

# SUMMARY OF THE GENERAL CONDITIONS OF THE OPALE HEALTH INSURANCE CONTRACT

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## PREAMBLE :

An optional-membership group insurance contract has been concluded between Association Schetland and certain underwriters at Lloyd's of London. This Contract is governed by the general conditions, the special agreements, the special conditions, the schedule and the membership certificate.

The Insurer has appointed Amaris Limited, Imperial House, 1 Harley Place, Bristol, BS8 3JT, United Kingdom as Administrator. The latter shall have the authority to review application forms, collect premiums and administrate claims up to their payment. All communications and notices to the Insurer concerning this Contract shall be made direct to the Administrator.

## DEFINITIONS :

The following definitions apply to this Contract :

**SUBSCRIBER:** The Association Schetland, signatory to the Contract for the benefit of one or several Members.

**MEMBER:** The actual person(s) benefiting from cover under the Contract.

**INSURER:** Certain underwriters at Lloyd's of London.

**POLICYHOLDER:** The group of Members.

**ILLNESS:** Any change in health or pathological state certified, treated or diagnosed by a qualified medical doctor, consultant or specialist.

The following, amongst others, are considered to be illnesses:

- dermatosis, even if caused by external agents;
- varicose veins, sciatica, rheumatism, attacks of poliomyelitis and non-traumatic epilepsy;
- cardiac, cerebral, or vascular injuries, such as aneurysmal rupture or apoplexy;
- blackouts and injuries which may result therefrom;
- consequences of exertion and overwork and other complaints resulting therefrom, such as a strained back, lumbago, muscular or tendinous ruptures and tears;
- all types of hernia;
- congealing, congestion, sunstroke and their consequences, and complaints resulting from atmospheric influences in general;
- consequences of surgical procedures undergone by the Member other than surgical procedures in respect of an accident covered hereunder;
- injuries caused by X-rays, radium and its constituents and derivatives, unless they are caused, for the person being treated, by defective functioning or false manipulation of instruments.

**CHRONIC ILLNESS:** Illness contained in the list of 30 chronic illnesses (ALD 30) recognised by the French Social Security and covered at 100% of the French Social Security's 'Base de Remboursement'.

**ACCIDENT:** Any bodily attack, unintentional on the part of the Member resulting from a sudden and unforeseen action from an external cause.

The following are assimilated to an accident:

- acts of aggression on the Member;
- suffocation, drowning or immersion syncope;
- poisoning or burns (including gas and steam burns) by poisonous or corrosive substances or by bad food;
- snake bites, cases of rabies or anthrax caused by animal bites or stings;
- electrocution, being struck by lightning;
- infectious stings or bites and their consequences.

**MATERNITY:** The state of pregnancy, childbirth, the consequences of childbirth as well as the pathological complications of these events.

**PREMATURE NEW-BORN:** The birth of a baby before the standard period of pregnancy is completed. In most systems of human pregnancy, prematurity is considered to occur when the baby is born sooner than 37 weeks after the beginning of the last menstrual period.

**'BASE DE REMBOURSEMENT DE LA SECURITE SOCIALE' OR RATE OF LIABILITY:** The base rate used by the French Social Security system to calculate its reimbursements. It is determined conventionally between the Social Security bodies, the medical practitioners' unions, and the hospitals and other medical establishments.

**EXCESS OF FEES:** Difference between the actual expenditure by the Member and the French Social Security's 'Base de Remboursement'.

**PATIENT'S CONTRIBUTION TO HOSPITAL ACCOMMODATION EXPENSES:** Lump sum contribution for each stay in a hospital or clinic, as well as in any establishment, centre and home for treatment, convalescence and rest.

**WAITING PERIOD:** The period following the commencement of membership or increased cover, at the end of which entitlement to benefits is established. The waiting period is counted from the date of inception of cover.

Treatment carried out during a waiting period, illnesses and maternities whose first symptoms appeared, or which were medically certified, treated or diagnosed during this period, cannot give rise to the payment of benefits, even after the waiting period has expired.

