Major Medical Expenses

Flex Plus®

General conditions

I. Definitions

For the purposes of the following contract, the definitions below shall apply:

1. Accident

An external, sudden, unforeseen and violent event causing bodily injuries which require medical care for the Insured within the first 90 (ninety) calendar days following the date of the event.

All bodily injuries sustained by a person in an Accident, its medical or surgical treatment as well as any recurrences or relapses, complications and sequelae are deemed as a single Loss.

2. Insured

Person included in the Policy who is entitled to the benefits provided under this Insurance Contract.

3. Insured Policyholder

Insured that signs as the responsible for the veracity of the answers contained in the Insurance Application and that, in addition to the Contracting Party, can request Policy modifications and/or adjustments.

4. Coinsurance

Amount for account of the Insured shown as a percentage of the covered expenses after applying the Deductible.

Said percentage is chosen by the Contracting Party or Insured Policyholder and is shown on the Policy Dec Page.

The Coinsurance applies for each Policy and for each Accident or Illness that is covered, and is neither reimbursable nor compensable.

5. Company

AXA Seguros, S.A. de C.V.

6. Medical Consultation

It's the attention that the Doctor offers in the hospital network, at his office, or at the address of the Insured and has the purpose of evaluating him clinically in order to determine a diagnosis and Treatment of the covered Accident or Illness.

The Physician must preserve the data and the time of the Medical Consultation in a medical record, according to the Official Mexican Standard of the clinical file and the electronic clinical file in the case of Mexico; for out of Mexico cases, as per the applicable laws.

This translation into english is a professional courtesy only. In case of controversy, the Spanish wording shall prevail.

7. Contracting Party

The individual or legal entity requesting the execution of the Insurance Contract for his/her own benefit or for the benefit of others and undertaking to make the payment of the insurance premium.

8. Insurance Contract or Policy

This Insurance Contract is composed of:

a. The insurance application form filled and signed by the Insured Policyholder in representation of the rest of the applicants

b. Medical questionnaire

c. Policy Dec Page

d. General conditions

e. Endorsements

f. Table of medical fees

g. Basic Insured Rights Brochure

h. Any other information provided by the Contracting Party and/or Insured to purchase this Policy

9. Deductible

Fixed amount to be paid by the Insured stipulated in the Policy Dec Page applicable to each covered Loss, under the terms of the current general conditions of the Insurance Contract.

Once the expenses covered exceed this Deductible, the obligation of payment will be for the account of the Company up to the Sum Insured agreed.

The Deductible is established by the Contracting Party or the Insured Policyholder.

This concept is neither reimbursable nor compensable.

10. Medical Devices

Any instrument, device, utensil, machine, implant, diagnostic agent, material, substance or product, including the software they have installed, meant to be used by human beings and that are classified by the Federal Commission for the Protection against Sanitary Risks (Cofepris) in 6 (six) types:

1. Medical equipment

2. Prosthesis, orthoses and functional aids

3. Diagnostic agents

4. Wound-dressing and surgical supplies

5. Dental supplies

6. Hygiene products

11. Medical Emergency or Medical Urgency

A sudden change in the health of the Insured displaying acute signs and symptoms of such severity that endanger the life, bodily completeness, or the viability of any of the Insured´s organs, requiring therefore immediate medical care.

After the pathogen- or trauma-related condition of the Insured is stabilized and under control, the Medical Emergency will be considered over.

12. Endorsement

Written agreement between the Contracting Party and the Company that modifies the general conditions of the Insurance Contract and forms a part thereof. Provisions set forth in said document shall prevail over the applicable general and special conditions whenever in conflict therewith.

13. Illness

Any health alteration resulting from the action of agents of internal or external origin affecting the physiological condition of the body and requiring medical or surgical treatment.

The alterations produced as an immediate or direct consequence of that mentioned in the previous paragraph or deriving from the medical or surgical treatment, as well as any recurrences or relapses, complications and sequelae shall be deemed as one single Illness or Medical Condition.

14. Pre-existing Diseases

Pre-existing Diseases shall be understood as those showing one or several of the following characteristics:

a. The Contracting Party declares it at the moment of the Addition Date of the Insurance Contract, and/or

b. Its existence has been proved before the execution of the contract or declared or proved by means of a medical record; and/or

c. By laboratory or imaging tests or by any other acknowledged means of diagnosis, and/or

d. As a consequence thereof, the Contracting Party has incurred in documented and provable expenses in order to receive diagnosis or medical Treatment for the respective Disease.

15. Addition Date

Date on which the Company accepted the Insured as a part of this Insurance Contract, and as of which he acquires the right of its benefits. This date is also considered as the date the Insurance Contract entered into effect and is shown on the Policy Dec Page.

For additional coverages subject to a cost, the Addition Date is the date when the coverage is acquired and was accepted by the Company.

Any Accident or Illness prior to this date will be considered a Pre-existing Disease.

16. Acknowledged Time Insured

Period of time the Insured has been continuously and uninterruptedly covered under a Major Medical Expense Policy issued by this or other insurance company and which purpose is to acknowledge the Time Insured.

If the Company decides to acknowledge the Time Insured, it will do so expressly at the moment of inception date and the date of Acknowledged Time Insured will be shown on the Policy Dec Page.

The Acknowledged Time Insured will only be considered to eliminate or reduce Waiting Periods as per Clause 3. Reduction or elimination of Waiting Periods.

The Acknowledged Time Insured shall under no circumstance imply retroactivity of the Policy Period of the Insurance Contract, and neither will it validate coverage for Pre-existing Medical Conditions.

After acknowledging the Time Insured, the Company shall be under no obligation to reimburse medical or hospital payments arising out of Illnesses, Accidents and/or Losses that might stem from or whose first medical expenses were covered under a different insurance Policy.

In case of cancellation or non-renewal of the Policy, the Insured shall lose the Time Insured.

