of joining your **plan**. The limit shown for your **plan** includes the cost of any eligible consultation needed as part of the screening process.
Pre-existing conditions, maintenance of pre-existing **chronic** conditions and the 'acute phase' of a pre-existing **chronic** condition	Benefits only become available and eligible claims payable for expenses incurred after the **member** has been continuously covered under their chosen **plan** for 270 days and has paid the annual premium. Benefits are further limited, within the first two **years** of membership to the lower limit shown for this benefit in the **benefits table**. All eligible conditions that existed or for which there were symptoms before the inception of the **policy** or the introduction of this additional benefit will be paid for from this benefit and subject to the limit shown for your **plan**. All such conditions must, in good faith, be declared to **us**, in writing, at the time of application. Please note that the **treatment** of the acute phase of any pre-existing condition, whether **chronic** or not, will be paid for out of this benefit and the limits of this benefit will apply in any event. **We** reserve the right to refuse to pay benefit for any such condition which was not declared on a **member's** application form.
Chronic conditions arising after **enrolment**	Benefits only become available and eligible claims payable for expenses incurred after the **member** has been continuously covered under their chosen **plan** for 270 days and has paid the annual premium. Benefits are limited within the first two **years** of membership to the lower limit shown for this benefit in the **benefits table**. The initial diagnosis and stabilization of a **chronic** condition arising after **policy** inception is covered under the main benefits of your **plan**. Thereafter the maintenance, including any acute phase of a **chronic** condition will be covered under this benefit. This benefit provides for the maintenance of one or more **chronic** conditions up to the limit shown each **year**. Please note: that the **treatment** of the acute phase of any pre-existing condition, whether **chronic** or not, will be paid for out of the pre-existing condition benefit above and the limits of that benefit will apply in any event. Please note: that the limit shown is an aggregate one, payable once for all such conditions collectively. Only recognized, proven and necessary **treatment** that is prescribed by a **medical practitioner** will be eligible for benefit.

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) within **our** network **hospitals**. This assessment will apply even when the treating **medical practitioner** refers **you** for **treatment** outside **our** network if that **treatment** would have been available within **our** network. Reasonable and customary (R&C) will apply in any event. If in doubt please contact **us** before receiving **treatment**.

Please refer to the **benefits table** on pages 26-27 for further information on the benefit levels of your **plan**.

Benefits	Clarifications
Oral and maxillofacial surgery	A list of **surgical procedures** covered by this benefit is available from **us** on request. Please note: this benefit does not cover routine dental care.
Ambulance transport	This is to pay for an ambulance for medically necessary emergency transport to or between **hospitals**. Your **medical practitioner** will determine if this is medically essential. **We** reserve the right to ultimately determine whether such transportation was medically appropriate. (This does not form part of the International Emergency Medical Assistance service shown below.)
International Emergency Medical Assistance	Emergency evacuation is covered in full when **you** are away from your **principal country of residence**. Evacuation, when medically necessary, will always be to the nearest place where appropriate **treatment** can be given. A **member** evacuated in an emergency will subsequently be returned to their **principal country of residence**. Repatriation of mortal remains if a **member** is away from their **principal country of residence** is included – this may be to the **principal country of residence** or to the home country. Please note: that entitlement to the evacuation service does not mean that the **member's treatment** following evacuation or repatriation will be eligible for benefit. Any such **treatment** will be subject to the terms and conditions of the **member's plan**.
Psychiatric **treatment**	This benefit is subject to **our** pre-authorization. The limit shown applies to in-patient, daycare and out-patient **treatment** in aggregate.
Accidental damage to teeth	Under accidental damage to teeth, **we** will pay for **treatment** required immediately (within seven days) following accidental damage to natural teeth caused by an external trauma when that **treatment** is given by a **medical practitioner**. This is for the initial **treatment** only; it does not include any follow-up **treatment**. Please note: there is no cover for **treatment** required as the result of the consumption of food or drink or any foreign bodies contained in such food or drink.
Pre and post-natal complications	Benefit only becomes available and eligible claims payable for expenses incurred after the **member** has been continuously covered under their chosen **plan** for 12 consecutive months and has effected the annual renewal of that **plan** for the coming **policy year**. This benefit will, subject to the limitations and exclusions of this **policy**, cover **treatment** of both the mother and any unborn child up to the moment of delivery. Thereafter cover will be restricted to eligible **treatment** for the mother alone. Any newborn infant may be added to the mother's **policy** and enjoy cover commencing at the time of birth provided **we** are requested to add that infant to the mother's **policy** within 30 days from the time of birth and the parental cover is in force at the time of delivery. If the mother is not covered by **us** at the time of delivery a newborn baby may only be added to the father's **policy** and be eligible for benefit after final discharge of the child into parental care. This benefit does not cover the costs of delivery of any child whether such delivery is normal, by caesarean section or by any other assisted means. This benefit will not automatically be upgraded to a higher level of **plan**. In the case of an upgrade in cover this benefit will be restricted to the level of the original **plan** until the **member** has been covered under the upgraded **plan** for a period of not less than 12 consecutive months and has effected the annual renewal of the upgraded **plan**. Please also see 3.1(f).

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) within **our** network **hospitals**. This assessment will apply even when the treating **medical practitioner** refers **you** for **treatment** outside **our** network if that **treatment** would have been available within **our** network. Reasonable and customary (R&C) will apply in any event. If in doubt please contact **us** before receiving **treatment**.

Please refer to the **benefits table** on pages 26-27 for further information on the benefit levels of your **plan**.

Benefits	Clarifications
Pregnancy and delivery (**International**Exclusive Plus plan only)	Benefit only becomes available and eligible claims payable for expenses incurred after the **member** has been continuously covered under the **International**Exclusive Plus plan for 12 consecutive months and has effected the annual renewal of that **plan** for the coming **policy year**. This benefit is only available for women over the age of 18 years and covers pre-natal care, delivery and post-natal care, in aggregate, up to the limit shown for your **plan**. The limit shown is the maximum **we** will pay under this benefit for each: · **policy year**, even if there is more than one pregnancy in that **policy year** · pregnancy, even if a pregnancy, which is eligible for benefit, falls across the **policy** anniversary, and provided the **policy**, including this benefit, has been renewed for the subsequent **policy year** This benefit will not automatically be upgraded to a higher level of **plan**. In the case of an upgrade in cover this benefit will be restricted to the level of the original **plan** until the **member** has been covered under the upgraded **plan** for a period of not less than 12 consecutive calendar months and has effected the annual renewal of the upgraded **plan**. Please also see 3.1(f).
Vaccinations	Benefit is payable for necessary vaccinations up to the limit shown for your **plan**.
Routine dental care (**International**Exclusive Plus plan only)	Benefit only becomes available for eligible expenses incurred for conditions arising after the **member** has been continuously covered under the **International**Exclusive Plus plan for 270 consecutive days and has paid the annual premium. This benefit provides for extraction, composite fillings, root canal **treatment**, scaling/ polishing, bridgework, crowns and the **treatment** of gum disease. **We** will pay 80% of all eligible **treatment** shown above up to the limit shown for your **plan**.
Routine optical care (**International**Exclusive Plus plan only)	This benefit provides for the fees charged for eye examinations carried out by a qualified and registered ophthalmologist recognized by **us**, the cost of spectacle frames, corrective lenses prescribed by the ophthalmologist, up to the limit shown for your **plan**. This excludes tinted/reactive lenses, sunglasses, non-corrective contact lenses, lazer eye surgery and/or similar, whether prescribed or not.

