

GENERAL CONDITIONS

2010



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. 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, on the condition that no claims have been submitted yet.

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. Financial Mediation Bureau

If you do not agree with the rejection or 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 Centre for Arbitration and Mediation
Rue des Sols/Stuiverstraat 8
1000 Brussels
Belgium
Tel. + 32 2 515 08 35
Fax + 32 2 515 08 75
info@cepina-cepani.be

4. Contact

- For any enquiries or complaints pertaining to any International Medical Insurance related matter on this policy you may refer to our Medical Claims Contact Center at the following address:

Vanbreda International
P.O. Box 69
2140 Antwerp - Belgium
Tel. + 32 3 217 69 72 (24/7)
Fax + 32 3 235 83 51
claims@expatplus.com

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

Vanbreda International
P.O. Box 69
2140 Antwerp - Belgium
Tel. + 32 3 217 65 29
Fax + 32 3 663 73 14
info@expatplus.com
www.expatplus.com

Chapter I: General policy provisions

I-1. Order of precedence and purpose of the insurance	6
I-2. Definitions, in alphabetical order	6
I-3. Eligibility and acceptance into the insurance	9
I-4. Effective date of coverage	10
I-5. Cooling-off period	10
I-6. Duration and cancellation of policy	11
I-7. Termination of cover	11
I-8. Premium and premium increase	11
I-9. Return to the Home Country	12
I-10. Currency	12
I-11. General exclusions	12
I-12. War and terrorism	13
I-13. Dispute settlement	13
I-14. Data protection	14
I-15. Subrogation	14
I-16. Defence	14
I-17. Complaints procedure	14
I-18. Governing law	14

Chapter II: Benefits and provisions proper to the different types of cover

CORE PLAN

II-1. International Medical Insurance	18
II-2. Medical Evacuation and Assistance Services	25
II-3. Personal Liability	29

ADDITIONAL INSURANCES

II-4. Dental Care	32
II-5. Accidental Death and Invalidity	34
II-6. Temporary Incapacity	38
II-7. Permanent Disability	40

I-1. Order of precedence and 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 Medical Evacuation and Assistance Services, 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 benefits, intended to offer social protection to Expatriated persons.

CORE PLAN

1. International Medical Insurance

The International Medical Insurance cover reimburses - up to the limits defined in this policy - 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. Medical Evacuation and Assistance Services

Emergency Medical Evacuation and Assistance Services are included within the Core Plan.

3. Personal Liability

The Personal Liability of the Insured for claims made by a third party is insured under the Core Plan.

ADDITIONAL INSURANCES

Persons insured under the Core Plan can also apply for the following Additional Insurances:

4. Dental Care

This insurance can be taken out by Insured who are accepted into the Core Plan.

5. Accidental Death and Invalidity

This insurance can be taken out as an Additional Insurance to the Core Plan, and guarantees the payment of a lump sum in case of accidental death or in case of permanent Invalidity caused by an Accident.

6. Temporary Incapacity

This insurance can be taken out as an Additional Insurance on top of the Core 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.

7. Permanent Disability

This insurance can only be taken out as a supplement to the Temporary Incapacity insurance and guarantees the payment of a monthly allowance 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.

I-2. Definitions, in alphabetical order

'Accident'

A sudden, unexpected event, the cause of which is situated outside the victim's body, which 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.

'Administrator'

The Administrator is the Claims Handler and Plan Administrator.

Vanbreda International NV, Plantin en Moretuslei 299, 2140 Antwerp, Belgium or P.O. Box 69, 2140 Antwerp, Belgium, hereafter called the Administrator.

'Assistance Provider'

The provider for emergency Medical Evacuation and Assistance is Mondial Assistance.

‘Complementary Medicine Practitioner’

An acupuncturist, chiropractor, homeopath or osteopath who is legally qualified and allowed to practise complementary medicine by the authorities in the country in which the Treatment is received.

‘Chronic Conditions’

Sickness, Illness, Disease or Injury which has one or more of the following characteristics:

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

‘Day Care’

Treatment in a hospital or medical day-care centre, for which the patient does not have to stay overnight.

‘Day Surgery’

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

‘Deductible’

The (first) part of the (Eligible) Medical Expenses, not reimbursed by the Insurer and deducted from the amount (of Eligible Medical Expenses) on which the reimbursement is calculated.

‘Dentist (or Dental Surgeon)’

A person officially qualified and licensed to practise dentistry in the country where the dental Treatment is received.

‘Dependant’

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 child, who are financially dependent on the Expat.

‘Disease’

A condition marked by a pathological deviation from the normal healthy state confirmed by a Doctor.

‘Doctor’

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.

‘Eligible Medical Expenses’

Medically Necessary expenses incurred due to a covered Illness, Accident or maternity but not exceeding the limits in the Benefits Overview.

‘Expat (or Expatriated person)’

A person living and/or working outside his/her Home Country.

‘Family Doctor or GP (General Practitioner)’

A Doctor providing Medical Treatment not requiring a Specialist Doctor’s training.

‘GP (General Practitioner)’

See definition of ‘Family Doctor’.

‘Home Country’

The country where the Insured normally resides or used to reside and out of which he/she is expatriated to another country (as declared in the application form). If the Home Country cannot be named according to this definition, it is the country of which the Insured has the nationality and is holding a passport from.

‘Host Country’

The country where the Insured is expatriated to, as declared in the application form.

‘Infertility Treatment’

The Treatment of infertility (surgical or by using IVF procedures) and all investigative procedures necessary to establish the cause(s) of infertility (e.g. hysterosalpingography, laparoscopy, hysteroscopy).

‘Injury’

Bodily Injury caused solely by Accident.

‘Illness’

See definition of ‘Disease’.

‘Inpatient Treatment’

Treatment for which, for medical reasons, the patient has to stay overnight in a hospital.

‘Insurance Year’

A twelve-month period, starting on the effective date of coverage of the Insured.

‘Insured’

The person(s) covered by the ExpatPlus insurance and whose names are mentioned in the Special Conditions.

'Insurer'

The insurance company underwriting the risks covered by the insurance plan.

Justitia N.V., Plantin en Moretuslei 301, 2140 Antwerp, Belgium.

'Intensive Care Unit'

A section within a hospital that is designated as an Intensive Care Unit, and which is maintained on a twenty-four (24) hour basis solely for the Treatment of patients in critical condition and which is equipped to provide special nursing and medical services not available elsewhere in the hospital.

'Invalidity'

Sickness, Disease, Illness or the entire Injuries arising out of a single or continuous series of causes, which is of a permanent nature.

'Maximum Annual Reimbursement'

Benefits payable in respect of expenses incurred for Treatment provided to the Insured during the period of insurance shall be limited to overall annual limits as stated in the Benefits Overview. 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'

An accidental Injury or a 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 reasonably be expected to result in loss of life or limb or significant impairment to bodily function or permanent dysfunction of a body part, as determined by the Doctor in attendance.

'Medically Necessary'

A medical service which is:

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

'Outpatient Treatment'

Medical Treatment for which the patient does not have to stay overnight in a hospital.

'Physician'

See definition of 'Doctor'.

'Policyholder'

The employer or the individual Expat 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'

Medical conditions or any related conditions, for which symptom(s) has/have been shown at some point during the five (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 the Insured or his/her Dependants know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

'Prescription Drugs'

Drugs/medicines that are necessary to treat a confirmed medical diagnosis or medical condition, and which are not available without prescription by a Doctor (excluding over-the-counter (OTC) drugs).

'Reasonable and Customary'

Medical expenses will be considered Reasonable and Customary if they correspond to the charge usually made 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 Administrator will determine on behalf of the Insurer to what extent the charge is reasonable, taking into account:

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

'Salary'

The gross Salary being paid to the Insured at the commencement of his/her insurance, before deduction of any income tax. Gross Salary does not include any benefits in kind such as car, living accommodation, bonuses or overtime. In the event of a claim, satisfactory proof of income will be required.

The Salary for a self-employed Insured shall mean the gross average Salary during each of the three (3) years leading up to the date of the event entitling to benefits.