17. Time Insured under an AXA Group Policy (AXA Time Insured)

Period of time the Insured has been continuously and uninterruptedly covered under a Major Medical Expense Group Policy issued by this insurance company and which purpose is to acknowledge the Time Insured.

If the Company decides to acknowledge the Time Insured, it will do so expressly at the moment of inception date and the date of Acknowledged Time Insured under an AXA Group Policy will be shown on the Policy Dec Page as AXA Time Insured.

The AXA Acknowledged Time Insured will only be considered to eliminate or reduce Waiting Periods as per Clause 3. Reduction or elimination of Waiting Periods.

The Acknowledged Time Insured shall under no circumstance imply retroactivity of the Policy Period of the Insurance Contract, and neither will it validate coverage for Pre-existing Diseases.

After acknowledging the Time Insured, the Company shall be under no obligation to reimburse medical or hospital payments arising out of Illnesses, Accidents and/or Losses that might stem from or whose first medical expenses were covered under a different insurance Policy.

In case of cancellation or non-renewal of the Policy, the Insured shall lose the Time Insured under an AXA Group Policy.

18. Time Insured under an AXA Individual Policy (AXA Time Insured)

Period of time the Insured has been continuously covered under a Major Medical Expense Individual Policy issued by this insurance company and which purpose is to acknowledge the Time Insured.

If the Company decides to acknowledge the Time Insured, it will do so expressly at the moment of inception date and the date of Acknowledged Time Insured under an Individual Policy will be shown on the Policy Dec Page.

This translation into english is a professional courtesy only. In case of controversy, the Spanish wording shall prevail.

The Acknowledged Time Insured will only be considered to eliminate or reduce Waiting Periods as per Clause 3. Reduction or elimination of Waiting Periods.

The Acknowledged Time Insured shall under no circumstance imply retroactivity of the Policy Period of the Insurance Contract, and neither will it validate coverage for Pre-existing Diseases.

After acknowledging the Time Insured, the Company shall be under no obligation to reimburse medical or hospital payments arising out of Illnesses, Accidents and/or Losses that may have originated from or whose first medical expenses were covered under a different insurance Policy.

In case of cancellation or non-renewal of the Policy, the Insured shall lose the Time Insured under an Individual Policy.

19. Fracture

Medical condition during which a partial or total rupture (fissure) in the continuity of the bone occurs.

20. Hospital Plan

List of Hospitals, Clinics or Sanatoriums with similar characteristics in terms of technology and cost of available equipment from which the Insured may choose to receive medical care.

The Insured can check the list of Hospitals, Clinics or Sanatoriums that are part of the Hospital Range online on the site of axa.mx at the following link: https://axa.mx/web/servicios-axa/prestadores-de-servicios, or he may call AXA contact center number: 800 900 1292.

21. Hospital, Clinic or Sanatorium

Any institution legally authorized by the corresponding sanitary authority to provide medical, hospital or surgical services to patients.

For the purpose of this Policy, nursing homes, rest homes, clinics for natural treatments, thermal treatments, massages and aesthetic treatments are not deemed as Hospitals, Clinics or Sanatoriums.

22. Hospitalization

Uninterrupted stay in a Hospital, Clinic or Sanatorium, provided that such stay to attend an Accident, or Illness covered is medically justified and evidenced with the intention of restoring the health of the Insured; such stay begins as of the time the Insured is admitted in the Hospital, Clinic or Sanatorium and ends when discharge is provided by the treating Physician or a letter of acceptance of liability is signed by the Insured, the relatives of the Insured or the Physician who, in such case, will be liable for the insured patient.

23. Insured Mother

Person included in this Policy who gets pregnant and gives birth.

24. Surrogacy

Medical procedure of Assisted Reproduction consisting of the transference of human embryos into a woman that is not the Insured Mother of this Policy, produced by the fertilization of an egg by sperm, and ending with the birth.

25. Medicine

Medicine will be considered any substance or mix of substances of natural or synthetic origin that has either therapeutic or rehabilitation effect, that is presented in a dosage form and is identified as such due to its pharmacological activity, physical, chemical and biological characteristics. It should also have some kind of defined dosage form and the indication of usage contemplates either therapeutic or rehabilitation effect.

For the substance to be considered Medicine, it must have a sanitary registration in vigor and issued by the Cofepris.

26. Physician

Medical practitioner holding a degree and legally authorized to practice his/her profession who may be a general Physician, specialist Physician or homeopath, certified by the Ministry of Public Education or competent authority to perform the corresponding medical procedures according to his/her degree of specialization.

The Specialist Physician must have a certification in vigor of the respective Board of Medical Specialties. For the usage of highly specialized Medical Devices the Specialist Physician must have a certification in vigor that corroborates his training in the usage of said Medical Device.

It is always the obligation of the Insured to make sure that the Physician that treat him have a professional degree, a specialty certification, as well as medical certifications that are necessary for the respective specialty.

27. Bilateral Organs

Those organs or areas that have a pair, so they always have a right and a left side.

28. Direct Payment

Proceeding by means of which the Company makes the payment to the In-network Provider for the medical care provided to an Insured.

If the Insured should require and request services from any of the In-network Providers, he/she can make use of the Direct Payment System, subject to previous written authorization of the Company which shall make payment of the expenses covered by the Policy to the In-Network Providers, and the Insured shall have to pay the expenses not covered, as well as the corresponding Deductible and Coinsurance.

As the Physician, Hospital, Clinic, Sanatorium, laboratory, imaging center, drugstore or equipment providers is chosen by the Insured, the Company shall not be liable for any deficiencies, malpractice or deficient services rendered by such providers.

The Direct Payment will be made only after the Company has gathered enough information to determine whether the procedure is admissible or not. If the Insured fails to provide in a timely manner all the necessary information to determine whether the payment is admissible or not, the Company won’t be able to make the Direct Payment.