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) within **our** network **hospitals**. This assessment will apply even when the treating **medical practitioner** refers **you** for **treatment** outside **our** network if that **treatment** would have been available within **our** network. Reasonable and customary (R&C) will apply in any event. If in doubt please contact **us** before receiving **treatment**.

Please refer to the **benefits table** on pages 26-27 for further information on the benefit levels of your **plan**.

Benefits	Clarifications
Hospice and palliative care	Benefit only becomes available and eligible claims payable for expenses incurred after the **member** has been continuously covered under their chosen **plan** for 12 consecutive calendar months and has effected the annual renewal of that **plan** for the coming **policy year**. This benefit becomes available when the **member** is admitted to a specialist palliative care centre or hospice, recognized by **us**, following diagnosis, written confirmation (including medical evidence) by a **medical practitioner** that the **member** is suffering from a terminal eligible **medical condition** or conditions. The benefit must be pre-authorized, in writing, by **us** in advance of admission. Once the **member** is admitted, all costs of care and any **treatment** related to the terminal condition and related conditions will be taken from this benefit and may not be claimed from any other benefit applicable to the **member's plan**. Any eligible **medical conditions** not related to the **member's** terminal condition will be covered under the **member's** normal **plan** benefits. **We** reserve the right to determine, on the advice of **our** medical panel, whether a **medical condition** is or is not related to the terminal **medical condition**. This benefit is payable, up to the limit shown for the **member's plan**, once in a **member's lifetime**, in aggregate for all such conditions. The **member** must maintain the same level of cover throughout the palliative or hospice care admission. This means that, if the period of palliative or hospice care falls across a **policy** anniversary, the **member** must pay the premium for the subsequent **year** or benefit will cease at the **policy** anniversary. In the event that the costs of the **member's** admission reach the limit shown for this benefit no further benefit will be payable. Once the limit of this benefit is reached no benefit of any kind will be payable in respect of any **medical condition** for which palliative and/or hospice care has been received. This benefit will not automatically be upgraded to a higher level of **plan**. In the case of an upgrade in cover this benefit will be restricted to the level of the original **plan** until the **member** has been covered under the upgraded **plan** for a period of not less than 12 consecutive months and has effected the annual renewal of the upgraded **plan**. The waiting period will apply in the event of an upgrade in cover.

All benefits are subject to assessment on the basis of what is reasonable and customary (R&C) within **our** network **hospitals**. This assessment will apply even when the treating **medical practitioner** refers **you** for **treatment** outside **our** network if that **treatment** would have been available within **our** network. Reasonable and customary (R&C) will apply in any event. If in doubt please contact **us** before receiving **treatment**.

claims procedure

The following notes deal with some specific aspects and commonly asked questions relating to your cover. You should contact us for advice on any aspect of your policy that you do not understand.

How you obtain the benefits your plan provides

In any event, if you are receiving treatment in any part of our global network you must always identify yourself as a member to ensure that your treatment enjoys the advantages of our negotiated rates. Failure to do this may expose you to additional costs which you will have to bear.

What to do before receiving in-patient and daycare treatment

Before receiving any planned in-patient or daycare treatment recommended by your medical practitioner, you or the treating hospital must contact us to obtain our authorization for your proposed treatment. We will confirm, in writing, to you and/or the hospital the extent of your cover for the proposed treatment and the amount we are prepared to pay for it. In the unlikely event that there is any difference between our confirmed level of cover and what is requested by the hospital when you are discharged you must make arrangements to pay this when you are leaving the hospital.

Pre-authorization

The reason that we require pre-authorization of planned treatment is to protect you from unexpected costs. When issuing confirmation of cover in this way, we confirm the following:

- the planned treatment is eligible under your policy
- the planned treatment is medically necessary
- the planned treatment is within reasonable and customary (R&C) cost
- the planned treatment cost falls within the remaining benefit limit of your plan

Our agreement with you requires you to seek pre-authorization for the following treatment and services:

In-patient and daycare

- all in-patient and daycare admissions
- all non-emergency tests, diagnostics, treatment, surgery and other medical services
- all in-patient maternity services
- all in-patient dental services
- special nursing in hospital and/or any nursing at home after discharge

Out-patient

- non-emergency computerized tomography, magnetic resonance imaging, positron emission tomography, x-rays and gait scans and internal diagnostics such as but not limited to endoscopy, colonoscopy, gastroscopy and other such scans
- courses of chiropractic treatment, acupuncture, homeopathy, osteopathy and physiotherapy
- prescriptions covering consumables for 30 days or more
- psychiatric treatment
- any out-patient services requested on a direct billing basis

Failure to obtain pre-authorization as required above may prevent us from settling all or part of any claim. In the event that we are obliged to pay for any item not covered by our confirmation we will recover that amount from you. In any event any cost that is not directly related to treatment will be borne by the member.

Treatment outside network

If you are planning treatment outside the direct settlement network shown for your plan you must arrange pre-authorization ideally five workings days prior to commencement of the treatment for which authorization is required. You must confirm with the hospital that it has received our written authorization before you undergo treatment. If it has not you must contact us immediately.

We must be advised of any proposed treatment before treatment begins. Failure to allow us to manage your care, wherever it is received, may expose you to additional costs.

Emergency treatment

The only exception to this will be if the treatment requires an emergency admission, then you may not be able to contact us beforehand. Do, however, ask somebody to contact us as soon as possible and make sure that, when you are admitted to hospital, the hospital is given your membership card and proof of identity so that it can contact us straight away. In any event, under these circumstances, our authorization must be sought and given before you are discharged otherwise you may be required to pay the entire cost of your admission.

Claim forms

You can visit our website at www.axa-insurance.com.hk to obtain a printable claim form if you need one or call our Health Service Team at the number shown on the reverse of your membership card.

You must provide a completed claim form, signed by the medical practitioner and the member, for any visit made whether this is to a practitioner, hospital, clinic, pharmacy, diagnostic centre or any other facility where medical services may be received.

Claim forms outside our direct-billing network

You must take a claim form with you (also available from our website) and make sure it is filled in and signed by yourself and the medical practitioner treating you and sent back to us as quickly as possible, giving us all the information we request. (Only original receipted invoices can be accepted with your claim). A fully completed claim form will ensure that your claim will be processed promptly. An incomplete or unsigned claim form may delay settlement of your claim and in some cases may lead to the claim form being returned to you for completion. It may be necessary for us to obtain a medical report from the attending medical practitioner. If the medical practitioner does not respond quickly to such a request your claim may be delayed. We do not pay for medical reports. For treatment requiring our pre-authorization, such authorization must be received from us, in writing, prior to treatment commencing. A copy of that authorization must be included in your subsequent claim. Please note that, for reimbursement claims, we will only consider claims made within 90 days of treatment being received.

Where to send your claims

Any bills, together with your completed claim form, should be sent to:
AXA General Insurance Hong Kong Limited
21/F, Manhattan Place, 23 Wang Tai Road, Kowloon Bay, Kowloon, Hong Kong

Schedule of procedures

In this handbook we refer to a schedule of procedures which is a document that lists the proven surgical procedures for which we pay benefit and classifies them by complexity. Each of the procedures is also given a code number for administrative purposes. There are in excess of 1,000 procedures listed, of which about 250 are commonly performed on a daily basis. This document is written in medical language and it is intended for use by medical practitioners and us to assess the eligibility of proposed treatment and your claim. The schedule is regularly updated to include new, proven, procedures and is retained by us.