‘Sickness’

See definition of ‘Disease’.

‘Special Conditions’

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.

‘Specialist Doctor’

A Doctor having a specialised qualification in the field of, or expertise in, the Treatment of the Illness or Injury.

‘Standard Private Room’

A room with one bed. A Standard Private Room is the lowest rate (regular) private room in a hospital.

‘Surgery’

Any of the following medical procedures:

- incision, excision or electrocauterisation of any organ or body part, except for dental services;
- repair, revision, or reconstruction of any organ or body part, both invasive and non-invasive;
- reduction of a fracture or dislocation by manipulation;
- 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’

Medical examinations and/or medical procedures needed to restore health, performed or prescribed by a Doctor.

I-3. Eligibility and acceptance into the insurance

3.1. Eligibility

3.1.1. Individual Expats

The ExpatPlus insurance is available for individual Expats (private persons) and their Dependants⁽¹⁾ whose Home Country and/or Host Country is located within the European Economic Area.

3.1.2. Expatriate employees sent on assignment abroad by their employer

The ExpatPlus insurance is available for employers located in the European Economic Area to cover their Expatriated employees (and their Dependants⁽¹⁾) on foreign assignment outside their Home Country.

3.2. Acceptance into the insurance

3.2.1. Individual Expats (‘individual cover’)

A medical questionnaire has to be completed for each Insured (including each Dependant) and has to be sent at the time of application by the candidate-Insured to the medical consultant of the Administrator. The medical consultant can define partial exclusions, total exclusion from cover (refusal of cover), or, at his discretion, propose an additional premium to waive exclusions.

3.2.2. Expatriated employees (‘group cover’)

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

A medical questionnaire has to be completed for each employee and each Dependant and has to be submitted by the candidate-Insured to the medical consultant of the Administrator. The medical consultant can define partial exclusions, total exclusion from cover (refusal of cover) or, at his discretion, propose an additional premium to waive exclusions.

In case of compulsory enrolment by the employer of a group of five (5) or more employees:

No health declaration(s) will be required for the International Medical Insurance plan, meaning that there will be immediate and full acceptance into the International Medical Insurance (including the Emergency Medical Evacuation and Assistance

(1) For the definition of ‘Dependants’ see Art. I-2.; the Core Plan (including Medical Evacuation and Assistance Services and Personal Liability) as well as the Dental Care plan are open to the Insured’s Dependants. The Additional Insurances Temporary Incapacity and the Permanent Disability are not open to the Dependants. The Accidental Death and Invalidity cover, however, can be taken out for the spouse (or legal partner) and dependent adult children (i.e. as from age 18) of the employee or the individual Expat, insofar as these persons are also covered by the Core Plan.

services cover as well as the Dental Care plan) of both employees and Dependants. However, for the Accidental Death and Invalidity cover/Temporary Incapacity cover/Permanent Disability cover, the Insurer can still define partial or total exclusion from cover, or, at his discretion, propose an additional premium to waive exclusions.

3.3. Addition of new Dependants into the insurance

Addition of a spouse/legal partner, subject to the conditions of Art. I-3.2., is possible, provided that the application for the spouse/legal partner is made within one (1) 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 (2) months following the date of birth or adoption. In case the declaration of a new-born has not been made within two (2) months or in case the adopted child is older than two (2) months at the time of declaration, a medical questionnaire has to be completed and has to be sent to the medical consultant of the Administrator. The medical consultant can propose an additional premium of up to one hundred and fifty per cent (150%) to waive exclusions.

Premiums for the new-born baby are to be paid as from the first (1st) month of enrolment.

3.4. Age limits for enrolment

- For individuals Expats, 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 no specific age limit set for enrolment into the Core Plan. For the Additional Insurances, reference is made to the conditions applying to each of these insurance plans.

3.5. Change of level of cover or geographical scope

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

Changing the geographical scope (territoriality) of the cover is always possible in function of the Host Country. 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).

The change of level has to be requested at least one (1) month before the renewal date, the change of territoriality at least one (1) month before the change of Host Country, in writing, to the Administrator.

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 the insurance 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, Art. I-3.4. and I-3.5. are still applicable.

I-4. Effective date of coverage

The insurance cover takes effect on the day immediately following the acceptance by the 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, the insurance cover cannot take effect before the initial premium has been duly received by the Administrator on behalf of the Insurer.

With regard to the declaration of new Dependants, reference is made to Art. I-3.3. 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, the insurance cover cannot take effect before the initial premiums have been duly received by the Administrator (on behalf of the Insurer).

I-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 Administrator for cancellation, provided such request for cancellation is delivered by the Insured to the Administrator within fifteen (15) days from the date of delivery of the policy. The Insured is entitled to the return of the full premium paid, on the condition that no claims have been submitted yet.

I-6. Duration and cancellation of policy

6.1. Period of cover and renewal

The duration of the insurance policy is fixed at three (3) months, starting from the effective date of coverage as stipulated in Art. I-4. above, unless otherwise agreed upon by the parties (Policyholder and Insurer). At the end of the three-month (3-month) period, the policy will be automatically renewed by tacit agreement for successive periods of three (3) months each, unless otherwise agreed upon by the parties. If the effective date of coverage is other than the first (1st) day of a calendar quarter, the policy will be renewed on the first (1st) day of the next calendar quarter.

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 (1) month before the renewal date of the policy. Termination of the Accidental Death and Invalidity cover and/or the Temporary Incapacity cover and/or the Permanent Disability cover and/or the Dental Care 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

Except for changes in the state of health of the Insured incurred after acceptance into the insurance, the Insured is obliged to inform the Administrator of any change in circumstances or conditions that may increase the risk of Illness or Accident (e.g. dangerous professional activity). The Insurer may then propose new insurance conditions (within a period of one (1) month after having received notification of the aggravation of the risk) or cancel the insurance cover (within one (1) month) retro-actively as from the moment of the start of the aggravation of the risk.

I-7. Termination of cover

7.1. 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;
- if the Insured is a dependent child, on the thirty-first (31st) of December of the year during which the dependent child

becomes twenty-eight (28) years old or when he/she is no longer considered to be a dependent child 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.

7.2. 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 fifteen (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 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 fifteen (15) days, starting from the first day of suspension. Claims incurred during the period of suspension are not covered.

I-8. Premium and 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 Administrator) on a quarterly basis in advance, unless otherwise agreed upon between the Policyholder and the Insurer. 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 the fifteenth (15th) of November of the expiring calendar year. The new premium rates will become effective as of the next renewal date, starting on or after the first (1st) of January 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 Administrator at least fifteen (15) days before the renewal date of his policy.

I-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 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 terminated. The Policyholder can nevertheless request - in writing and before the termination date - cover for one additional three-month (3-month) period (without interruption of cover), at the conditions prevailing on the first day of this additional three-month (3-month) 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.

I-10. Currency

The ExpatPlus plan can be taken out in EUR, GBP, USD, or CHF. The choice of currency has to be made (by the Policyholder) before the cover takes effect, and can only be changed at the annual renewal date. Premiums and claims shall be payable in EUR, GBP, USD or CHF, 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 Administrator 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.

I-11. General exclusions

The cover described in this policy does not extend to:

- consequences of a voluntary or intentional act committed by the Insured or his/her beneficiary;
- consequences of hazardous competitions;
- consequences of insurrections or riots if by taking part the Insured or his/her beneficiary has broken the applicable laws;
- consequences of brawls, fights and all kinds of disturbances and measures taken to combat them, except in case of self-defence;
- consequences of the preparation of or participation in crimes or misdemeanours;
- consequences of drug addiction and alcoholism;
- 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;
- events related to bets or challenges;
- expenses resulting from any kind of competition with motor vehicles;
- 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 International Medical Insurance plan and Dental Care;
- consequences of war or acts of war and terrorism, to the extent mentioned in Art. I-12. hereafter. However, this exclusion is not applicable to the International Medical Insurance plan and Dental Care.