29. Reimbursement Payment

Paying back by the Company of payable expenses incurred by the Insured as a result of any covered Accident or Illness, according to provisions in the Insurance Contract.

30. Waiting Period

A continuous period of time that must elapse for each Insured from the Date of Addition of the Insured in this Policy to the date of the occurrence of the Loss, in order that certain expenses may be covered by the Company, as agreed on Section III, Basic Coverage Item B, Covered Expenses with Waiting Periods.

The Waiting Periods can only be reduced pursuant to the provisions of Clause 3, Reduction or elimination of Waiting Periods.

31. Claim Payment Period

Period of time chosen by the Contracting Party or the Insured Policyholder at the time of entering the Insurance Contract, during which the Company undertakes to settle the payable expenses incurred by the Insured as per specifications in this Insurance Contract.

The Claims Payment Period shall begin on the date of the first expense reported to the Company for each covered Accident or Illness, and shall last for the period chosen by the Insured and stipulated in the Policy Dec Page, provided that the Insurance Contract is in force.

For the purpose of this contract the "first expense date" shall be understood as the oldest expense incurred by the Insured for the attention of a covered Accident or Illness.

32. In-Network Providers

Independent Hospitals, Physicians, laboratories, imaging centers, drugstores and medical equipment providers that have executed Direct Payment agreements with the Company. Modifications may be made by the Company at any time without any previous notice.

The list of In-Network Providers can be found at axa.mx: https://axa.mx/web/servicios-axa/prestadores-de-servicios or can be requested by calling the AXA contact center: 800 900 1292.

Since the Insured chooses which Physician, Hospital, laboratory, imaging center or drugstore will provide the service, the Medicines or the medical products, the Company shall not be liable for any deficiencies, malpractice or services rendered by the providers.

The Company is only responsible for the payment to In-Network Medical Providers or Reimbursement of medical expenses and hospital costs payable to the Insured and covered under this Insurance Contract.

33. Service Scheduling

Benefit the Company may provide, prior to any covered surgical intervention or medical Treatment, by way of which payment authorization is evaluated in respect of the medical and hospital expenses incurred for the surgery or treatment and in respect of Direct Payment Service, if applicable.

As the Physician, Hospital, Clinic, Sanatorium, laboratory, imaging center, drugstore or equipment providers is chosen by the Insured, the Company shall not be liable for any deficiencies, malpractice or deficient services rendered by such providers.

The service of Service Scheduling will be made only after the Company has gathered enough information to determine whether the payment is admissible or not. If the Insured fails to provide in a timely manner all the necessary information to determine whether the payment is admissible or not, the Company won't be able to provide the Service Scheduling.

34. Anatomical Region

It's a subdivision of the human body, based on the anatomical and functional characteristics specific to the human being.

For the purpose of this Insurance Contract they will be classified as follows:

Name of the body segment	Anatomical region
Head	Skull Face
Neck	Anterior Sternocleidomastoid Lateral Posterior
Trunk	Dorsal Pectoral Abdomen
Upper limbs	Perineal Deltoid Arm Elbow Forearm Hand (dorsal and palmar)
Lower limbs	Gluteus Thigh Knee Leg Foot (dorsal and plantar)

35. Assisted Reproduction

A group of techniques and processes that substitute the natural process of reproduction and that are applied depending on the cause and type of infertility.

36. Loss

Loss is the sum of medical expenses incurred as a result of any one Accident or Illness covered by these general conditions, that are specified per Insured for their identification.

All the health conditions or bodily injuries suffered by the Insured due to a covered Accident or Illness; its medical and/or surgical Treatment and recurrence, complications and sequelae will be considered a single Loss.

37. Insurance Application Form

Document which states the will of the Contracting Party to purchase this insurance and stipulates the protection required and the information for due risk assessment. This document forms a part of the Contract.

38. Sum Insured

Maximum limit of liability of the Company for each Insured and for each covered Accident or Illness and deemed as a single Claim as per provisions set forth in the Insurance Contract. This Sum Insured is chosen by the Contracting Party at the time of purchasing the insurance and is shown in the Policy Dec Page.

39. Table of medical fees

Maximum amount that the Company covers the Insured on account of medical, surgical team, nurse, therapists, chiropractors, and acupuncturists derived from medical or surgical Treatment, Therapy and/or therapeutic procedures, for each Accident or Illness covered under this Insurance Contract.

The Contracting Party is free to choose the table of medical fees at the time of entering the contract; the name of the Table of Medical Fees is shown on the Policy Dec Page.

The respective Table of medical fees may be found in the following link: https://axa.mx/web/seguro-de-salud/flex-plus published in the webPage axa.mx or in the AXA contact center by calling the number: 800 900 1292

40. Coinsurance Cap

The maximum amount that the Insured shall pay on account of Coinsurance for each covered Illness or Accident.

41. Treatment or Therapy

A group of measures of any kind (hygienic, dietary, pharmacologic, surgical, physical) that help treat and/or restore the health of the Insured affected by a covered Illness or Accident.

42. Treatments in Testing Phase

Those Treatments that have not been considered safe and effective by the Health Ministry or other sanitary entities that are legally authorized, and are not specified in the national and international clinical practice guidelines. Also those treatments are considered experimental when they are administered in modalities, indication, dosages or route of administration that differ from the ones authorized by Cofepris.

43. Policy Period

Validity period of the Insurance Contract as shown on the Policy Dec Page, which may not be longer than one year.

II. Subject-matter of Insurance

The subject-matter of this contract is to compensate expenses incurred by the Insured for covered medical services by reason of the improvement of his health according to a definitive medical diagnosis and the tests that corroborate it. These expenses must arise out of Treatments related to a covered Accident or Illness, and they must be related to the diagnosis, and issued by institutions and people legally authorized to exercise their practice.

These expenses will be covered according to the limits and conditions stipulated in this Policy.