Second opinion

We can ask an independent medical practitioner to advise us about the medical facts relating to a claim or to examine the member concerned in connection with the claim. This is needed only very rarely and we use this right only where there is uncertainty as to the nature or extent of the medical condition and/or our liability under the policy. In the event of any differences between our medical team and the attending medical practitioner, our medical team's opinion shall prevail.

If you need treatment abroad

If you need treatment abroad, you will need to call our Health Service Team on the number shown on the reverse of your membership card.

If your medical practitioner recommends hospitalization or a major out-patient procedure then call the above telephone number to confirm that you are entitled to benefit.

Any bills, together with your completed claim form, should be sent to
AXA General Insurance Hong Kong Limited
21/F, Manhattan Place, 23 Wang Tai Road, Kowloon Bay, Kowloon, Hong Kong

Payment in local currency

Your premiums are payable in either Hong Kong Dollars or United States Dollars depending on which currency you have chosen at the time of your application and has been agreed by us.

Claim reimbursement will be paid in the same currency unless we have previously agreed otherwise in writing.

Benefits paid in a local currency will be converted using the spot rates prevailing at the time we assess the claim.

Any questions?

Although we have tried to include as much useful information in this handbook as possible, if you have any questions about your cover then please direct these to our Health Service Team. Please refer to page 28 of this handbook for details on your AXA office.

important information about your plan

Our policy on changing your level of cover or moving to another plan

We reserve the right to refuse any request to upgrade or amend cover. In the event that we do accept a request for an upgrade we may restrict cover for conditions existing at the time of the upgrade to the level of benefits enjoyed under the original policy. In any event, final acceptance of any amendment by us and particularly the application of upgraded benefits will only be made at the next renewal following such a request. Neither amendments nor upgrades can be made during the policy year. Any condition known about or that should reasonably be known about at the time of an amendment or upgrade must be advised to us before the policy amendment takes effect.

What to do if you wish to add other members to your policy

If you want to add someone else to an existing policy we will send you the forms to complete and you must give all the information we request. You can ask to add family members to your policy at any time. Any newborn infant may be added to the mother's policy and enjoy cover commencing at the time of birth provided we are requested to add that infant to the mother's policy within 30 days from the time of birth and the parental cover is in force at the time of delivery. If the mother is not covered by us at the time of delivery a newborn baby may only be added to the father's policy and be eligible for benefit after final discharge of the child into parental care. Please note that we are not obliged to accept any additional member. If we do accept an additional member during the policy year we may add an administration fee to the pro-rata premium charged. The additional member's policy anniversary will be the same as that of the original policy.

What happens if you change your principal country of residence

If you are planning to change your principal country of residence (where you live for most of the year) you must tell us as this may affect your eligibility.

InternationalExclusive is also available from AXA in several other Asian countries and AXA PPP healthcare also offers similar plans both in the UK and elsewhere. Where appropriate, we may be able to transfer you to another AXA plan, with no additional medical underwriting exclusions.

Please contact us for information on availability and terms and conditions.

What happens if you wish to cancel your policy

You have a free-look period of 14 business days from the date that you receive this policy to review it. You are deemed to have been received the policy within 3 days after we have dispatched it. If you decide that this policy does not suit your needs, you may request to cancel it by giving us clear, written instructions and returning the policy documents and membership card(s) to us within the free-look period. Provided that no claims have been made during this period, we shall refund the premiums paid by you, in full, without interest. This free-look period shall not apply to policies with terms of less than 1 year. It will also not apply to policy renewals.

In addition, you may cancel your policy at any time by giving us no less than 30 days notice in writing. Bearing in mind that this is an annual contract we will not refund premiums if any claim, however small, has been made in the current policy year. In the event that we do agree to make a refund (and this will be at our sole discretion), we will only refund premiums on a pro-rata basis from the end of the Gregorian calendar month in which cancellation takes effect and provided you have returned to us the policy documents including the membership card(s).

Please also note that no claim of any kind will be considered after notification by you and acceptance by us of any cancellation.

When the terms of your policy might change

We have the right to cancel or change all or any part of your policy from any renewal date. We will not change the terms of your policy alone simply as a result of your personal claims. However, we will make changes only to reflect any past or foreseeable changes in medical practice or procedures and the type and frequency of claims made generally by all those of our members covered under the same plan as you. The purpose of such changes will be to seek, as far as possible, to maintain substantially the same level and type of cover in place while ensuring that the plan remains affordable.

We may also change premiums if costs, taxation, regulations or benefit changes make this necessary. In the event that we are required by law to make a change during the policy year, for example if a new tax is introduced, we will be obliged to do so before the next renewal date. We do reserve the right to apply underwriting terms to your policy at any time if a medical condition that should reasonably have been declared comes to our attention, a chronic condition manifests itself within an excluded period or a medical condition becomes chronic in nature during a policy year.

Our position on chronic and other medical conditions which existed, or of which you were aware, before you applied for your plan

As you would expect, private healthcare is designed primarily to provide cover for treatment of new medical problems arising after joining.

Our plans provide cover for treatment of conditions declared on the original application form, whether chronic or not, which existed before each member became eligible for benefit under a particular plan. This is subject to a waiting period of 270 consecutive days of membership under the same plan. In those first 270 days of cover treatment of specific medical conditions may be excluded. However, treatment of certain conditions, which are unlikely to recur, may be covered from the date each member is first eligible for benefits under a particular plan.

For us to be able to determine whether treatment of a condition will be covered in the first 270 days and/or to be eligible for benefit thereafter each member must have completed a full medical declaration, in detail, when first applying for any level of cover. Upon completion of a full medical history declaration your membership statement will clearly show the medical conditions for which you are not covered for treatment for the first 270 days. We may ask for a medical report, at your own cost, to clarify the status of any medical condition.

Even if treatment of a medical condition is not covered by us on a particular plan for the first 270 days you will still be entitled to take advantage of our negotiated network rates when paying for your own treatment for these conditions.

No treatment of any pre-existing condition, whether chronic or not, will be eligible for benefit at any time if the condition has not been declared to us on the member's original application form.

Please note that it is important you give us full details of any member's medical history on an application. Failure to declare any medical condition of which you should reasonably have been aware may result in treatment of that condition being excluded from all future cover with us or cancellation of your policy.

Our position on chronic conditions first arising after you have been accepted for membership

Cover for such conditions is provided up to the limit shown in the benefits table for your plan, which applies for each member each year. This benefit is only available for treatment of chronic conditions for which first symptoms became apparent after the member was accepted, by us, for cover on a particular plan. Cover for treatment of such conditions only becomes available and eligible claims become payable for expenses incurred after the member has been continuously covered under the same plan for 270 days and has paid the annual premium.

If there were any symptoms prior to inception of your policy these must have been declared to us, in good faith, on the member's original application form. Provided such a declaration was made and accepted by us treatment of the condition would be covered under the 'pre-existing conditions' benefit in the clarifications and benefits table appropriate to your plan.