Important remark

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

I-12. War and terrorism

12.1. Definitions

‘War’

- armed conflict, declared or undeclared, between one State and another, an invasion or a state of siege.
- also considered as acts of war are: 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 (2) or several parties belonging to one and the same state, the members of which are of different ethnic origin, religion or ideology.
- also considered as acts of civil war are: an armed rebellion, a revolution, a sedition, an insurrection, a coup d'état, the consequences of martial law and border closings ordered by a government or by local authorities.

‘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.

12.2. Description of benefits

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 cover.

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 is covered within the limits and the ceilings of the cover.

However, the insurance cover is not valid when the Insured (or covered Dependants) was travelling to or from or was 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 the Insured or his/her covered Dependants happened. In case of a dispute about whether a given country is known to be in state of war or civil war, the list of countries (or parts of countries) the UK Foreign and Commonwealth

Office (FCO) advises not to travel to ('advises against all travel'), as published on its official website (www.fco.gov.uk), will be decisive.

In the event the Insured whilst abroad is faced with the sudden, unanticipated occurrence of a new (outbreak of) war or warlike situations and activities, the insurance cover remains valid for fourteen (14) days starting from the beginning of the hostilities.

I-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 all disputes or differences which arise between them out of or in connection with this insurance policy, by negotiation between them in good faith. 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 timeframe 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 and 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 (50%) of the total costs. The costs of arbitration do not comprise the costs of each party's counsellor or defence, which remain at the charge of each party.

13.2. Medical disputes

In case the Insured does not agree with decisions of the Administrator's medical consultant, 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 an 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 (2) Doctors cannot agree on the choice of a third Doctor, he/she will be appointed by the President of the Belgian Order of Physicians/Antwerp Provincial Council (called 'Ordre des Médecins/Conseil Provincial d'Anvers' in French and 'Orde van Geneesheren/Provinciale Raad van Antwerpen' in Dutch) in Belgium. Each party has to pay the fees of its own Doctor, the fees of the third Doctor to be paid half by each of the parties.

I-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 and 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 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.

I-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.

I-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.

I-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 ExpatPlus Claims Unit, Vanbreda International, P.O. Box 69, 2140 Antwerp, Belgium.
- if still not satisfied, the Insured can write to the: Chief Executive Officer, Vanbreda International, P.O. Box 69, 2140 Antwerp, Belgium.
- if still not satisfied, the Insured may then refer the case to the Financial Mediation Bureau (see point 3 under Important Information).

I-18. Governing law

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

CORE PLAN

All benefits are valid per Insured person, per Insurance Year (unless specifically stated).

For full benefit details and definitions, please consult the General Conditions on www.expatplus.com.

BENEFITS OVERVIEW - International Medical Insurance

	GLOBE	ORBIT	UNIVERSE
Maximum Reimbursement per Insured and per Insurance Year	€ 1,000,000 £ 650,000 \$ 1,250,000 CHF 1,500,000	€ 1,500,000 £ 1,000,000 \$ 1,875,000 CHF 2,250,000	€ 3,000,000 £ 2,000,000 \$ 3,750,000 CHF 4,500,000
Area 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 Treatment per Insured and per year	€ 0 - £ 0 - \$ 0 - CHF 0 € 100 - £ 65 - \$ 125 - CHF 150 € 300 - £ 200 - \$ 375 - CHF 450	€ 0 - £ 0 - \$ 0 - CHF 0 € 100 - £ 65 - \$ 125 - CHF 150 € 300 - £ 200 - \$ 375 - CHF 450	€ 0 - £ 0 - \$ 0 - CHF 0 € 300 - £ 200 - \$ 375 - CHF 450 € 500 - £ 325 - \$ 625 - CHF 750 € 1,000 - £ 625 - \$ 1,250 - CHF 1,500
1. Hospitalisation Inpatient Treatment (Day Care with overnight stay in hospital)			
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 £ 975 100% up to \$ 1,875 100% up to CHF 2,250	100% up to € 1,500 100% up to £ 975 100% up to \$ 1,875 100% up to CHF 2,250	100% up to € 1,500 100% up to £ 975 100% up to \$ 1,875 100% up to CHF 2,250
2. Outpatient Treatment			
Doctor's fees (generalist, specialist)	80%	90%	100%
Diagnostic tests, lab tests, medical imaging (x-ray, MRI and CT scan)	80%	90%	100%
Prescription Drugs	80%	90%	100%
Physiotherapy	80% up to € 1,000 80% up to £ 650 80% up to \$ 1,250 80% up to CHF 1,500	90% up to € 2,000 90% up to £ 1,300 90% up to \$ 2,500 90% up to CHF 3,000	100% up to € 3,000 100% up to £ 2,000 100% up to \$ 3,750 100% up to CHF 4,500
Preventive care • Yearly 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 CHF 900	100% up to € 800 100% up to £ 535 100% up to \$ 1,000 100% up to CHF 1,200	100% up to € 1,000 100% up to £ 650 100% up to \$ 1,250 100% up to CHF 1,500
Alternative medicines such as homeopathy, acupuncture, chiropracy and osteopathy	80% up to € 1,000 80% up to £ 650 80% up to \$ 1,250 80% up to CHF 1,500	90% up to € 2,000 90% up to £ 1,300 90% up to \$ 2,500 90% up to CHF 3,000	100% up to € 3,000 100% up to £ 2,000 100% up to \$ 3,750 100% up to CHF 4,500
Therapies • 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 CHF 1,500	50% up to € 2,000 50% up to £ 1,300 50% up to \$ 2,500 50% up to CHF 3,000

	GLOBE	ORBIT	UNIVERSE
3. Other Medical Treatment			
Pregnancy and childbirth (a waiting period of 10 months is applied) ¹			
• Pregnancy	Reimbursement according to type of Outpatient Treatment	Reimbursement according to type of Outpatient Treatment	Reimbursement according to type of Outpatient Treatment
• Infertility Treatment and sterilisation (IVF, ICSI, AI and all similar treatments) (per lifetime)	Not covered	Not covered	100% up to € 16,800 (4x € 4,200) 100% up to £ 11,200 (4x £ 2,800) 100% up to \$ 21,000 (4x \$ 5,250) 100% up to CHF 25,200 (4x CHF 6,300)
• Childbirth (without complications)	80% up to € 5,000 80% up to £ 3,250 80% up to \$ 6,250 80% up to CHF 7,500 (100% if home confinement)	100% up to € 7,500 100% up to £ 5,000 100% up to \$ 9,375 100% up to CHF 11,250	100% up to € 10,000 100% up to £ 6,500 100% up to \$ 12,500 100% up to CHF 15,000
• Childbirth (with complications)	see 1. Inpatient Treatment	see 1. Inpatient Treatment	see 1. Inpatient Treatment
Cancer Treatment (excluding experimental Treatments)			
• Hospitalisation and chemo- or radiotherapy	100%	100%	100%
• Other costs	Reimbursement according to type of 2. Outpatient Treatment	Reimbursement according to type of 2. Outpatient Treatment	Reimbursement according to type of 2. Outpatient Treatment
Chronic and Pre-Existing Conditions ²	Covered	Covered	Covered
AIDS/HIV Treatment			
• Inpatient Treatment	100%	100%	100%
• Outpatient Treatment	80%	90%	100%
Nursing at home	80% up to € 160 /day 80% up to £ 110 /day 80% up to \$ 200 /day 80% up to CHF 240 /day (maximum 60 days)	90% up to € 180 /day 90% up to £ 120 /day 90% up to \$ 225 /day 90% up to CHF 270 /day (maximum 60 days)	100% up to € 200 /day 100% up to £ 135 /day 100% up to \$ 250 /day 100% up to CHF 300 /day (maximum 100 days)
Organ transplant (excluding costs for donor – prior approval required)	100% up to € 100,000 100% up to £ 65,000 100% up to \$ 125,000 100% up to CHF 150,000	100% up to € 125,000 100% up to £ 83,500 100% up to \$ 156,250 100% up to CHF 187,000	100% up to € 150,000 100% up to £ 100,000 100% up to \$ 187,500 100% up to CHF 225,000
Kidney dialysis (excluding experimental Treatments)	100%	100%	100%
Local ambulance (to nearest hospital)	100% up to € 1,500 100% up to £ 975 100% up to \$ 1,875 100% up to CHF 2,250	100% up to € 3,000 100% up to £ 1,950 100% up to \$ 3,750 100% up to CHF 4,500	100% up to € 4,500 100% up to £ 3,000 100% up to \$ 5,625 100% up to CHF 6,750
Accident related dental Treatment			
• Emergency dental Treatment	100% up to € 750 100% up to £ 500 100% up to \$ 937.50 100% up to CHF 1,125	100% up to € 1,000 100% up to £ 650 100% up to \$ 1,250 100% up to CHF 1,500	100% up to € 1,250 100% up to £ 850 100% up to \$ 1,562.50 100% up to CHF 1,875
• Dental Surgery	100% up to € 2,000 100% up to £ 1,300 100% up to \$ 2,500 100% up to CHF 3,000	100% up to € 2,500 100% up to £ 1,625 100% up to \$ 3,125 100% up to CHF 3,750	100% up to € 3,000 100% up to £ 2,000 100% up to \$ 3,750 100% up to CHF 4,500

¹ For individuals and companies with less than 5 Insured employees.