The Company may grant the benefits of Service Scheduling and Direct Payment only after the previous analysis and authorization of the Company.

This product consists of a basic coverage and additional coverages subject to charge that the Contracting Party or the Insured Policyholder may purchase at his/her option, which according to the selected plan are specified in the Policy Dec Page and shall be subject to the conditions and limits stipulated in this Insurance Contract.

III. Basic Coverage

Expenses incurred in the Mexican territory for each covered Accident or Illness, and the corresponding expenses shall be covered until the Benefit Period is exhausted, and the Deductible and Coinsurance stipulated in the Policy Dec Page shall apply.

a. Mayor Medical Expenses covered

1. Medical fees

The medical expenses shall be paid according to the amounts described on the agreed Table of medical fees stipulated on the Policy Dec Page, provided that the healthcare professionals whose fees are claimed have participated directly and actively in the medical or surgical Treatment or therapeutic procedure or Medical Consultation of the Insured and such participation can be corroborated on the clinical file with the prescription and the respective signature.

The corresponding amount derived from the attention given by a Physician to the Insured shall be covered in respect of:

a. **Medical fees without surgical intervention**

The Insured shall be paid the amount that corresponds to the Medical Consultation fee based on the agreed Table of medical fees.

The Company shall cover any Medical Consultations that the Insured may need derived from the covered Accident or Illness, a payment subject to the limit of one daily Medical Consultation per specialty.

b. **Medical fees with surgical intervention**

In case of a surgery, the medical fees shall be covered according to agreed Table of medical fees, and based on the following table:

Physician	Percentage on the Table of medical fees
Surgeon	100%
Anesthesiologist	30% *
First Assistant	20% *
Second Assistant	10% *
Specialist Technician	10% *

* This percentage is calculated based on the fee of the surgeon

This translation into english is a professional courtesy only. In case of controversy, the Spanish wording shall prevail.

The Insured shall be paid the amount that corresponds to the performed surgical procedure based on the agreed Table of medical fees, said amount includes the Medical Consultations of the surgical team during the following 15 (fifteen) days after the surgery. After such period only one daily Medical Consultation per specialty shall be paid.

The agreed Table of medical fees stipulates the total amount of the performed surgical procedure, irrespective of the number of professionals that participate actively in the surgical intervention.

When during the same surgical session, the Insured undergoes 2 (two) or more surgeries on the same Anatomical Region, the fees will be covered 100% (one hundred percent) for the intervention of the higher value plus 50% (fifty per cent) of the second intervention. **If there are more interventions in the same Anatomical Region, they will not be covered by the Company.**

When during the same surgical session, the Insured undergoes 2 (two) surgeries on different Anatomical Regions, the fees will be covered 100% (one hundred percent) for the intervention of the higher value plus 50% (fifty per cent) of the second intervention. If there is a third (3rd) surgery on the same session, on the second Anatomical Region or on another Anatomical Region that is not the first, only 35% of that surgery shall be covered. **If there are more interventions, they will not be covered by the Company.**

The aforementioned also applies to Bilateral Illnesses.

In case of medical care provided to a polytraumatized Insured, the fees of each Physician will be covered (100%) one hundred percent per performed procedure in the same surgical event as per the agreed Table of medical fees.

In case of medical care provided to an Insured by more than one specialist in the same surgical session, the fees will be covered (100%) one hundred percent as per the agreed Table of medical fees, with the previous authorization of the Company.

As for the payment of medical, fees, if a new medical intervention is needed and is performed within the following 24 (twenty-four) hours after the conclusion of the first, this will be considered as an immediate complication of the first surgery, and no additional medical fee shall be covered. If the new intervention is carried out after the period of 24 hours, it will be considered a separate and distinct intervention and the Table of medical fees shall apply.

If there were a discrepancy between the claimed amount on account of the medical fee and the amount specified in the agreed Table of medical expenses, it will not be reimbursable and will be covered by the Insured.

2. Hospital Expenses

The following expenses within the Hospital, Clinic or Sanatorium incurred for hospitalization are covered:

a. Standard private room with bathroom.

b. Food supplied to the Insured.

c. Laboratory, auxiliary diagnostic tests, imaging tests and diagnostic agents prescribed and justified by the treating physician and related to the covered Accident or Illness that requires medical attention at that time.

d. Operating room, healing room, recovery, medical emergency, intensive or intermediate therapy, or coronary care unit.

e. Blood transfusions, plasma, serum and other similar substances that may have been used, as well as the compatibility tests of said substances.

f. Medicines: Medicines that are supplied to the patient in the Hospital, Clinic or Sanatorium, provided they meet the definition of “Medicine” of these general conditions, are prescribed and justified by the treating Physician, and are related to the Accident or Illness that requires medical attention. For the substance to be considered Medicine, it must have a sanitary registration in vigor and issued by the Cofepris and the provider must have a commercial license in Mexico.

g. Only the cost of an extra bed for the Companion of the affected Insured is covered.

h. General Nursing Care.

If derived from a surgical intervention for a covered Illness, the Insured reports expenses (or they are detected) related to medical care or Treatment of an Illness that is not covered, there will a penalty of 40% (forty percent) of the payment of the total of the hospital invoice, and the Insured will have to pay the medical fees of said medical care from an Illness that is not covered under the Insurance Contract.

The medical fees from the medical care of the covered Illness shall be covered by the Company as per these general conditions, with the corresponding percentage from the Insured.

3. Home Care or Out-of-Hospital Care

The following “care at home” expenses are covered:

a. Nurses: hereunder are covered: nurses legally licensed to exercise their profession, and nurses’ fees that, under the prescription of the treating Physician, are necessary for the handling, preparation and/or administration of medicines highly specialized, pulmonary rehabilitation, home parenteral feeding; the above described shall be paid for a maximum period of 30 (thirty) consecutive days or 720 (seven hundred and twenty) hours each Loss.