Please note that the limit shown in the benefits table for your plan, which applies for each member each year, is an aggregate one. Thus each member may benefit annually up to the level shown for their plan for all such conditions collectively. Only recognized, proven and necessary, treatment that is prescribed by a medical practitioner will be eligible for benefit. As for all reimbursement claims, claims must still be submitted within 90 days of the date of treatment being given.

Our position on cancer care

Oncology treatment and related eligible expenses, where applicable to a medical condition or symptoms that existed prior to the member first being accepted by us for cover, will be subject to the terms and limits applying to the benefit for 'pre-existing conditions' shown in the clarifications and benefits table.

Where oncology treatment and related eligible expenses apply to a medical condition arising after the date of acceptance of a member, by us, for cover under any plan such costs will be payable out of the overall limits of the plan under which the member is covered at the time of first diagnosis of the condition. The maintenance phase of any treatment (such as the administering of herceptin or similar drugs which are not classed as active treatments) will fall under and be taken from the 'chronic condition' benefit for your plan. Upgrades will not be accepted for cancer care, after initial diagnosis, under any circumstances.

In any event benefits for oncology and related treatment will only be payable for three years (in aggregate) in a member's lifetime.

Our position on kidney dialysis

We will consider kidney dialysis treatment, received for any reason, as treatment of a chronic condition and therefore subject to the limits of those benefits covering treatment of chronic conditions (either pre-existing or arising after policy inception, whichever is applicable) applicable to your plan.

Our position on genetic testing

As you can see from the membership agreement we only pay for illness or injury. There is also an exclusion saying that we do not pay for preventative treatment. It follows, therefore, that we do not pay for genetic tests, nor for any counselling made necessary following genetic tests, when those tests are undertaken to establish whether or not the member may be genetically disposed to the development of a medical condition in the future. This is because such tests are carried out for purposes of establishing whether a medical condition might develop and not for the treatment of a medical condition. It follows that benefit cannot be paid for genetic testing or associated counselling carried out for such purposes.

Our position on psychiatric illness

Your policy covers treatment of psychiatric illness up to the level shown in the benefits table for your plan. The member being treated or any member of his/her immediate family must contact us to obtain our written approval of the treatment planned and the proposed cost before treatment begins.

what this membership agreement means

This document sets out the terms of your membership agreement with **us** and must be read in conjunction with any supplementary documentation **we** provide to **you** from time to time (e.g. your **policy** schedule, membership card and International Emergency Medical Assistance terms). **We** have tried to keep this as simple as possible however, if there is anything **you** do not understand or would like to clarify, please contact **us**. Decisions regarding your benefits and/or changes to the terms of your membership agreement cannot be made verbally but must be confirmed by **us** in writing. **We** may record calls for your protection in the event of subsequent query or for training purposes.

In any insurance document **you** will find detailed definitions, terms and exclusions. This is where **you** will find those that form a part of the contract between **us**. Please read them carefully and ask **us** if there is anything **you** do not understand.

1 Definitions

Some words and phrases have special meanings. These meanings are set out below. When **we** use these terms they are in bold print.

1.1 **area/area of cover** – one of the following:

Worldwide: worldwide

Worldwide excluding USA: worldwide excluding the USA and US Minor Outlying Islands

Asia: Afghanistan, Bangladesh, Bhutan, Brunei, Burma, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Nepal, North Korea, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, Vietnam.

1.2 **area of residence** – normally your **principal country of residence** as defined in 1.20.

1.3 **benefits table** – the table applicable to your **plan** showing the maximum benefits **we** will pay for each **member**.

1.4 **chronic** – a **medical condition** or episode of ill health which persists for a long period or indefinitely.

1.5 **currency** – the currency in which claims reimbursed to the **member** will be paid and in which premiums must be paid.

1.6 **enrolment/time of enrolment** – with effect from 00:01 hours on the date that a **member** is accepted by **us** and premium for the **member's plan** has been received and accepted by **us**. Any anniversary at which **we** have accepted the **member** under the conditions above.

1.7 **family member** – your partner and your unmarried children (or those of your partner) living with **you** when **you** take out the **policy** or when it is renewed. By partner **we** mean your husband or wife with whom **you** live permanently. Children cannot stay on your **policy** after the renewal date following their 21st birthday.

1.8 **hospital** – any establishment which is licensed as a medical or surgical hospital, clinic, specialist centre or provider in the country where it operates and which is recognised by **us**.

1.9 **directory of hospitals/direct billing network list** – a document **we** maintain in which those **hospitals** with which **we** have direct settlement facilities are shown.

Policyholders should use a **hospital** listed in the directory of hospitals except in the case of emergency where this may not be possible.

1.10 **lifetime** – the period in which the **member** is alive. This does not refer to the duration of the **policy**.

1.11 **medical condition** – any disease, illness or injury, including psychiatric illness.

1.12 **medical practitioner** – a person who, being recognised by **us**, has the primary degrees in the practice of medicine and surgery following attendance at a recognised medical school and who is licensed to practice medicine by the relevant licensing authority where the **treatment** is given. By 'recognised medical school' **we** mean 'a medical school which is listed in the current World Directory of Medical Schools published by the World Health Organisation'.

This would also, whenever appropriate, include a person qualified as a dental practitioner by a degree in dentistry and duly licensed and registered with the relevant statutory dental board or council to provide dental **treatment**.

1.13 **member/policyholder** – **you** and any **family member** included in your **policy**.

1.14 **notice of cancellation at policy renewal/ anniversary date** – unless **we** and/or **you** have agreed before the end of the **year** to renew the **policy**, cover will cease on the **policy** renewal/ anniversary date. This will happen whether or not written notice of cancellation has been given by **us** to **you**.

1.15 **nurse** – a qualified nurse who is registered to practice as such where the **treatment** is given and is recognised by **us**.

1.16 **physiotherapist** – a person who is qualified and licensed to practice as a physiotherapist where the **treatment** is given and who is recognised by **us**.

1.17 **plan** – any AXA **International**Exclusive plan.

1.18 **policy** – the insurance contract between **you** and **us**. Its full terms are set out in the current versions of the following documents as sent to **you** from time to time:

- any application form **we** ask **you** to fill in
- these terms and the **benefits table** setting out the cover under your **plan**
- your policy schedule and/or endorsements
- the international **directory of hospitals**

Changes to these terms must be confirmed in writing and **we** will write to **you** to confirm any changes, undertakings or promises that **we** make.

1.19 **prescription** – out-patient drugs and dressings as prescribed by a **medical practitioner** for the **treatment** of a **medical condition** covered by the **member's policy**.

1.20 **principal country of residence** – the country where **you** live or intend to live for most of the **year** being 185 days or more and which will be shown as your address and place of residence in **our** records.

1.21 **schedule of procedures** – a document **we** maintain which lists the **surgical procedures we** pay benefits for and classifies them according to their complexity.

1.22 **surgical procedure** – an operation or other invasive surgical intervention listed in the **schedule of procedures**.

1.23 **treatment** – a **surgical procedure** or medical procedure carried out by a **medical practitioner**. This includes:

- diagnostic procedures – consultations and investigations needed to establish a diagnosis
- in-patient treatment – treatment at a **hospital** where the **member** has to stay in a **hospital** bed for one or more nights
- daycare treatment – treatment at a **hospital**, daycare unit or out-patient clinic where the **member** is admitted to a **hospital** bed but does not stay overnight
- out-patient treatment – treatment at an out-patient clinic, a **medical practitioner's** consulting rooms or in a **hospital** where the **member** is not admitted to a bed

1.24 **United Kingdom** – Great Britain and Northern Ireland, including the Channel Islands and the Isle of Man.