² Acceptance of your application is subject to a medical questionnaire and approval by the medical consultant. For companies with more than 5 Insured employees, medical history can be disregarded. 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.

BENEFITS OVERVIEW - International Medical Insurance

Psychiatric care			
• Inpatient Treatment	Not covered	90% up to € 10,000 90% up to £ 6,500 90% up to \$ 12,500 90% up to CHF 15,000	100% up to € 20,000 100% up to £ 13,500 100% up to \$ 25,000 100% up to CHF 30,000
• Outpatient Treatment	see Therapies	see Therapies	see Therapies
Vision care (glasses, frames, contact lenses)	80% up to € 100 80% up to £ 65 80% up to \$ 125 80% up to CHF 150	90% up to € 200 90% up to £ 135 90% up to \$ 250 90% up to CHF 300	100% up to € 300 100% up to £ 200 100% up to \$ 375 100% up to CHF 450
Medical aids (hearing aids and orthopaedic appliances)	80% up to € 1,500 80% up to £ 975 80% up to \$ 1,875 80% up to CHF 2,250	90% up to € 2,500 90% up to £ 1,650 90% up to \$ 3,125 90% up to CHF 3,750	100% up to € 3,000 100% up to £ 2,000 100% up to \$ 3,750 100% up to CHF 4,500

II-1. International Medical Insurance

1.1. Purpose

The International Medical Insurance 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

With respect to eligibility and acceptance into the insurance, reference is made to conditions as set out in Art. I-3.

1.3. Types of International Medical Insurance plans

There are three (3) different plans:

- Globe
- Orbit
- Universe

The plan chosen by the Policyholder is mentioned in the Special Conditions of the insurance policy. Each plan corresponds to a different level of benefits, details of which are mentioned in the Benefits Overview above. With regard to the change of level of cover, reference is made to Art. I-3.5.

1.4. Territorial scope of the insurance

The Policyholder can choose between two (2) geographic areas of cover:

- Worldwide cover
- 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 ninety (90) days (in total) per Insurance Year, medical expenses incurred in the USA or Canada as a direct

consequence of an Accident or a Medical Emergency are covered up to the limits of the policy. If the medical condition concerned already existed prior to the travel to the USA or Canada or 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.

1.5. Benefits

1.5.1. Definitions

Reference is made to Art. I-2.

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 Overview above.

The International Medical Insurance reimburses eligible Reasonable and Customary expenses for outpatient as well as inpatient medical services, provided that these expenses have been incurred because of Illness, Accident or maternity.

Moreover, to qualify for reimbursement, all 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 Overview - always applicable per Insured and per Insurance Year. This means that each ceiling is applicable for a twelve-month (12-month) period of uninterrupted cover, starting on the effective date of coverage of the Insured.

1.5.2.1 Inpatient Treatment

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

Hospital room and board

Reimbursement of the Reasonable and Customary charges 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 stay but in no event shall the benefit exceed, for any one (1) day, the rate of a Standard Private Room.

Intensive Care Unit

Reimbursement of the Reasonable and Customary charges for actual room and board incurred during the Insured's stay as an inpatient in the Intensive Care Unit of the hospital. This benefit shall be payable equal to the Reasonable and Customary actual charges made by the hospital.

No hospital room and board benefits shall be paid for the same hospitalisation period where the daily Intensive Care Unit benefit is payable.

Doctor's fees

- Surgical fees

Reimbursement of the Reasonable and Customary charges for Surgery by a Specialist within the maximum indicated in the Benefits Overview.

- Anaesthetist's fee

Reimbursement of the Reasonable and Customary charges by the anaesthetist for the administration of anaesthesia not exceeding the limits as set forth in the Benefits Overview.

Other medical expenses

- Operating theatre

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

- Hospital supplies and services

Reimbursement of the Reasonable and Customary charges actually incurred for general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, medical imaging (x-ray, CT, MRI, etc), medical aids, laboratory examinations, electrocardiograms, physiotherapy, logopaedic Treatment, speech therapy, occupational therapy and ergotherapy.

Parent accommodation

Reimburses up to the limits stated in the Benefits Overview the expenses for meals and lodging for accompanying an insured dependent child, aged below sixteen (16) years, in hospital.

Hospital cash benefit

Hospital cash benefit is the daily allowance, only when room and board and Treatment are received free of charge. It amounts to 75 EUR/50 GBP/93.75 USD/112.50 CHF per night (Globe) or 100 EUR/65 GBP/125 USD/150 CHF per night (Orbit and Universe) with a maximum of sixty (60) nights.

Convalescence and rehabilitation

Convalescence and rehabilitation rest/care (in a recognised centre and when the admission is medically motivated) is covered when the admission immediately follows (within five (5) days) a hospitalisation for Illness or Surgery and with a maximum of twenty-eight (28) days.

1.5.2.2 Outpatient Treatment

This benefit provides for the reimbursement of actual expenses incurred for Outpatient Treatment subject to the stated sub-limits set forth in the Benefits Overview (if applicable).

Doctor's fees

Consultation with a legally registered General Practitioner, Family Doctor, Specialist Doctor as a result of Sickness and bodily Injuries, when hospitalisation is not required.

Diagnostic tests

Reimbursement of the Reasonable and Customary charges for tests (ECG, x-ray, laboratory tests, etc) which are performed for diagnostic purposes on account of an Injury or Illness, within the amount as set forth in the Benefits Overview and which are recommended by a qualified medical practitioner.

Prescription Drugs/Medicines

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 Preventive care and wellness benefits apply.

Preventive care and wellness benefits

- one (1) adult physical examination per Insurance Year;
- one (1) routine eye test per Insurance Year;
- one (1) (bilateral) mammogram per Insurance Year for insured females as of age thirty-five (35);
- one (1) Pap smear test per Insurance Year for insured females as of age thirty-five (35);
- one (1) PSA test per Insurance Year for insured males as of age fifty (50);

- well baby care;
- vaccinations (adults and children).

Physiotherapy

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

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 overall annual limit per Insured per Insurance Year for:

Pregnancy

Cost are reimbursed according to the type of Outpatient Treatment.

Childbirth

The covered amount includes reimbursement for Doctor's fees, hospital accommodation and other related medical expenses incurred during the hospital stay.

Elective caesarean Surgery is excluded from cover. However, if caesarean Surgery is Medically Necessary, it is covered as Inpatient Treatment. All other deliveries with complications are also covered as Inpatient Treatment.

Infertility Treatment

- Infertility diagnosis

Investigative procedures necessary to establish the cause of infertility.

- Infertility Treatment

The expenses related to Infertility Treatment are covered as outpatient or inpatient expenses, subject to the following conditions:

- it has to concern a primary infertility;
- maximum four (4) attempts per female Insured and per lifetime are covered;
- maximum 4,200 EUR/2,800 GBP/5,250 USD/6,300 CHF per attempt;
- maximum age of the female Insured of forty (40) years;
- the expenses related to the sperm/egg donation are not covered;
- the expenses related to a surrogate mother are not covered;

- prior approval of the Insurer's medical consultant is always required.