   The amount for this coverage will be subject to the stipulations of the agreed Table of medical fees.

   According to the Company, this period may be extended up to 30 (thirty) more days, provided that it is medically justified and it is scheduled and coordinated by this Company.

b. Expenses incurred for consumption of oxygen: provided that these are prescribed by the treating Physician, provided there is a medical prescription with a date no older than three months. Said prescription must be surrendered to the Company every 30 (thirty) calendar days.

   The Company will lend the Insured an oxygen tank a for as long as the Insured needs it, and it must be returned to the Company after either the Treatment or the coverage of this Policy ends.

4. Rehabilitation Therapies

Provided that they are medically necessary and have the purpose of improving the Insured's health, expenses incurred for the following rehabilitation therapies are covered: musculoskeletal, hydrotherapy neuro-rehabilitation, neuro-development, inhalation therapy or pulmonary physiotherapy and cardiac rehabilitation.

For the coverage of the expenses of the rehabilitation therapies covered hereunder it's necessary that the Insured ensures that:

- The therapies are prescribed by the treating Physician, who will refer the Insured to a Physician who specializes in physical medicine and rehabilitation.
- Both the type of medical Treatment and the number of sessions that the Insured requires will be determined by the Physician who specializes in physical medicine and rehabilitation.
- In case of inhalation therapies, the treating Physician is the one who prescribes and justifies the type of Treatment and the number of sessions that the Insured requires.
- The therapies shall be done in specialized, certified centers and provided by staff with specialty card to practice physical and rehabilitation Medicine issued by the "Professional Board of the Public Education Ministry".
- Only one session per day shall be paid, irrespective of the type of Therapy and the specialty number that provide it, **with the exception of a polytraumatized Insured, who may get up to 2 (two) physical rehabilitation sessions per day subject to a maximum period of 15 (fifteen) days.**

The Company's coverage will be subject to the following limitations in respect of rehabilitation Therapies, in-hospital or out-of-hospital:

- 30 (thirty) sessions for musculoskeletal rehabilitation
- 30 (thirty) sessions for hydrotherapy
- 180 (one hundred and eighty) sessions for neuro-rehabilitation
- 90 (ninety) sessions for psychomotor therapy, exclusively for Newborn under AXA Benefit (coverage 1.3)
- 30 (thirty) sessions for swallow function therapy
- 365 (three hundred and sixty-five) sessions for neuro-development
- Inhalation therapy or pulmonary physiotherapy shall be covered according to the prescription of the Treating Physician
- 40 (forty) sessions for cardiac rehabilitation

Due to the specific characteristics of the Rehabilitation Therapies, the Company may request the documentation it deems necessary to corroborate that said Therapies are medically necessary.

For the payment of the Therapies, the Insured must surrender to the Company the invoice(s) that corroborate said medical Treatment, where the number of claimed sessions is stated, with the limit of the maximum amount specified on the agreed Table of medical fees, and said amount already includes the medical fees of the therapists.

This translation into english is a professional courtesy only. In case of controversy, the Spanish wording shall prevail.

5. Radiotherapy and/or Chemotherapy Treatments

For any kind of cancer, as per these general conditions, the expenses for radiotherapy and/or chemotherapy Treatments that are medically necessary are covered, provided that they are prescribed and justified by the treating Physician, whose safety and effectiveness have been established and therefore they have been authorized by the Health Ministry or other related health organisms through a sanitary registration, and are prescribed for the cancer type and stage of the Insured in the National Comprehensive Cancer Network (NCCN). The aforementioned applies even if the additional coverage subject to charge Section IV. Additional coverages subject to charge, item 1 Medicines bought out of the hospital (MFH) has not been agreed upon.

6. Reconstructive Surgery

Expenses incurred for Reconstructive Surgery medically-necessary are covered where resulting from an Accident covered.

When resulting from a covered Illness only the Reconstructive Surgeries related to primary malignant tumors are covered where the resection of other structures is medically necessary.

Only the surgeries with the intention of reestablishing the function of an affected organ shall be covered. In case of cancer in the mammary glands, even though the function of the organ is not reestablished, only the reconstruction and the prosthesis of the affected gland shall be covered provided that the Waiting Period specified in Section III. Basic coverage, item b Expenses with a Waiting Period has finished.

7. Organ Transplants

The following expenses are covered: the ones that arise out of the protocol of pre-transplant testing approved by the transplant committee of the institution where the procedure takes place, and also the expenses derived from the Hospitalization of the Insured transplant recipient, the fees from the surgeon and the expenses of the post-transplant follow-up of the Insured transplant recipient.

In case the organ that is going to be transplanted is from a live donor, only the expenses of the protocol of pre-transplant testing of the definitive donor shall be covered. Said protocol must be approved by the transplant committee of the institution where the procedure takes place, the Hospitalization expenses of the donor and the medical fees of the surgical team.

The amount of medical fees that arise out of the protocol of pre-transplant testing and the surgical procedures of the recipient and donor are covered according to the agreed Table of medical fees.

In case of cadaveric donors, only the expenses of the recipient will be covered, as per the rules of the CENATRA (National Centre of Transplant of the Health Ministry).

The Organ Transplants must comply with the sanitary standards of the CENATRA.

The expenses derived from the transportation or the handling of the organ are not covered.

8. Transplant of tissue and cells

The expenses derived from corneal transplantation will be covered for covered Accident or Illness under this Policy.

In the event of Congenital and/or Genetic Diseases of the cornea with AXA benefits, it will be covered provided that the Insured is added to the Policy within the following 30(thirty) days after his birth and the Insured Mother has been covered for 10 (ten) uninterrupted months under this Policy at the time of birth, or the same period of Individual AXA Time Insured.

In the event of Genetic and/or Congenital Illness without AXA benefits, the Genetic Illnesses of the cornea and the expenses derived from the transplant, provided that the Illness is not detected at birth, was not evident to the eye, or diagnosed or treated prior to the Addition Date of the Insured.