1.25 **visit** – each separate occasion that the **member** meets with a **medical practitioner** and receives a consultation and/or **treatment** for a **medical condition**.

1.26 **we/us/our** – AXA General Insurance Hong Kong Limited, being the AXA company issuing your **policy**.

1.27 **year** – twelve Gregorian calendar months from when your **policy** began or was last renewed unless **we** have agreed something different.

1.28 **you** – the **policyholder** named on your policy schedule.

2 What we pay for

2.1 This **policy** insures the **members** against the cost of necessary **treatment** carried out by a **medical practitioner**. However, **we** will pay only:

(a) for charges actually incurred for items listed in your **benefits table** subject to the limits shown there. Note: if **you** incur costs in excess of the limits **you** will have to pay the difference;

(b) for **treatment** of a **medical condition** which is commonly known to respond quickly to **treatment**. When the **medical condition** has been stabilized **we** may stop making payments. **We** reserve the right to determine when a **medical condition** has become **chronic** or recurrent in nature;

(c) charges made by the **medical practitioner**, laboratory or other such medical services when

they are at the level customarily charged by **medical practitioners** generally for the services received. Where **we** consider any charge not to be reasonable and customary (R&C), **we** will base **our** challenge on the degree of deviation from **our** average negotiated charges. **We** calculate what is reasonable and customary (R&C) based on the average negotiated cost of the **treatment** within the network applicable to **your plan** in the **area** in which **treatment** is received; or, where no network exists or the **treatment** is not available in a network **hospital we** will base that calculation on the average cost of the **treatment** in that **area** or country. If necessary **we** can delay paying the claim until **we** are satisfied that the charges are appropriate. If the charges made by the **medical practitioner**, are higher than is customary **we** will only pay the amount which is, in **our** experience, customarily charged and the **member** will have to pay the rest;

(d) for **treatment** by a suitably qualified **physiotherapist**, chiropractor, osteopath, homeopath, acupuncturist and traditional Chinese medical practitioner recognised by **us** or for the services of a **nurse** if the **plan** covers it and then only as allowed by the **benefits table**;

(e) provided the costs are not for something excluded by the terms of this **policy**;

(f) for costs incurred during a period for which the premium has been paid;

(g) **treatment** of conditions that existed, and were specifically declared to **us**, prior to inception of this **plan** except where such **treatment** relates to a **condition** that has previously been excluded or subject to a moratorium (waiting period) by AXA or any previous insurer and such exclusion or moratorium has not expired; or as allowed for by your **plan**;

(h) the initial diagnosis and stabilization of a **chronic condition** (a **medical condition** that does not respond quickly to **treatment** or recurs). Stabilization means, in the event of such a **medical condition** entering an acute phase (flaring-up), **treatment** to return the **condition** to a stable state. **We** will not normally pay for subsequent stabilization, routine, long term maintenance aimed at controlling and monitoring the **condition** once stabilized such as routine consultation and/or medications whether or not these are prescribed by a **medical practitioner** unless allowed for by the **benefits table** and accepted by **us** in writing;

(i) **prescriptions**, being out-patient drugs and dressings as prescribed by a **medical practitioner** for the **treatment** of a **medical condition** covered by the **member's policy** provided that this cover is included in your **plan**.

Please note that **we** do not pay for standard toiletries such as, but not limited to shampoos, soaps, tooth-pastes, contraceptives, proprietary headache and cold cures, and vitamins which may be bought over the counter, without **prescription**, at a local pharmacy nor do **we** pay for telephone calls.

2.2 If **treatment** is received in United Arab Emirates, Saudi Arabia, Bahrain, Oman, Kuwait or the **United Kingdom**, **we** will normally only make direct settlement payments for charges made by, or incurred in, a **hospital** listed in the international **directory of hospitals** attached to this document (1.8 & 1.9 refer). If it is medically necessary to use another **hospital** and **we** have specifically agreed, in writing, to its use before the **treatment** begins (and **we** will not unreasonably refuse to agree), **we** will try to arrange direct settlement facilities. Please be aware that some providers refuse to entertain such arrangements. **We** will only pay the **hospital** accommodation charges associated with the **treatment** up to a reasonable level i.e. the use of a lowest cost available single en-suite room.

3 What we do not pay for (exclusions and limitations)

3.1 **We** do not pay for the following:

(a) **treatment** of any **medical condition** which the **member** already had when he or she joined and which **you** should have told **us** about but did not tell **us** at all or did not tell **us** everything unless **we** had agreed otherwise in writing that there was no need for **you** to tell **us**. This includes any **medical condition** or symptoms whether or not being treated and any previous **medical condition** which recurs or which the **member** should reasonably have known about even if he or she has not consulted a **medical practitioner**;

(b) non-surgical **treatment** of a **medical condition** which does not respond quickly to **treatment** or which continues or recurs unless allowed for by the **benefits table** and accepted by **us** in writing;

(c) the monitoring of a **medical condition** once it has been stabilized unless allowed for by the **benefits table** and accepted by **us** in writing;

(d) any **surgical procedure** which is not listed in the **schedule of procedures**, unless **we** have agreed, in writing, beforehand;

(e) any **treatment** which only offers temporary relief of symptoms rather than dealing, when it is reasonable to do so, with the underlying **medical**

condition;

(f) normal pregnancy or childbirth (delivery) unless this is specifically included in your **benefits table** – but **we** will pay for **treatment** of a **medical condition** which is due to and occurs during the pregnancy or childbirth except caesarean section Caesarean section and any complication related to it is not covered unless your **plan** provides for 'Delivery' and this is not limited by any waiting period applicable to your **plan**. In this event Caesarean section and any related complications will be covered under the 'Delivery' benefit and subject to the limit shown there. **We** will not pay for **treatment** of any **medical condition** that arises during pregnancy or childbirth (delivery) if the pregnancy was a result of any form of assisted conception including artificial insemination. **We** will send **you** a list of the **medical conditions we** pay for if **you** ask **us**;

(g) **treatment** begun, or for which the need had arisen, during the first 90 days after birth for any child conceived by artificial means or any form of assisted conception including artificial insemination;

(h) termination of pregnancy or any consequences of it, except where eligible under the pre and post-natal complications benefit;

(i) investigations into and **treatment** of infertility, contraception, assisted reproduction, sterilization (or its reversal) or any consequence of any of them or of any **treatment** for them;

(j) **treatment** of impotence or any consequence of it;

(k) **treatment** of sexually transmitted diseases;

(l) sex change including **treatment** which arises from or is directly or indirectly made necessary by a sex change;

(m) **treatment** of any **medical condition** which arises in any way from HIV infection;

(n) the removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons;

(o) the costs of collecting donor organs for transplant surgery or any administration costs involved even if such transplants are allowed by the terms of this **plan**.