- Expenses related to sterilisation

One (1) sterilisation per Insured and per lifetime.

- Ceiling

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

- Waiting period

There is a ten-month (10-month) waiting period for all medical expenses related to Pregnancy, Childbirth and Infertility Treatment 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 groups. Such waiver is only valid if explicitly mentioned in the Special Conditions of the group contract in question.

Cancer Treatment

If an Insured is diagnosed with cancer as defined below, the Insurer will reimburse the Reasonable and Customary charges incurred for the Treatment of cancer performed at a legally registered cancer Treatment centre subject to the limit specified in the Benefits Overview. Such Treatment (e.g. radiotherapy or chemotherapy excluding experimental Treatment, consultation, examination tests) must be received on an inpatient or outpatient basis at a hospital or a registered cancer Treatment centre immediately following diagnosis, or discharge from hospital stay or Surgery.

Cancer is defined as 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.

Organ transplant

Reimburses Reasonable and Customary charges incurred for transplantation Surgery for the Insured being the recipient of the transplant of an organ. Payment for this benefit is applicable whilst the policy is in force and shall be subject to the limit as set forth in the Benefits Overview. The covered amount includes Doctor's fees, hospital accommodation (Standard Private Room) and other related medical expenses during the hospital stay. Prior approval of the medical consultant of the Administrator 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.

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 Treatment of kidney dialysis performed at a Hospital or at a legally registered dialysis centre subject to the limits as specified in the Benefits Overview. Such Treatment (dialysis excluding consultation, examination tests) must be received on an inpatient or outpatient basis.

Kidney failure means end stage chronic renal failure which indicates the irreversible loss of the ability of both kidneys to function as a result of which renal dialysis is initiated. These benefits exclude all experimental Treatments.

Medical aids

Reimbursement of expenses for hearing aids, orthopaedic appliances and stockings, artificial limbs, wheelchairs, etc.

Local ambulance to the nearest hospital

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

Psychiatric care

Outpatient psychiatric care only reimburses care prescribed by and performed by a Doctor. The covered amount includes fees of the Doctor and/or (Treatment fees of) the medical practitioner, but does not include drugs. Drugs are covered according to the provisions for Prescription Drugs.

The following expenses will also fall under the same ceiling as outpatient psychiatric care: ergotherapy, logopaedics and/or speech therapy, occupational therapy.

Dental Treatment following Accident

Dental Surgery is only covered if required to restore damage to natural teeth as a result of an Accident.

1.6. Pre-certification requirement

All inpatient Medical Treatments (except emergency hospital admissions), as well as Day Surgery and Day Care are subject to pre-certification. This means that in case of non-emergency hospitalisation, Day Surgery or Day Care, 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 or Day Surgery), the Administrator 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 hospitalisation, the Administrator 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 per cent (25%) will be applied by the Insurer, meaning that the reimbursement of the eligible expenses will be reduced to seventy-five per cent (75%) 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 Art. I-11., 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 Benefits Overview;
- 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-Prescription Drugs;
- OTC ('over-the-counter') medicines; lifestyle products, dietary products, vitamins, food supplements and food products, baby food, mineral waters, tonics, cosmetic products etc;
- 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), 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;
- participation in any sport as a professional or under contract providing remuneration, as well as any preparatory training.

1.8. Claims procedure/Coordination of benefits - other insurance/Claims payment

1.8.1. Claims procedure

Each claim has to be submitted to the Administrator, in writing - using the special claim forms made available by the Administrator - 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 Administrator.

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 cover - in accordance with the provisions of Art. II-1.5. - will be applied on the difference between the Eligible Medical Expenses and the reimbursement made by the other Insurer.

However, in case ExpatPlus is offered as a supplementary Insurance (and this is reflected in the premium rates of ExpatPlus), the amount reimbursed by the other insurance will be deducted from the amount of reimbursement as determined in accordance with the provisions of Art. II-1.5.

In any 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. Claims payment

The Administrator shall effect reimbursement of the covered Reasonable and Customary medical expenses (up to the limits defined in these General Conditions) following the receipt

of the claim form and the relevant and complete written evidence of the medical expenses (original invoices of medical service providers, etc).

Reimbursements shall be made to the Insured, but if the Insured has deceased, payment shall be made at the sole discretion of the Insurer, or to any person submitting satisfactory evidence that he/she is entitled to such payment. Benefits may be directly assigned to hospitals.

1.9. Medical information and examination

Whenever required for the smooth settlement of 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 Administrator. Confidential information may be forwarded under sealed envelope to the Administrator's medical consultant.

Whenever deemed necessary for the assessment of a claim, the Administrator 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 Administrator as soon as possible after their occurrence. For some Treatments, pre-certification is required (Art. II-1.6.).

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

BENEFITS OVERVIEW - Medical Evacuation and Assistance Services

	GLOBE	ORBIT	UNIVERSE
4. Medical Evacuation and Assistance Services			
Evacuation/Repatriation			
• Emergency medical evacuation to the nearest hospital or emergency medical repatriation	100%	100%	100%
• Accommodation expenses patient and one other insured person (max. 10 days)	€ 100 / day £ 65 / day \$ 125 / day CHF 150 / day	€ 100 / day £ 65 / day \$ 125 / day CHF 150 / day	€ 100 / day £ 65 / day \$ 125 / day CHF 150 / day
• Transport costs of one accompanying Insured person and/or minor children if left alone	100% one-way	100% one-way	100% one-way
Emergency hospitalisation outside home country (> 5 days for adults; > 2 days for children)			
• Transport costs family member	100%	100%	100%
• Accommodation expenses (max. 10 days)	€ 100 / day £ 65 / day \$ 125 / day CHF 150 / day	€ 100 / day £ 65 / day \$ 125 / day CHF 150 / day	€ 100 / day £ 65 / day \$ 125 / day CHF 150 / day
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	€ 1,500 £ 975 \$ 1,875 CHF 2,250	€ 1,500 £ 975 \$ 1,875 CHF 2,250	€ 1,500 £ 975 \$ 1,875 CHF 2,250
Psychological support (2 telephone discussions/Insured)	Covered	Covered	Covered
Cash advance in case of theft papers, travel documents etc	€ 400 £ 260 \$ 500 CHF 600	€ 400 £ 260 \$ 500 CHF 600	€ 400 £ 260 \$ 500 CHF 600
Assistance death			
• Repatriation of mortal remains	100%	100%	100%
• Transport costs of all insured family members	100%	100%	100%
5. Personal Liability³			
Maximum combined reimbursement/event	up to € 4,500,000 up to £ 3,000,000 up to \$ 5,625,000 up to CHF 6,750,000	up to € 4,500,000 up to £ 3,000,000 up to \$ 5,625,000 up to CHF 6,750,000	up to € 4,500,000 up to £ 3,000,000 up to \$ 5,625,000 up to CHF 6,750,000
Bodily Injury and resulting financial loss/claim	up to € 4,500,000 up to £ 3,000,000 up to \$ 5,625,000 up to CHF 6,750,000	up to € 4,500,000 up to £ 3,000,000 up to \$ 5,625,000 up to CHF 6,750,000	up to € 4,500,000 up to £ 3,000,000 up to \$ 5,625,000 up to CHF 6,750,000
Property damage and resulting financial loss/claim	up to € 450,000 up to £ 300,000 up to \$ 562,500 up to CHF 675,000	up to € 450,000 up to £ 300,000 up to \$ 562,500 up to CHF 675,000	up to € 450,000 up to £ 300,000 up to \$ 562,500 up to CHF 675,000
Deductible per claim	€ 75 £ 50 \$ 100 CHF 112.50	€ 75 £ 50 \$ 100 CHF 112.50	€ 75 £ 50 \$ 100 CHF 112.50

³ Personal Liability is included for individuals if the Home and/or Host Country is in the EEA and for companies if the Policyholder is based within the EEA.

II-2. Medical Evacuation and Assistance Services

2.1. Purpose and eligibility

The purpose of the cover is to provide to the Insured the benefits mentioned in Art. II-2.3., in particular the worldwide Medical Evacuation and Assistance Services.