The transplant of ligaments and tendons from cadaveric donors is covered, provided it derives from Covered knee and shoulder Accidents or Illnesses performed exclusively in certified Hospitals by specialist Physicians with recertification in vigor, as per the definition of Physician of these conditions. Said device must comply with the corresponding sanitary legislation and regulation to validate its origin.

The cornea or ligaments and tendons transplants from cadaveric donors must comply with the sanitary standards of the CENATRA.

The amount from medical fees derived from cornea or ligaments and tendons transplant from cadaveric donors shall be covered according to the Table of medical fees.

This benefit shall only be covered in the form of surgery scheduling.

The expenses derived from the transportation or the handling of the cornea are not covered.

The transplants of hematopoietic stem cells shall comply with the health regulations established by the CNTS (National Center of Blood Transfusion of the Health Ministry).

Coverage is provided for the hematopoietic stem cell transplants for treatment of leukemia and lymphomas, as long as they are approved by the normative guide of the Health Ministry and the therapeutic guide of the National Comprehensive Cancer Network (NCCN) and are not considered Treatments and/or interventions in testing phase in the Health Law.

The following expenses are covered: the ones that arise out of the protocol of pre-transplant of hematopoietic stem cells approved by the hematopoietic stem cells transplant committee of the institution where the procedure takes place, and also the expenses derived from the Hospitalization of the Insured transplant recipient, the fees from the surgical team and the expenses of the post-transplant follow-up of the Insured transplant recipient.

Only the expenses of the protocol of pre-transplant testing of the definitive donor shall be covered. Said protocol must be approved by the transplant committee of the institution where the procedure of hematopoietic stem cells takes place.

The following expenses shall not be covered: Administrative expenses and the ones that arise out the import, preservation and conservation of the hematopoietic stem cells that are going to be transplanted.

9. Medical Devices

Expenses incurred for the rental or purchase of Medical Devices shall be covered where necessary as a result of an Accident or Illness covered, provided always these are medically indicated for the Treatment required by the Insured. Such devices must have the current sanitary registry in file with the Cofepris and must be approved for commercialization in Mexico

The Company may pay for these Medical Devices under the scheduled service, provided that the Insured furnishes evidence of the medical indication and of its benefit for the Insured's Treatment.

For such purpose, Cofepris classes these medical devices as follows:

1) Medical equipment

a. In- hospital medical equipment

Expenses incurred for medical equipment shall be covered where necessary for the Insured's Treatment during the stay of the Insured in the hospital and where indicated by the treating physician.

b. Out-of-hospital medical equipment

The rental or purchase of medical equipment indicated by the treating Physician shall be covered where necessary for home convalescence of the Insured or to continue with the Treatment stipulated by the treating Physician at home. The foregoing shall be covered, provided that it is justified by reason of the Accident or Illness covered and the service is authorized, scheduled and coordinated by the Company, taking into account that:

- The Insured shall be responsible for the maintenance of said medical equipment and must follow the instructions for the use and repair thereof. In case of failure of said equipment prior to completion of its useful life, an expert assigned by the provider will be sent to issue an opinion and verify if the Insured meets with the instructions for use.
- If at the time of receiving said equipment, the Insured discovers it is damaged, the Insured must give prompt notice to the provider to make valid the warranty of the equipment and receive one in good conditions.
- The Company shall make the medical equipment available to the Insured for the time needed until recovery of health of the Insured, who shall return such equipment to the Company thereafter.

Regarding wheel chairs, electric beds and hoists, the maximum amount payable to the Insured shall be $150,000.00 (One hundred and fifty thousand pesos 00/100 Mexican currency) per equipment.

20% (twenty percent) Coinsurance shall always apply for medical equipment. **Coinsurance Cap agreed upon does not apply to this coverage.**

2) Prostheses, orthoses and functional aids

Expenses incurred for the rental or purchase of prostheses, orthoses and functional aids needed shall be covered where resulting from an Accident or Illness insured, provided that prior approval is given by the Company, these are recommended and justified by the treating Physician, have a sanitary registry, a permit for commercialization in Mexico and are not defined as a Treatment under research according to the definition in this Insurance Contract.

- The following devices are deemed as Functional aids: Deep brain stimulators, lumbar and/ or cervical spine stimulators, unicameral or bicameral pacemakers, defibrillators, internal ventricular assist device, cochlear implant and insulin infusion pumps.

- The Insured shall be responsible for the maintenance and repair of the Device medically indicated, as well as for observing correctly the instructions for use. If at the time of receiving such equipment, the Insured discovers it is damaged, the Insured must give prompt notice to the Company.

- In case of failure of the delivered equipment prior to completion of its useful life as stipulated in the Provider's warranty and if the Insured has followed all the instructions for use, the Provider undertakes to replace the equipment and the Company to pay the expenses incurred for the reposition of such equipment. In case the Insured did not follow the instructions for use, the Insured must pay the cost of replacement and the Company the expenses incurred for the reposition of the equipment.

- The Company shall make the device available to the Insured for the time needed by the Insured, who must return the equipment to the Company after finish using such equipment.

- In case the cost of the medical devices exceeds $ 1,500,000.00 (one million five hundred thousand pesos 00/100 Mexican Currency), 50% (fifty percent) Coinsurance shall apply on the full amount of the prosthesis, without applying any Coinsurance cap.

Expenses incurred for the replacement, change, substitution, adjustment and/or inspection of prostheses and orthoses shall not be covered hereunder.

Only and exclusively shall expenses incurred for the replacement, change, substitution, adjustment and/or inspection of functional devices specified in this coverage be covered, the aforementioned shall apply provided that the following conditions are met:

- The first installation of the functional aid was covered by this Company.