(p) **treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide;

(q) **treatment** which arises from or is in any way connected with alcohol abuse or drug or substance abuse;

(r) any **treatment** to correct long or short-sightedness;

(s) **treatment** directed towards developmental delay in children whether physical or psychological or learning difficulties;

(t) preventive (i.e. prophylactic) **treatment**;

(u) vaccinations and routine or preventative medical examinations, including routine follow-up consultations, unless allowed for by the **benefits table** and accepted by **us** in writing;

(v) the costs of providing or fitting any external prosthesis or appliance;

(w) out-patient drugs or dressings except those defined in 2.1(i), **prescriptions**, and where your **policy** provides this cover;

(x) orthodontics, periodontics, endodontics, preventative dentistry, and general dental care including fillings, no matter who gives the **treatment** unless provided for by your **plan** and agreed, in writing, by **us**;

(y) claims in respect of **treatment** received outside the **area of cover** or if the **member** travelled against medical advice even inside the **area of cover**;

(z) **treatment** of injuries sustained from playing professional sport or from base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hangliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste;

(aa) any **treatment** specifically excluded by the terms shown on your membership statement or the schedules forming part of this agreement;

(bb) any charges which are incurred for social or domestic reasons or for reasons which are not directly connected with **treatment**;

(cc) any charges from health hydros, spas, nature cure clinics (or practitioners) or any similar place, even if it is registered as a **hospital**;

(dd) any claim or part of a claim in respect of which **you** have to pay an excess (or deductible or co-insurance). In this case **we** will only pay the balance of the claim after **we** have deducted the excess (or deductible or co-insurance) amount;

(ee) in-patient or daycare **treatment** in United Arab

Emirates, Saudi Arabia, Bahrain, Oman, Kuwait or the **United Kingdom** unless as defined in 2.2 above;

(ff) in-patient charges for any **hospital** which are not reasonable and customary (R&C). **We** will pay only for the reasonable cost of a lowest cost available single en-suite room as the accommodation charge associated with the **treatment** given;

(gg) any charges for **treatment** related to and/or the correction of congenital conditions and/or deformities whether or not manifest and/or diagnosed or known about at birth.

3.2 Special terms apply in the following cases.

We will not pay benefits for:

(a) cosmetic (aesthetic) surgery or **treatment**, or any **treatment** which relates to or is needed because of previous cosmetic **treatment**. However **we** will pay for reconstructive surgery if:

(i) it is carried out to restore function or appearance after an accident or following surgery for a **medical condition**, provided that the **member** has been continuously covered under a **plan** of **ours** since before the accident or surgery happened; and

(ii) it is done at a medically appropriate stage after the accident or surgery; and

(iii) **we** agree the cost of the **treatment** in writing before it is done.

(b) any dental procedure unless provided for by your **plan**. However, **we** will pay for some **surgical procedures** which need to be carried out by an oral and maxillofacial surgeon. **We** will send **you** a list of these procedures if **you** ask **us**.

(c) special nursing in **hospital** and/or any nursing at home unless **we** have agreed in writing beforehand that it is necessary and appropriate.

(d) hormone replacement therapy, except when it is medically indicated (rather than for the relief of physiological symptoms), when **we** will pay for the consultations and for the cost of the implants or patches (but not tablets). **We** will only pay benefits for a maximum of eighteen months from the date of the first consultation.

(e) in-patient rehabilitation except when:

- it is an integral part of **treatment**; and
- it is carried out by a **medical practitioner** specialising in rehabilitation; and
- it is carried out in a rehabilitation **hospital** or unit which is recognised by **us**; and
- the costs have been agreed, in writing, by **us** before the rehabilitation begins.

We will not pay for in-patient rehabilitation for more than 28 days except in cases such as in severe central nervous system damage caused by external trauma.

(f) **treatment** which has not been established as being effective or which is experimental. However **we** will pay if, before the **treatment** begins, it is established that the **treatment** is recognised as appropriate by an authoritative medical body and **we** have agreed in writing, with the **medical practitioner**, what the fees will be.

3.3 **We** will not pay benefits for more than 100 days in total in any **member's lifetime** for in-patient **treatment** of psychiatric illness.

3.4 **We** will not pay for any **treatment**, or for International Emergency Medical Assistance, if they are needed as a result of nuclear contamination, biological contamination or chemical contamination, whilst engaging in or taking part in war, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed.

Please note, for clarity: there is cover for **treatment** required as a result of a terrorist act providing that terrorist act does not result in nuclear, biological or chemical contamination.

3.5 **We** will not pay benefits for any **treatment** if **we** have not received a properly completed claim form and original invoices within 90 days of the **treatment** being given.

3.6 **We** will not pay benefits for any **treatment** needed as a result of work related accident or injury where the cost of such **treatment** is recoverable under a Workman's Compensation policy or similar cover required by Government Act prevailing in the country where the work related accident or injury took place or elsewhere at the time of injury or accident. **We** may, at **our** absolute discretion, consider the claims provided **we** are able to recover such costs. **You** must advise **us** if any claim is work related.

3.7 **We** will not allow **members** to upgrade their level of cover except at each **policy** anniversary and only then when requested, in writing, to do so. Acceptance by **us** of such an upgrade must be confirmed in writing by **us** before the upgrade can become effective.

3.8 **We** will not pay upgraded benefit levels for **treatment** of any **medical condition** which arose or should reasonably have been foreseen by the **member** prior to the upgrade becoming effective. **Members** are required to declare any such **medical condition** to **us** when requesting the upgrade. Where such a **medical condition** is, or becomes, apparent benefits for such a **medical condition** will be restricted to the level of cover that would have been applicable to such a **medical condition** prior to the upgrade.

4 Making claims

Please refer to page 11 for details of how to make a claim.

4.1 Before **we** can consider a claim **you** must ensure that:

- the **member** sends us a completed claim form as soon as they can and no later than 90 days from the date the **treatment** starts; and
- **we** receive original invoices for **treatment** costs; and
- the **member** promptly gives **us** all the information **we** request.

4.2 The **member** must tell **us** on the claim form if they think any of the cost can be claimed from anyone else or under another insurance policy or source (such as but not limited to any Workman's Compensation policy). If so, then:

- if another insurance policy is involved **we** will only pay **our** proper share; or
- if benefits are claimed for **treatment** to a **member** whose injury or **medical condition** was caused by some other person (the "third party"), **we** will pay only those benefits the **member** can claim under the **policy** (unless these are covered by another insurance policy, when **we** will only pay **our** proper share of the benefits). However, in paying those benefits **we** obtain both through the terms of the **policy** and by law a right to recover the amount of those benefits from the third party. In this case the following shall apply:
  - (a) **you** must tell **us** as quickly as possible that the injury or **medical condition** was caused by, or was the fault of, a third party. **We** will then send **you** a form on which the **member** can give **us** full written details;
  - (b) if **you** or the **member** is making a claim, or has not made (or refuses to make) a claim against the third party, **you** or the **member** must act in good faith and do all the things **we** shall require to ensure that monies are recovered from the third party and are repaid to **us** up to the amount of the benefits **we** have paid (and any interest). **You** will be asked to sign a written undertaking to this effect; and
  - (c) if **you** or the **member** do not repay to **us** monies recovered from the third party up to the amount of benefits (and any interest), **we** shall be entitled to recover the same from **you** and/or the **member**.

4.3 **We** can appoint and pay for an independent **medical practitioner** to advise **us** on the medical issues relating to any claim. If required by **us** the independent **medical practitioner** will also medically examine the **member** making the claim and provide **us** with a report. The **member** must co-operate with the independent **medical practitioner** otherwise **we** will not pay the claim.