**HOSPITALISATION:** A medically-prescribed stay of at least one night in a private or public hospital approved by the Department of Health, in order to medically or surgically treat an illness or accident. Hospitalisations at home, day case hospitalisations and courses of therapy are considered to be 'everyday medical treatment'.

**COOLING-OFF PERIOD:** The period of time after signature of the application form during which the Member is able to cancel his/her membership without incurring any penalties.

## ARTICLE 1 :

This Contract is governed by the general conditions, the special agreements, the special conditions and the schedule.

## ARTICLE 2: PURPOSE AND SCOPE OF THE INSURANCE

### BENEFICIARIES

In order to benefit from cover under the Contract, the main Member must be a member, former member or honorary member of Association Schetland, Subscriber of the Contract.

All the persons listed on the membership certificate and paying their premiums are beneficiaries of the insurance, ie. the Member, his/her spouse, his/her dependants up until the 31st December following their 20th birthday, at which time they should take out their own OPALE membership.

The purpose of the insurance is to reimburse the medical, surgical, hospital and clinical expenses actually incurred by the Member resulting from an illness, chronic illness or accident occurring during the course of the Contract on the basis of the option chosen by the Member, within the limits chosen by the Subscriber and indicated in the table of benefits, and subject to the exclusions. Cover and the entitlement to benefits cease on the effective date of cancellation. When the Member ceases to be covered for whatever reason, his/her spouse or partner and dependent children will no longer be covered. Cover is for life, provided this Contract remains in force. In the event of deterioration of the Member's state of health, the Insurer shall not be able to exclude him/her from the Contract or increase his/her premiums.

## ARTICLE 3: COMMENCEMENT AND DURATION OF THE CONTRACT

Cover commences on the date requested by the Member and on the date of receipt of his/her application form at the earliest, subject to medical acceptance. In the event of further medical investigation being necessary for one or more of the persons listed on the application form, it will be forwarded to the Insurer for acceptance. Until the Insurer's decision has been received, accident cover only shall be provided for a maximum of two months from subscription. The Insurer reserves the right to ask for any proof of state of health or medical examination. The foregoing does not apply to the newborn children of a Member who has been paying premiums for more than three (3) months, and who are registered within two (2) months of their birth. For the premature new-born children of a Member who has been paying premiums for more than three (3) months, an application must be completed for the child within fourteen (14) days of the child being born. Commencement of the Contract is subject to the payment of the first premium.

### RENUNCIATION

The Member has a 30-day cooling-off period from notification of the acceptance of his/her membership by the Insurer during which he/she can renounce his/her membership. The Member must thus send a recorded delivery letter with advice of delivery to the Administrator based on the following model:

*« I the undersigned: (Surname and First Name) ..... Born on the: ..... and residing at: ..... renounce my application for membership to the OPALE contract made on the ..... Signed at ..... on the ..... Signature. »*

### WAITING PERIODS

#### Private Health Insurance cover and Economy Private Health Insurance cover:

- No waiting period for accidents. A medical certificate as confirmation of the accident will be required.
- 3 months for illnesses and medical treatment.

-10 months for maternity.

- 9 months for dentures and orthodontic treatment, psychotherapy and neuropathology, orthopaedic and auditory prostheses and equipment, hydrotherapy and sun-and-sea-air therapies and cures, sexually-transmitted diseases.

#### Hospitalisation cover:

- No waiting period for accidents. A medical certificate as confirmation of the accident will be required.
- 3 months for illnesses and medical treatment.

-10 months for maternity.

- 9 months for psychotherapy and neuropathology, orthopaedic and auditory prostheses and equipment, hydrotherapy and sun-and-sea-air therapies and cures, sexually-transmitted diseases.

#### Top-up cover:

- 10 months for maternity (Level 2 cover).
- 6 months for dentures and orthodontic treatment (Level 2 cover).

- No waiting period for Level 1 cover.