Every person who is accepted into the ExpatPlus International Medical Insurance, and who is aged under seventy-five (75), can automatically enjoy these services.

Newborn children however can only be covered under the Medical Evacuation and Assistance Services after the thirty-first (31st) day from the date of birth.

2.2. Definitions

This article lists the definitions that are relevant to this cover and that are not listed in Art. I-2.

'Family'

Parents, grandparents, descendants, and dependent children aged under twenty-eight (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.

2.3. Description of benefits

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

2.3.1. Evacuation/Repatriation

Should the Insured's condition require repatriation, the Assistance Provider will assist him/her as follows:

- organise and cover his/her return or transportation to a hospital;
- organise and cover the return to his/her home, either in his/her country of origin or in the country in which the Insured is staying;
- organise and cover the transportation to the hospital closest to the Insured's home and/or best equipped to provide the care the Insured's condition requires. In the latter case, if the Insured wishes so, the Assistance Provider can, as soon as the Insured's condition allows it, subsequently organise and cover the return to the country in which he/she is staying;
- organise and cover the return of an insured accompanying person and of minor children. After agreement from its

medical service, the Assistance Provider organises and covers the trip of an Insured to another Insured in order to accompany the latter. The Assistance Provider covers the return to their home of minor children travelling with the Insured if no adult member of the Insured's Family is present on the spot with them and if the Insured's repatriation takes place more than twenty-four (24) hours before the initial date of return of the minor children;

- reimburse the costs of accommodation of both the Insured and his insured Dependants (upon presentation of the necessary proof and within the limits shown in the Benefits Overview) starting as from the date of the Insured's immobilisation up to the date of his/her repatriation to the country of origin.

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

The Assistance Provider will be responsible for implementing the services related to medical emergencies such as hospitalisation and repatriation. Any urgent hospitalisation shall be notified to the Administrator, who 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 the Administrator.

Important remark

Decisions are made based on the Insured's medical condition only.

The Assistance Provider's Doctors will contact the medical organisations on the spot, and, if necessary, the Insured's usual General Practitioner, in order to collect all the information needed to take the decisions best suited to the Insured's state of health.

The Insured's 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 the Insured refuse to comply with the decisions made by the Assistance Provider's medical department, he/she releases the Assistance Provider from any liability with respect to the consequences of such an initiative, and will lose all rights to compensation by the Assistance Provider.

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

2.3.2. Hospitalisation on the spot

The Assistance Provider covers the return ticket, for a member of the Insured's Family coming to the Insured's bedside if the Insured is hospitalised for more than five (5) days (more than

forty-eight (48) hours for minor children or disabled persons who are not accompanied by an adult Family member during their stay).

Moreover, provided that proof of expenditure is submitted, and within the limits indicated in the Benefits Overview, the additional accommodation costs incurred by that said person will be refunded.

This service cannot be combined with the benefit described in Art. II-2.3.1.

2.3.3. Early return

Insofar as the means initially scheduled for the Insured's return to his/her country of origin cannot be used, the Assistance Provider organises and covers the costs of a return trip in the following cases:

2.3.3.1 Transport costs in case of emergency hospitalisation

The Assistance Provider organises and covers the costs in the event of Illness or Accident resulting in emergency hospitalisation of the Insured's de jure or de facto spouse and/or one of his/her minor or disabled descendants not taking part in the trip and living in their country of origin, starting during the period of the Insured's expatriation and involving a life-threatening situation in the opinion of the Assistance Provider's medical staff.

2.3.3.2 Transport costs because of death

The Assistance Provider organises and covers the costs of to attend the funeral, following the death of the Insured's de jure or de facto spouse, one of his/her forbears, descendants, brothers, sisters, his/her legal guardian, the person under his/her guardianship, not taking part in the trip, living in the Insured's country of origin and less than eighty-five (85) years old.

2.3.4. Temporary replacement colleague

In case the professional assignment of the Insured is interrupted as a result of a covered event, the Assistance Provider covers the transportation costs incurred by the Insured's company to enable a colleague to replace him/her and continue the interrupted assignment.

2.3.5. Delivery of essential medicines

Subject to approval of the Insured's prescribing General Practitioner, the Assistance Provider will cover the costs of sending medication which is not available on the spot, provided that

- such medicine is indispensable for an ongoing Medical Treatment;
- no equivalent medicine can be prescribed on the spot;
- that national or international health and customs regulations do not prohibit the sending of such medicine.

The medicine will be sent in the shortest possible time.

The Assistance Provider cannot, however, be held liable for the time taken by the transport companies used or for any unavailability of the medicine.

2.3.6. Rescue costs

The Assistance Provider refunds the costs of search at sea or in the mountains and/or the rescue costs incurred up to the limit as indicated in the Benefits Overview.

2.3.7. Psychological support

In the event of any major trauma following an Illness or covered Accident, two telephone discussions through the Assistance Provider helpline can be offered to the Insured.

2.3.8. Assistance for unforeseen events

2.3.8.1 Communication with the Insured's Family or firm

If the Insured can no longer communicate with his/her Family or company, but has managed to contact the Assistance Provider, the latter will forward any urgent messages.

2.3.8.2 Theft of the Insured's identity papers, credit card, transport tickets or professional documents

If the Insured's identity documents, credit cards and/or travel tickets are stolen:

- the Assistance Provider can give him/her advice on the steps to be taken;
- the Assistance Provider can contact the financial institutions to block the Insured's accounts, insofar as he/she faxes the Assistance Provider a written proxy to do so;
- if the Insured is left without any means of payment, the Assistance Provider grants him/her a money advance up to the ceiling mentioned in the Benefits Overview.

In that case, the Insured has to refund the said advance or the costs incurred by the Assistance Provider on behalf of the Insured within three (3) months as from the date on which the funds were made available. After three (3) months, the Assistance Provider may claim additional legal costs and interest.

2.3.9. Assistance in the case of death

2.3.9.1 Repatriation of mortal remains

The Assistance Provider organises and/or covers

- the transport of the body from where it is placed in the coffin to its place of burial in the country of origin or to its place of burial on the spot;
- the costs required for transport of the body.

2.3.9.2 Transport costs of all insured Family members

The additional costs for the return of the insured accompanying Family members of the deceased Insured to their Home Country, insofar as own means initially planned for their return can no longer be used as a result of the death.

2.3.10. Additional Expat assistance

The Insured has access to a dedicated website enabling him/her to consult the health and geopolitical information on the geographic area of his/her Host Country with the list of health establishments and of medical practitioners, and practical information (translation of medical terms, list of embassies, etc), links to service providers (e.g. car rental firms), plans of airports, city maps, and a guide to customs of the Insured's Host Country.

2.4. Exclusions

2.4.1. Are excluded from cover:

- costs incurred without the prior agreement of the Assistance Provider;
- the consequences of an Illness under Treatment that was not stabilised and/or for which the Insured is in convalescence;
- the consequence of an Illness occurring during a trip undertaken for diagnostic or Treatment purposes;
- the eventual sequelae (control, additional Treatment, recurrences) of an Illness having already resulted in two (2) previous repatriations;
- the consequences of Illnesses or benign lesions that can be treated on the spot;
- pregnancy (except in case of clear, unforeseeable complications), voluntary termination of pregnancy, childbirth, in vitro fertilisation and their consequences;
- evacuation/repatriation as a consequence of psychiatric conditions;
- 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 neurotoxins or agents with remnant neurotoxic effects;which are subject to quarantine or preventive measures or specific monitoring by the local and/or national health authorities in the Insured's Host Country, except for a sudden occurrence after his/her arrival in the area of contamination.
- the Insured's participation in any sport as a professional or under contract providing for remuneration, as well as any preparatory training;
- the Insured's failure to comply with official prohibitions, as well as failure to observe official safety regulations linked to the practice of a sport;
- the consequences of an Accident during the Insured's participation in an air sport (including hang gliding, paragliding, gliding) or in any of the following sports:

skeleton, bobsleigh, ski-jumping, mountain-climbing with roping, rock-climbing, skin diving with self-contained apparatus, spelunking, bungee-jumping, skydiving;

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

2.4.2. Moreover, the Assistance Provider never insures the consequences of the following circumstances and events:

- civil or foreign war, riots, demonstrations, strikes, hostage-taking, handling of weapons;
- voluntary participation in bets, crimes or brawls, except in the case of legitimate self-defence;
- any and all effects of nuclear origin, or effects caused by any source of ionising radiation;
- intentional acts and faults, including suicide and suicide attempts;
- consumption of alcohol, drugs or any other narcotic mentioned in the Public Health Code not prescribed by a Doctor;
- 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 13 July 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;
- the Insured's refusal to embark on the flight initially Benefits Overview by the authorised agency.