4.4 If a **member** makes a claim which is in any way dishonest:

- **we** will not pay any benefits for that claim; and
- if **we** have already paid benefits for that claim before **we** discovered the dishonesty **we** can recover those benefits from **you** (the **member** and/or the **company**); and
- ***we*** can take any of the actions listed in 7.2 below.

4.5 Claim costs incurred in any **currency**, other than that which **you** have chosen at the time of your application and has been agreed by **us**, will be converted using the prevailing spot rates when **we** assess the claim. If **we** agree, in writing in advance, to reimburse benefits to a **member** in a **currency** other than the above, the exchange rate used will be as stated. Any exchange costs incurred will be payable by the **member** and will be subtracted from any payment made to the **member** in respect of such a claim.

5 Joining and renewing

Please refer to AXA for details of how to change your **policy**.

5.1 **We** will tell **you** in writing the date your **policy** starts and any special terms which apply to it. **We** can refuse to give cover and will tell **you** if **we** do.

5.2 Your **policy** is for one **year** unless **we** have agreed something different. At the end of that time, provided the **plan you** are on is still available, **you** can renew it on the terms and conditions applicable at that time. **You** will be bound by those terms. However, **we** reserve the right to refuse to accept **you** as a customer or to renew your **policy** at any **policy** anniversary.

6 What we expect from you

6.1 **You** must make sure that whenever **you** are required to give **us** information all the information **you** give is true, accurate and complete. If it is not then **we** can set the **policy** aside or apply different terms of cover.

6.2 **You** must tell **us** if a **member** changes their **principal country of residence** even if they are staying in the same **area**. If **you** don't tell **us we** can refuse to pay benefits.

6.3 **You** must pay your premium when it is due. **We** will decide the amount at the start of each **year** and tell **you** how much it is. **You** can pay it in the way **you** have agreed with **us**. As your **policy** runs for a **year you** must pay your premium for the whole **year** no matter how it is paid. If your premium payments are not up to date your **policy** will end.

6.4 **You** must write and tell **us** if **you** (or any **member**) change your address. **You** are acting on behalf of any **member** covered by your **policy** so **we** will send all correspondence about the **policy** to your address.

6.5 If there is a dispute between **you** and **us we** have a complaints procedure, set out on page 25, which the **member** must follow so that **we** can resolve it.

7 General

7.1 **We** can change all or any part of the **policy** including the **benefits table** or these terms, but only for the reasons shown in **our** handbook or agreement, and the changes will only apply to **you** when **you** renew unless **we** are obliged by law to apply any change with immediate effect. **We** will give **you** reasonable notice of the changes and will send details of them to the address **we** have for the **company** or the **member** on **our** records. The changes will take effect from when **you** renew or when applied by law even if, for any reason, any **member** does not receive details of them.

7.2 If any **member** breaks any of the terms of the **policy** or makes, or attempts to make, any dishonest claim, **we** can:

- refuse to make any payment; and
- refuse to renew your **policy**; or
- impose different terms to any cover **we** are prepared to provide; or
- end your **policy** and all cover under it immediately.

7.3 This **policy** is governed by the laws of Hong Kong. The parties hereby submit to the jurisdiction of the courts of Hong Kong.

7.4 **We** do not pay for administration costs or reports of any kind.

7.5 The terms of your **policy** cannot be changed nor claims authorization given by any verbal communication between **you** and **us**. Any changes, approvals, or other statements relating to your **policy** must be confirmed, in writing, by **us**. **We** are not bound by any verbal commitment not confirmed by **us** in writing.

7.6 For the purposes of determining premiums payable, a **member's** age shall be deemed to be his attained age, and any premium tables or other material **we** provide in this connection shall be read accordingly.

Health at Hand

How could Health at Hand help me?

Health at Hand is a telephone based multi-clinic information service, so you will have the reassurance of immediate access to a qualified and experienced team of healthcare professionals 24 hours a day, 365 days a year.

The team of nurses, pharmacists, counsellors and midwives is on hand to give you the benefit of their expertise. They will also answer your questions and give you all the latest information on specific illnesses, treatments and medications as well as details of local and national organisations. They can also send you free fact sheets and leaflets on a wide range of medical issues, conditions and treatments, and will happily phone you back afterwards to discuss any further questions you may have from what you have read.

Please note:
Health at Hand does not diagnose or prescribe and is not designed to take the place of your General Practitioner. However, it can provide you with valuable information to help put your mind at rest. As Health at Hand is a confidential service, any information you discuss is not shared with our Health Service Team. If you wish to authorize treatment, enquire about a claim or have a membership query our Health Service Team will be happy to help you.

Health at Hand can help you make informed choices day or night

Whether you are calling because you have late night worries about a child's health or you have some questions that you forgot to ask your General Practitioner, it's likely that Health at Hand will be able to provide you with the help you need. Here are just a few examples of the range of topics you can discuss at each of the clinics:

Family Clinic – babies, toddlers, teenage trouble, pregnancy or retirement.

Care and Counselling Clinic – stress, addiction, depression or bereavement.

Healthy Living Clinic – exercise, diet, drinking, smoking and cholesterol control.

Travel Clinic – inoculations, taking children abroad and medical advice by country.

Pills and Prescriptions Clinic – medicines, side effects and pain relief.

Women's Health Clinic – fertility, screenings, menopause and osteoporosis.

Men's Health Clinic – prostate issues, testicular cancer, impotence and fertility.

Health at Hand: (44) 1737 815607

Health at Hand is available to you anytime – day or night, 365 days a year.

You only pay for the call charge to access the service and the service is entirely confidential.

If calling from the UK and Channel Islands please dial 0800 003 004 – calls are free.

if any problems arise...

We will make every effort to provide a high level of service expected by all our policyholders. If on any occasion our service falls below the standard of your expectation, the procedure below explains what you can do:

You may submit your feedback to:

Head of Health Service
AXA General Insurance Hong Kong Limited
21/F, Manhattan Place, 23 Wang Tai Road, Kowloon Bay, Kowloon, Hong Kong

Or alternatively, you can always contact your insurance agent or broker.

If the outcome of your complaint is not handled to your satisfaction, you can write to:

Chief Executive Officer
AXA General Insurance Hong Kong Limited
21/F, Manhattan Place, 23 Wang Tai Road, Kowloon Bay, Kolwoon, Hong Kong

We will respond to your appeal within 14 working days.

AXA General Insurance Hong Kong Limited is a member of the Insurance Claims Complaints Bureau. If your complaint arises over a claims issue, you may write to the Insurance Claims Complaints Bureau at the following address:

Insurance Claim Complaints Bureau
29/F, Sunshine Plaza, 353 Lockhart Road, Wanchai, Hong Kong

Please note: you can only write to the Bureau for a claims dispute when **you** have gone through the required stages of the complaints procedure set out above.

Please remember to quote policy/membership numbers on all correspondence.

your customer charter

As a valued customer of AXA you have important rights and entitlements. You are entitled to expect:

Courtesy. Your requirements will always be dealt with promptly, considerately and courteously. No customer query is too trivial or too much trouble to sort out.

Helpful advice and guidance. AXA staff will help you, if you have any doubts, to understand the terms of your contract and any other factors which affect your cover. They will help you to make proper use of your cover should you need to make a claim.