- At least a 5 (five) year period must have elapsed after its installation or the expiration of its useful life or power source. Useful life shall be understood to mean that specified by the manufacturer.

If failure to comply with the 2 (two) conditions above, the Company shall cover Hospitalization expenses and medical fees only.

3) Diagnostic agents
Expenses incurred for purchasing diagnostic agents used by the respective treating Physician or specialist shall be covered during the medical care provided to the Insured.

Additional fees of staff carrying out diagnostic tests shall not be covered, since such fees are already included in the test cost.

4) Wound-dressing and surgical supplies:
a. In-hospital

Coverage shall be provided only to supplies for surgeries or treatment of injuries and skin lesions or skin appendages that have a sanitary registry on file with the Cofepris and a license for commercialization in Mexico.

b. Out-of-hospital

Out-of-hospital surgical and wound supplies shall be covered where used by the treating Physician that have a sanitary registry on file with the Cofepris and a license for commercialization in Mexico.

5) Dental supplies and 6) Hygiene products

Within the Medical Devices classification, dental supplies and hygiene products shall not be covered, except as stated in coverage 10. Accident-related Dental Treatment.

10. Accident-related Dental Treatment

Expenses incurred for treatments necessary to restore or replace damaged or lost natural teeth are covered as a consequence of an insured Accident, including dental prosthesis. Coverage includes placing of dental prosthesis and dental supplies, provided that the emergency dental treatment and first expense or medical assistance is provided within the first 90 (ninety) days following such Accident.

This Insurance Contract does not cover any type of expenses incurred for dental Diseases regardless its origin.

11. Amateur Sports Practice

Expenses incurred for injuries sustained by the Insured are covered where resulting from an occasional and unprofessional Sports Practice, that is to say, the Insured is not paid for this Sports Practice.

12. Ambulance

The expense incurred for the service of air and land ambulance to or from the Hospital in Mexican territory shall be covered provided always it is medically necessary as a consequence of an insured Accident or Illness.

This coverage shall not be provided:

a. **When the reason for the transportation is not by medical advice.**

b. **If for any circumstance the transportation of the Insured should be prevented by a competent authority in the exercise of his/her duties and up to the time that such circumstance is solved.**

c. **When transportation of the Insured to the selected destination has not been authorized by a Physician or paramedic.**

Air ambulance shall be covered only through reimbursement payment.

13. Psychological support

A maximum of 10 (ten) psychiatric or psychological Consultations shall be covered when in the opinion of the treating Physician these are necessary, only for the following concepts:

a. Victim of robbery, kidnapping or rape.

b. Multiple trauma involving injuries that may provoke drastic changes to quality of life of the Insured.

c. The amputation of a complete limb.

d. The following Illnesses, medical Treatment or procedure:

- Terminal stage cancer
- Chronic renal insufficiency
- Coronary Surgery: open thoracic surgery for the placing of bypass to revascularize the myocardium, whether the surgery involves veins or arteries.
- Myocardial infarct requiring coronary revascularization or bypass or causing irreversible neurological damage.
- HIV or AIDS
- Cerebrovascular Accident producing permanent damage or when total and permanent disability is diagnosed due to such Illnesses covered.
- The following organ transplants: liver, kidney, heart, pancreas and lung
- Spinal cord accident when total or partial spinal section is determined.

Medicines shall not be covered under this coverage, even though coverage 1. Out-of-hospital Medicines (MFH) has been agreed upon.

The medical Consultation fees shall be covered according to the Table of Medical Fees agreed upon. For the payment of said amount, the Insured must submit to the Company the bill(s) providing evidence of such Treatment.

14. Alternative Medicine

Under this concept, expenses shall be covered only where incurred for acupuncture, homeopathic and chiropractic Treatments to control chronic pain resulting from an Accident or Illness covered.

Professional fees shall be covered to professionals holding a license as per Table of Medical Fees agreed in connection with the respective general Physician Consultation.

15. Robot-assisted surgery

- Minimally invasive robot-assisted surgery shall be covered only and exclusively for the following surgical procedures:

- Prostatectomy
- Hysterectomy for endometrial cancer
- Hysterectomy for ovarian cancer
- Hysterectomy for cervical cancer
- Nephrectomy for kidney cancer
- Partial nephrectomy for kidney cancer
- Colectomy for colon cancer
- Mitral valve replacement

Any other robot-assisted surgical procedure other than that specified in this coverage will not be covered.

For the coverage of expenses incurred, it is a requirement that the Insured ensures surgery is performed by a specialist Physician in minimally invasive surgery with a current medicine recertification in the respective specialty according to the provisions set forth by the Mexican Association of Robotic Surgery (Asociación Mexicana de Cirugía Robótica) which specifies the Physician must have completed for the procedure at least 20 (twenty) robot-assisted surgeries.

In case the Physician, who carries out any of the procedures mentioned in this clause, does not have the respective specialty or certification issued by the Mexican Association of Robotic Surgery, the Company shall not pay the medical expenses in connection with said surgery.

16. Hyperbaric Medicine

Hyperbaric chamber under medical supervision is covered only for the following: Air embolism, acute decompression sickness, cyanide poisoning, carbon monoxide poisoning, chronic osteomyelitis refractory to conventional Treatment, second and third- degree burns, soft tissue radionecrosis.

17. Neurophysiological Monitoring

Neurophysiological Monitoring shall be covered only and exclusively for the following procedures:

- Cervical spine surgery
- Cranial nerves surgery: facial, hypoglossal, trigeminal, glossopharyngeal and spinal nerves.
- Thyroid cancer surgery - total thyroidectomy.
- Lumbar spine surgeries, reintervention due to failed procedure on the same damaged segment.

The Company shall only pay expenses incurred for neurophysiological monitoring of the procedures expressly stipulated in this coverage, provided always said procedures are performed by Physicians and at Hospitals with a certificate in neurophysiology, it is therefore the Insured´s obligation to verify that his/her treating Physician and the Hospital where he/she is going to be treated has the certificates and permits required.