2.5. Financial commitment of the Assistance Provider

The organisation by the Insured or by those with him/her can give entitlement to reimbursement of one of the cases of assistance set out above only if the Assistance Provider has been previously advised thereof and given his 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 the Assistance Provider to organise the service.

2.6. Subrogation

The Assistance Provider is subrogated, up to the compensation paid and the services provided thereby, in the rights and actions of the Policyholder or the Insured against any person responsible for the facts having caused his intervention.

When the services provided in performance of this contract are covered, totally or partially, by a Social Security Fund or by any other institution, the Assistance Provider 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 Medical Evacuation and Assistance Services is time-lapsed after a period of two (2) years as from the event of the causal event.

2.8. Claims Procedure

2.8.1. Request for assistance

The Insured must contact the Assistance Provider, or have a third party contact the latter, as soon as the Insured's situation leads him/her to presume that he/she will require an early return or emergency evacuation, or will incur expenses falling within the scope of this cover.

The Assistance Provider is available twenty-four (24) hours a day and seven (7) days a week by telephone on + 32 3 217 69 78.

The Insured will immediately be given a file number, and the Assistance Provider will ask him/her to:

- specify the contract number no. **241 676**;
- provide an address and telephone number where the Insured can be contacted, as well as contact information for the people taking care of him/her;
- allow the Assistance Provider's Doctors to have access to any and all medical information concerning the Insured.

2.8.2. Request for reimbursement

In order to benefit from reimbursement of the expenses paid by the Insured with approval of the Assistance Provider, the Insured will be required to submit all the documents serving as grounds for his/her claim.

Services that were not pre-authorized and that were not organized by the Assistance Provider do not entitle the Insured to any refund or compensation.

2.8.3. Cover of transport costs

When the Assistance Provider organises and covers transportation falling within the scope of its benefits, such transportation will be undertaken by train, 1st class, and/or by air, economy class, or by taxi, depending on the Assistance Provider's decision. In such cases, the Assistance Provider becomes the owner of the initial tickets and the Insured undertakes to return them to the Assistance Provider or to refund the amount reimbursed to the Insured by the body having issued the said travel tickets.

2.9. Framework of assistance interventions

The interventions of the Assistance Provider are undertaken within the framework of national and international laws and regulations. Its services are provided subject to obtaining the required permission from the authorities of the pertaining jurisdiction.

Moreover, the Assistance Provider cannot be held liable for delayed performance or failure to provide the services agreed upon in any case of force majeure or of occurrences of events mentioned in Art. II-2.4.

II-3. Personal Liability

3.1. Scope

The Assistance Provider guarantees the financial consequences of any private liability the Insured incurred under the application of the legislation or case law of his/her Host Country, resulting from:

- bodily Injuries;
- damage to property;
- consequential immaterial damage resulting from covered bodily Injuries or damage to property, following an Accident in the course of the Insured's private life and affecting a third party which is caused by the Insured, by people for whom he/she is responsible or by objects or animals in his/her charge.

3.2. Subsidiarity

The Insured benefits from this cover during his/her stay abroad only in those countries where he/she does 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 Benefits Overview.

- the limit per event shown in the Benefits Overview is the maximum amount guaranteed for one (1) and the same event, including all forms of bodily Injury, damage to property and direct consequential damages;
- in all cases, a Deductible per claim of 75 EUR/50 GBP/100 USD/112.50 CHF will apply.

3.4. Benefits exclusions

In addition to the exclusions mentioned in Art. I-11., the following exclusions apply:

- the consequences of damage caused to members of the Insured's Family, his/her agents, whether or not they are salaried, in the exercise of their functions or any other person listed as Insured under the present contract;
- the consequences of damage caused to animals or objects that belong to the Insured or that have been loaned, lent or entrusted to him/her;
- the consequences of damage caused by:
 - any overland motor vehicle corresponding to the definition of Art. 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;
- 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;

- 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;
- the consequences of damage caused in the course of the Insured's professional activity or during his/her participation in an activity organised by any non-profit association, institution or community;
- the consequences of the Insured's contractual responsibility;
- the consequences of any liability the Insured may have with relation to a fire, explosion or water damage.
- Moreover, 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 1 August 2003.

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

3.6. Claims Procedure

The Insured must neither accept any acknowledgement of liability nor any transaction without the Assistance Provider's agreement. Nevertheless, the admittance of a material fact or the performance of a simple duty of assistance does not constitute an acknowledgement of liability. The Insured must send a declaration of the claim to the Assistance Provider, in writing, within five (5) working days following his/her knowledge thereof, except for fortuitous cases and any case of force majeure.

Upon expiry of that period, if the Assistance Provider suffers any prejudice as the result of a late declaration, the Insured will lose all his/her rights to compensation;

In the event of any proceedings being taken against the Insured, he/she gives the Assistance Provider full power to handle the suit and to use any recourse in the civil courts or to ensure his/her defence and use any recourse in civil interests before the criminal courts. The Insured must forward to the Assistance Provider upon receipt any summons, writ, extrajudicial instrument or procedural exhibit sent to or served upon him/her. In the event of delay in forwarding such documents, the Assistance Provider is entitled to claim from the Insured compensation in proportion to the prejudice suffered by him (Art. L 113-11 of the Insurance Code).

If the Insured fails to meet his/her obligations, the Assistance Provider compensates the third parties and their beneficiaries, but can take proceedings against the Insured to recover the paid amounts.

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, the Assistance Provider constitutes the guarantee up to the amount of the cover.

If no cover is organised, 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 the Assistance Provider's guarantee, the annuity is entirely for the Assistance Provider's account. If it is higher, only the part of the annuity corresponding in capital to the amount of the Assistance Provider's guarantee is for the Assistance Provider's account.

ADDITIONAL INSURANCES

II-4. Dental Care

4.1. Eligibility

Dental Care is only open to Insured who are accepted into the International Medical Insurance plan.

The choice for taking out the Dental Care 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 insured Dependants who are accepted into the International Medical Insurance plan, have to

- take out Dental Care or not (i.e. all family members or none);
- opt for the same Dental Care cover (Basic or Comprehensive).

If the Dental Care cover has been subscribed, it has to be maintained for at least one (1) year (unless the contract is terminated).

4.2. Territorial scope of the insurance

With respect to the Core Plan and the Additional Dental Care Insurance, the Policyholder can choose between two (2) geographic areas of cover:

- worldwide cover
- 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 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.

4.3. Benefits

Only expenses that are Reasonable and Customary can qualify for reimbursement, subject to the limits and ceilings as mentioned in the Benefits Overview hereafter.

4.3.1. Basic Dental Care

Basic Dental Care includes up to two (2) periodic check-ups per year, prophylactic Treatments, fillings, root canal Treatment, extraction, paradental Treatment, Treatment of paradontosis, Treatment of gums, etc.

4.3.2. 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 is included under major dentistry.

4.4. 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. Such waiver is only valid if explicitly mentioned in the Special Conditions;
- orthodontic Treatment is only covered if started before age fifteen (15).

4.5. Other provisions

Apart from the General Policy Provisions as set out in Chapter I of the General Conditions, the provisions of Art. II-1.8. up to and including II-1.10. also apply to the Dental Care cover.