Confidential handling of your personal details and affairs wherever possible. Any medical details we require will always be kept confidential if possible. AXA may be required to provide information regarding claims you make or have made in the past or other details you have given us to your sponsor or employer or a government department if they are paying for all or part of this policy or are entitled by law to require this of us. No liability will be accepted by us for any outcome resulting from the provision of such information to any of the aforementioned parties.

Advance notification of change in cover. Essential changes to the terms of the cover (including benefits, premiums and your membership agreement) will be notified to you, in writing, in advance of the date from which the changes take effect.

Professional and efficient service. All requests for assistance and any claims you submit will be considered impartially (without any bias or preference) in accordance with the benefits and membership agreement of your plan.

For further information contact your AXA office, details of which can be found on page 28.

benefits table (InternationalExclusive)

Benefits			
Please note: benefit values are per person each year unless otherwise specified and are reduced each time you claim only by the net amount (less any deductible, excess or co-insurance) we have actually paid			
Area of cover	**Asia**	**Worldwide excluding USA**	**Worldwide**
Yearly maximum up to	HK$18,000,000 / US$2,300,000		
Outside area of cover	Emergency treatment only	Emergency treatment only	All areas covered
Level of reimbursement	Reasonable and customary (R&C) charges		
In-patient and daycare treatment (including surgery, consultations, consumables etc.)			
Daily accommodation charges	Included (single en-suite room)		
Parent accommodation up to	HK$1,200/US$150 per night		
Cash benefit	HK$1,200/US$150 per night		
In-patient direct billing	Included		
Applicable in-patient direct billing network	International directory of hospitals		
Level of cover	100% of reasonable and customary (R&C) charges in the international directory of hospitals		
Out-patient treatment (including diagnostics, prescribed drugs, dressings etc.)			
General Practitioner and Specialist consultation charges	Included		
Courses of chiropractic treatment, acupuncture, homeopathy and osteopathy up to	HK$9,000/US$1,150 Up to 5 visits per 5 consecutive weeks		
Traditional Chinese medicine up to	HK$300/US$40 per visit Up to 20 visits per year		
Courses of physiotherapy	Included - Up to 5 visits per 5 consecutive weeks		
Co-insurance applicable to all out-patient claims	10%		
Other benefits			
Health screen up to	No benefit		
Pre-existing conditions up to	Years 1 & 2: HK$18,000/US$2,300 Available only after 9 months membership Subsequent years: HK$36,000/US$4,600		
Maintenance of non pre-existing chronic conditions	Years 1 & 2 up to: HK$18,000/US$2,300 Available only after 9 months membership Subsequent years: included		
Oral and maxillofacial surgery	Included		
Ambulance transport	Included		
International Emergency Medical Assistance	Included		
Psychiatric treatment up to	HK$36,000/US$4,600		
Accidental damage to teeth	Included		
Pre and post-natal complications	Included – available only after 12 months membership		
Pregnancy and delivery up to	No benefit		
Vaccination up to	HK$9,500/US$1,200		
Routine dental care up to	No benefit		
Routine optical care up to	No benefit		
Hospice and palliative care up to	HK$240,000/US$30,000 in a member's lifetime Available only after 12 months membership		

Please see section 'what you're covered for' for terms applying to these benefits

benefits table (International Exclusive Plus)

Benefits			
Please note: benefit values are per person each year unless otherwise specified and are reduced each time you claim only by the net amount (less any deductible, excess or co-insurance) we have actually paid			
Area of cover	**Asia**	**Worldwide excluding USA**	**Worldwide**
Yearly maximum up to	HK$22,500,000 / US$2,900,000		
Outside area of cover	Emergency treatment only	Emergency treatment only	All areas covered
Level of reimbursement	Reasonable and customary (R&C) charges		
In-patient and daycare treatment (including surgery, consultations, consumables etc.)			
Daily accommodation charges	Included (single en-suite room)		
Parent accommodation up to	HK$1,200/US$150 per night		
Cash benefit	HK$1,800/US$230 per night		
In-patient direct billing	Included		
Applicable in-patient direct billing network	International directory of hospitals		
Level of cover	100% of reasonable and customary (R&C) charges in the international directory of hospitals		
Out-patient treatment (including diagnostics, prescribed drugs, dressings etc.)			
General Practitioner and Specialist consultation charges	Included		
Courses of chiropractic treatment, acupuncture, homeopathy and osteopathy up to	HK$9,000/US$1,150 Up to 5 visits per 5 consecutive weeks		
Traditional Chinese medicine up to	HK$300/US$40 per visit Up to 20 visits per year		
Courses of physiotherapy	Included - Up to 5 visits per 5 consecutive weeks		
Co-insurance applicable to all out-patient claims	Nil		
Other benefits			
Health screen up to	HK$8,000/US$1,000 Available only after 12 months membership		
Pre-existing conditions up to	Years 1 & 2: HK$18,000/US$2,300 Available only after 9 months membership Subsequent years: HK$36,000/US$4,600		
Maintenance of non pre-existing chronic conditions	Years 1 & 2 up to: HK$18,000/US$2,300 Available only after 9 months membership Subsequent years: included		
Oral and maxillofacial surgery	Included		
Ambulance transport	Included		
International Emergency Medical Assistance	Included		
Psychiatric treatment up to	HK$60,000/US$7,600		
Accidental damage to teeth	Included		
Pre and post-natal complications	Included – available only after 12 months membership		
Pregnancy and delivery up to	HK$110,000/US$13,800 Available only after 12 months membership		
Vaccination up to	HK$12,000/US$1,500		
Routine dental care up to	80% of eligible expenses incurred up to HK$9,500/US$1,200 Available only after 9 months membership		
Routine optical care up to	HK$2,200/US$280		
Hospice and palliative care up to	HK$300,000/US$38,000 in a member's lifetime Available only after 12 months membership		

Please see section 'what you're covered for' for terms applying to these benefits

your AXA office

AXA General Insurance Hong Kong Limited
21/F, Manhattan Place
23 Wang Tai Road
Kowloon Bay, Kowloon, Hong Kong

Tel: (852) 2523 3061
Fax: (852) 2810 0706
Email: axahk@axa-insurance.com.hk
Website: www.axa-insurance.com.hk

Health Service Team:
Tel: (852) 2867 8680
Email: healthcare@axa-insurance.com.hk

International Emergency Medical Assistance: (852) 2863 5514

Health at Hand: (44) 1737 815607

AXA: a world leader in financial protection

AXA Group in 2008

- 91 billion euros in consolidated revenues
- 981 billion euros in assets under management
- 214,000 employees worldwide working to deliver the right solutions and top quality service to our customers
- 80 million customers across the globe have placed their trust in AXA to:
  - Insure their property (vehicles, homes, equipment)
  - Provide health and personal protection coverage for their families or employees
  - Manage their personal or corporate assets
- Standard & Poor's Rating: AA

AXA General Insurance Hong Kong

- one of the top general insurers in Hong Kong
- over 170 years of local experience in Asia
- over 200 professional, well-trained and caring staff
- wide range of SMART products for individual and business needs

motor
property
leisure & travel
healthcare
personal accident
business packages
liability
marine

(852) 2523 3061

www.axa-insurance.com.hk

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AXA General Insurance Hong Kong Limited
21/F, Manhattan Place, 23 Wang Tai Road, Kowloon Bay, Kowloon, Hong Kong
Tel: (852) 2523 3061 Fax: (852) 2810 0706

redefining / standards