The waiting period is waived:

- If the Member can prove he/she was covered by an equivalent scheme up to 3 months or less before the inception date shown on the membership certificate (a detailed certificate of cancellation or similar justificatory document and details of the previous cover should be provided).

-For new-borns who join before they are two months old (provided that the parents have been paying premiums for more than 3 months).

**DURATION OF COVER, CANCELLATION:** The annual renewal date is the 1st January, the Contract having been concluded from the date it takes effect until the next annual renewal date. The Contract is renewed tacitly at each successive annual renewal date for a further period of one year. The Insurer, the Subscriber and the Member may cancel the Contract in accordance with the following conditions:

#### - By the Insurer

\* when the Member no longer fulfils the conditions required for belonging to the group.

\* in the event of non-payment of premiums, or in the event of deception, omission, or false information on the part of the Member, either on subscription or during the course of the Contract (no benefits will be paid for events occurring before the date of cancellation).

#### - By the Subscriber or the Member

\* by the Subscriber or the Member sending a recorded delivery letter at least one month before the annual renewal date.

\* in the case of a rate increase, the Subscriber and the Member have the option to cancel during the two weeks following the date on which they are notified of the new rates. The cancellation will take effect one month after notification by recorded delivery letter.

**PREMIUMS:** Premiums (applicable taxes included) are based on the age of the Member on joining, up to the age of 80. Premiums vary each year according to the claims experience of the group covered by this collective contract. Premiums are payable annually in advance. However, the Insurer accepts monthly, quarterly or six-monthly payments.

In the event of joining or cancellation during the course of a year, the premium only is due pro-rata, except in the event of non-payment of premiums where the Insurer is also entitled to the part of the annual premium falling due for the period after the date of cancellation.

**NON-PAYMENT OF PREMIUMS:** The payment of a premium only covers the Member until the due date of the following premium. Cover is suspended whilst the premium is unpaid. If one of the premiums is not paid within 10 days of its due date, the Administrator will send a recorded delivery letter to the Member informing him/her that after a period of 30 days from the date of sending of this letter, the non-payment of the premium will lead to the suspension of cover, and to cancellation of his/her membership 10 days thereafter. No benefits are due for medical or hospitalisation expenses incurred during periods of suspension of cover, or resulting from illnesses, accidents or maternities which were medically diagnosed or arose during these periods.

The Administrator will provide the Subscriber with regular updates on the status of the memberships to the Contract.

## ARTICLE 4: COVER

**COVERED INCIDENTS:** The Insurer reimburses directly, or via the Administrator or one of its authorised administrative organisations, the actual expenses incurred by the Member on his/her behalf and on that of the members of his/her family, provided that they have been medically prescribed and are covered by the special conditions.

**LIMITS:** After having deducted claims payments from other Insurers, reimbursements or acceptances of hospitalisations are subject to the upper limits indicated in the tables of benefits, but cannot however exceed the amount actually spent by the Member.

## ARTICLE 5: EXCLUSIONS

All expenses incurred before the date of inception of cover or resulting from illnesses, accidents or disabilities contracted prior to this date (unless otherwise agreed by the Insurer).

All expenses resulting from illnesses, accidents or disabilities which are first medically diagnosed after the end of cover are also excluded.

Any claim caused intentionally by the Member is excluded from cover under the Contract.

The Insurer is not obliged to reimburse claims for treatment and/or disabilities, costs and expenses:

- resulting from participation in military service, foreign or civil war, riots, strikes, lockouts, civil commotion, rebellion, revolution, insurrection, fighting (unless it is in legitimate defence), terrorism, military or usurped power or illegal act, including resultant imprisonment.
- resulting from illnesses or accidents caused by races, matches or bets, record attempts (other than normal competitive sport), exhibitions, acrobatics, aviation (other than as a passenger on normal commercial airlines).
- resulting from the release of weapon(s) of mass destruction, (nuclear, chemical or biological), whether such involve(s) an explosive sequence(s) or not.
- resulting from illnesses and/or accidents caused by drunkenness, alcoholism, or the use of drugs;
- which are not directly linked to an illness or accident, for example rejuvenation, weight control, sleep, detoxification, aesthetic treatments and therapies (unless they result from a covered accident), etc.;
- following ill-health due to explosions or radiation caused by nuclear reaction, transmutation of the nucleus of an atom or radioactivity;
- following abortions for non-medical reasons;
- caused by specific neuropsychiatry, with the exception of the psychiatric illnesses normally covered by the French Social Security as chronic illnesses;
- generated by the practice of the following sports: parachuting, rallying, and competitions involving the use of land-based motor vehicles, microkite and hang-glider;
- relating to the costs of all stays which are usually reimbursed according to the criteria applicable to 'long stays', whatever the type of establishment;
- for private rooms and daily lump sums in the following cases: convalescence and rest homes, neuropsychiatry, physiotherapy, gerontology or dietary centres, and other similar establishments.
- incurred by premature new-borns after 14 days from the date of birth until 30 days following discharge from hospital.

The fact that the Insurer has paid benefits, even on several occasions, does not mean that they tacitly renounce the right to apply a restriction or exclusion provided for under the Contract.

## ARTICLE 6: CLAIMS

Claims should be made to the Insurer or its representatives using the claim forms provided to the Member. Claims payments will be made by cheque or bank transfer payable to the Member. Medical expenses are reimbursed by the Insurer or the Administrator as quickly as possible and, in any case, within one month of receipt of the supporting documents. In the case of a hospital, clinic, chemist, radiologist or laboratory requesting settlement of an invoice, the Insurer or the Administrator shall pay the establishment in place of the Member, within the limits of cover. **CLAIMS FORMALITIES:** In order to be reimbursed, the Member should send the original treatment form, duly completed and signed, as well as any detailed supplementary fee notes and invoices confirming the amounts spent and the nature of the treatment provided. A request for prior authorisation should be sent to the Insurer or the Administrator for orthodontics as well as courses of physiotherapy and speech therapy, failing this reimbursement will be limited. The total of the various reimbursements obtained by a Member cannot exceed the amount he/she has actually spent. Previous reimbursements will therefore automatically be taken into account. Costs incurred during a stay of up to 3 months in any country outside the European Economic Area or Switzerland are reimbursed under the Contract. They are reimbursed in Euros according to the French Social Security's 'Base de Remboursement', provided that they are for medically-prescribed treatment. The receipt and the invoice should be sent together to the administrative organisation.

**DAILY LUMP SUM IN THE EVENT OF HOSPITALISATION:** In order to obtain the payment of benefits due, the Member must submit to the Administrator a medical certificate specifying the number of consecutive nights he/she has spent in hospital as well as the reason for the hospitalisation. Benefits will be paid to the Member monthly in arrears from the 4<sup>th</sup> night of hospitalisation until the Member is discharged or until the 365<sup>th</sup> consecutive night in hospital, subject to a maximum of EUR 27,080.00 per covered hospitalisation.

Where the Member is the victim of an accident caused by a third party, he/she must declare this accident to the Insurer as soon as possible. The Insurer has the right to recover any benefits they have paid out as a result of the accident from the responsible party and the Member shall do and concur in doing and permit all such acts as may be necessary or required by the Insurer for enforcing any rights or remedies against such party. The Member prevent this recovery from being carried out for any reason, the Insurer would not be liable for any benefits up to the amount which they would otherwise have been able to recover.

The Member must undertake any appraisal or examination considered to be necessary by the Insurer; failing this, payment of benefits will be declined.

**TIME LIMIT FOR DISPUTING CLAIMS:** Claims can only be disputed up to three months after their payment by way of recorded delivery letter sent directly to the Insurer or the Administrator.

## ARTICLE 7: TIME LIMIT FOR MAKING CLAIMS

Claims must be made within two years of the date of treatment.

## ARTICLE 8: TERRITORIAL LIMITS AND FOREIGN STAYS

Members may be of any nationality, but must reside in the European Economic Area or Switzerland. Cover is valid outside these territories for any stay of up to three months.