BENEFITS OVERVIEW - Dental Care

	BASIC	COMPREHENSIVE
Maximum Annual Reimbursement per Insured	€ 3,000 £ 2,000 \$ 3,750 CHF 4,500	€ 5,000 £ 3,250 \$ 6,250 CHF 7,500
Basic Dental Care (check-ups, basic Treatments)	80% up to € 1,500 80% up to £ 1,000 80% up to \$ 1,875 80% up to CHF 2,250	100% up to € 2,500 100% up to £ 1,625 100% up to \$ 3,125 100% up to CHF 9,750
Major dentistry (orthodontic, prostheses, bridges, implants) Orthodontic Treatment is only covered if started before age fifteen (15). A waiting period of twelve (12) months applies to all major dentistry for individuals.	60% up to € 1,500 60% up to £ 1,000 60% up to \$ 1,875 60% up to CHF 2,250	80% up to € 2,500 80% up to £ 1,625 80% up to \$ 3,125 80% up to CHF 3,750

II-5. Accidental Death and Invalidity

5.1. Purpose and eligibility

The Accidental Death and Invalidity cover guarantees:

- the payment of a lump sum in case of accidental death or;
- the payment of a lump sum in case of permanent Invalidity of at least 20%, caused by an Accident.

The Accidental Death and Invalidity cover can be taken out for or by the Expat, as well as for or by his/her adult Dependants as defined in Chapter I.

5.2. Time limits for the declaration of the Accident, claim assessment and benefits payment

5.2.1. 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 Administrator 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.

5.2.2. Time limit for claim assessment and benefits payment

In case of accidental death, which has to occur within twelve (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 one (1) year after the date of the Accident. However, if the Insured's condition has not entirely stabilised within two (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 two-year (2-year) period.

5.3. 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 EUR/32,500 GBP/62,500 USD/75,000 CHF and can be increased up to a maximum sum insured of 500,000 EUR/325,000 GBP/625,000 USD/750,000 CHF. Premiums and benefits (lump sum) are calculated on the basis of the sum insured.

5.4. Insured benefits

5.4.1. 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 Art. II-5.2. caused by the same Accident which led to the Invalidity will be reduced by the amount already paid for the Invalidity.

5.4.2. Accidental 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.

5.5. Assessment of the degree of permanent Invalidity and use of the table of Invalidity

5.5.1. Table of Invalidity

Following table of Invalidity will be used to determine the degree of Invalidity:

Table 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%	

5.5.2. 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.

5.5.3. 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.

5.5.4. 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.

5.5.5. 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.

5.5.6. 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.

5.5.7. 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.

5.5.8. 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 instead of upper left limb, and vice versa.

5.5.9. 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.

5.6. Additional exclusions

In addition to the general exclusions mentioned under Art. I-11. and I-12., following exclusions shall apply to the Accidental Death and Invalidity cover:

- accidents resulting from obviously foolhardy and/or reckless acts by the Insured, or Accidents he/she has intentionally caused or provoked;
- the consequences of suicide or of suicide attempts;
- accidents occurring in a state of drunkenness or under the influence of non-Prescription Drugs except if it is established by the Insured or his/her 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.

5.7. Obligations to be fulfilled by the Insured

5.7.1. 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 Administrator) 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.

5.7.2. 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 Administrator) within one (1) month. In the absence of such communication, any amount unduly paid to the Insured will have to be refunded by him/her to the Insurer.

5.7.3. 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.

5.7.4. Force majeure

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 majeure'), or if the good faith of the Insured cannot be called into question.

5.8. Payment of the benefit

At the inception of the policy, the Policyholder has to provide the Administrator with the duly completed and signed Designation of Beneficiaries form.

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 one (1) month of receiving:

- the documents mentioned under Art. II-5.7.1.; and
- copy of the birth certificate of the deceased or a certificate of civil status; and
- an original death certificate; and
- a detailed 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 Insured.

Following documents have to be provided to the Administrator:

- the documents mentioned under Art. II-5.7.1.;
- 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 (Art. II-5.5.).

After all documents have been received by the Administrator and the condition of the Insured concerned has sufficiently stabilised to allow the Insurer's medical consultant to assess the degree of Invalidity (according to the provisions as set out in Art. II-5.5.), payment of the insured sum due will be made within one (1) month.

II-6. Temporary Incapacity

6.1. 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 two (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.

6.2. 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 International Medical Insurance cover, a new medical questionnaire has to be filled out.

6.3. Temporary Incapacity benefit

The Temporary Incapacity cover provides for a monthly allowance in case the Insured - further to an Illness or an Accident - is totally unable to perform his/her own professional occupation (i.e. the usual professional occupation at the time the incapacity started).

6.4. Waiting period

The allowance is payable after a waiting period of ninety (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.

6.5. 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.

6.6. 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 EUR/ 650 GBP/1,250\$ USD/1,500 CHF (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 EUR/6,500 GBP/12,500 USD/15,000 CHF per month.

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

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

6.7. Partial resumption of work

Persons who (after the ninety-day (90-day) 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 two (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.

6.8. Relapse

In the event of a relapse, the payment of the allowance shall be resumed without application of a new waiting period. By 'relapse' is meant: the incapacity to work, which arises within three (3) 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 ninety (90) days.

6.9. Benefit payment

The incapacity allowance shall be payable to the Insured, 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;
- at the end of the period of two (2) years of payment of the allowances;
- in the event of the insurance policy being terminated for the non-payment of the premium;
- on the renewal date after the sixty-fifth (65th) birthday of the Insured;
- when the Insured fully resumes work.

6.10. Additional exclusions

In addition to the general exclusions mentioned in Art. I-11. and I-12., the following exclusions apply to the Temporary Incapacity cover:

6.10.1. 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.

6.10.2. 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.

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

6.11.1. 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 Administrator 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 Administrator, for the attention of the Insurer's medical consultant. Furthermore, a proof of income has to be provided.

6.11.2. 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 Administrator) within a month. In the absence of such communication, any amount unduly paid to the Insured will have to be refunded by him/her to the Insurer.

6.11.3. 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.

6.11.4. Force majeure/Good faith

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 majeure'), or if the good faith of the Insured cannot be called into question.

II-7. Permanent Disability

7.1. Purpose and eligibility

7.1.1. 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.

7.1.2. 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.

7.2. 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.

7.3. Definition of Permanent Disability (resulting from an Illness or Accident)

7.3.1. 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 has been reduced,
- 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 Table of Disability hereafter (Art. II-7.6.).

7.3.2. Permanent Disability

Permanent Disability means that the 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.

7.4. 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.

7.5. Assessment of Disability

The degree of Permanent Disability will be determined by means of a medical examination.

To this end, the Insurer (or the Administrator on behalf of the Insurer) will appoint a Doctor to determine the degree of Disability in accordance with the Table of Disability hereafter.

7.6. Amount and duration of the benefit

7.6.1. 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.

Degree of Permanent Disability of less than 33.33%

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 Art. II-7.3. and II-7.5. 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 (%).

Degree of Permanent Disability exceeding 66.67% (=2/3)

If the degree of Disability, as determined in accordance with the stipulations of Art. II-7.3. and II-7.5. above, exceeds 66.67%, then the amount of the Disability allowance will be equal to the amount of the insured allowance (100%).

Table of Disability

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

7.6.2. 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;
- using the toilet or bedside commode;
- 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 EUR/16,250 GBP/31,250 USD/37,500 CHF (single lump sum) to the Insured.

7.6.3. 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.

7.6.4. Duration of benefit

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

- reaches the age of sixty-five (65);
- deceases;
- resumes work;
- whichever event occurs first.

7.7. 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 Administrator should have received a copy of the Insured's birth certificate or a certificate of civil status.

7.8. Additional exclusions

In addition to the general exclusions mentioned in Art. I-11. and I-12., the following exclusion applies 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.

7.9. Obligations to be fulfilled by the Insured

7.9.1. 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 medically examined to assess the Disability. Furthermore, a proof of income has to be provided.

7.9.2. 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 Administrator) within one (1) month. In the absence of such communication, any amount unduly paid to the Insured will have to be refunded by him/her to the Insurer.

GENERAL CONDITIONS

If you need any additional information, please contact us.

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