Fees shall be paid as per Table of Medical Fees agreed upon.

The Sum Insured for neurophysiological monitoring is $60,000 (sixty thousand pesos 00/100 Mexican Currency).

18. Congenital and/or genetic disease coverage

Expenses incurred for congenital and/or genetic diseases shall be covered for Insureds who were not enrolled in the Policy when they were born, who had not been added to the Policy within 30 (thirty) days of birth or when the Insured Mother does not comply with 10 (ten) months of continuous coverage under this Policy at the time of birth or Time Insured under an AXA Individual Policy, provided that:

a. In respect of congenital Disease, said Disease has gone unnoticed, is not clearly visible, has not been diagnosed, nor any medical Treatment has been provided prior to the Addition Date of the Insured in this Policy and has not given rise to any expenses.

b. Regarding genetic Diseases, expenses incurred from said diseases shall be covered as of 5 (five) years of age of the minor, had said Diseases gone unnoticed, are not apparent under visual scrutiny, have not been diagnosed, nor any medical Treatment has been provided prior to the Addition Date of the Insured in this Policy and have not given rise to any expenses.

Treatment or Therapy of congenital structural malformations is excluded herefrom.

b) Expenses covered subject to Waiting Periods

Expenses incurred from medical events shall be covered, once the Waiting Periods specified for each case have elapsed, up to the Benefit Period, by applying the Deductible and Coinsurance stipulated on the Policy Dec Page.

The Waiting Period is counted as of the Addition Date in this Policy or Time Insured applying to each case as stipulated for each Waiting Period below, provided that this Policy is in force and as per conditions agreed upon.

1. Coverage shall become effective after 10 (ten) months have elapsed

1.1. Maternity financial support

The Company shall pay the Sum Insured specified for this coverage in the Policy Dec Page, without applying any Deductible or Coinsurance, provided that, at the time of the maternity event, at least 10 (ten) months of continuous coverage of the Insured under this Policy have elapsed or the Insured has a plan providing this agreed coverage.

In case additional coverage for Extended Coverage Benefit subject to charge has been agreed, the Sum Insured specified for this coverage in the Policy Dec Page shall be substituted with the amount agreed in this additional coverage, which shall apply, provided that 10 (ten) months of continuous coverage of the Insured have elapse with the same Sum Insured option.

The Company may pay in advance to the Insured the amount corresponding to the Maternity financial support from the 29 (twentieth nine) week of gestation, provided that:

- The Insured furnishes to the Company the interpretation of the ultrasound image
- at least 10 (ten) months of continuous coverage of the Insured Mother under this Policy have elapsed or a plan providing this coverage has been agreed at the time of requesting this benefit.

1.2. Complications of pregnancy, delivery, caesarean section or puerperium

Medical and hospital expenses shall be covered only and exclusively where incurred from the following Complications of pregnancy, delivery, caesarean section or puerperium, provided that at least 10 (ten) months of continuous coverage of the Insured have elapsed under this Policy or the Insured has a plan providing this coverage on the date of occurrence of the complication:

1. Extra-uterine pregnancy
2. Molar pregnancy
3. The states of puerperal fever
4. Hypertensive syndrome of the pregnancy, preeclampsia and eclampsia
5. Placenta accreta
6. Placenta previa
7. Uterine atony
8. Stillbirth, fetal death or retained dead egg
9. Gestational diabetes
10. Cerclage procedure
11. Thrombocytopenic purpura

1.3. Newborn coverage with AXA benefit

Expenses for medical or surgical Treatments of the immature and/or premature newborn shall be covered from the first day of birth, as well as genetic Diseases, Congenital diseases including cochlear implant, corneal transplant, strabismus, and circumcision due to phimosis only, as well as Accidents or Illnesses occurred since birth, provided that at the birth of the minor, at least 10 (ten) months of continuous coverage of the Insured Mother under this Policy have elapsed and the Company has been notified within 30 (thirty) calendar days following birth, and by paying the Addition of the new Insured(s).

If the Insured Mother complies with both conditions, the Newborn may be Included in the Insured Mother Policy without undergoing any medical selection process, thus being covered since birth.

If the Insured Mother does not comply with the above, she must request enrollment as per the Addition clause of these general conditions, by submitting the insurance application form filled out and signed, which shall be subject to the selection process and the benefit provided under this coverage shall not apply.

2. Coverage shall become effective after 12 (twelve) months have elapsed

Expenses incurred from the Illnesses described below shall be covered after 12 (twelve) months of continuous coverage of the Insured sustaining damage under this Policy or of the Acknowledged Time Insured or AXA Time Insured or AXA Time Insured under an Individual Policy:

2.1. Spine diseases, **except for herniated disc**

2.2. Renal and urinary lithiasis, and urinary tract Diseases

2.3. Any gallbladder and biliary tract Diseases

2.4. Gynecological Disorders, including mammary gland

2.5. Pelvic floor disorders

2.6. Venous insufficiency of the lower limbs, varicocele and varix of the vulva

2.7. Knee problems

2.8. Acid peptic diseases

2.9. Gastroesophageal reflux

For Newborns with AXA Benefit the Waiting Period after 12 (twelve) months shall not apply

3. Coverage shall become effective after 24 (twenty-four) months have elapsed

Expenses incurred from the Illnesses described below shall be covered after 24 (twenty-four) months of continuous coverage of the Insured sustaining damage under this Policy or of the Acknowledged Time Insured or AXA Time Insured or AXA Time Insured under an Individual Policy:

3.1. Septum o Septal deviation and accessory sinuses of the nose

3.2. Anorectal Diseases

3.3. Tonsils and adenoids

3.4. Hernias including herniated disc

3.5. Circumcision of Insureds born without AXA benefit, due to phimosis only

3.6. Cataract surgery for correction (including intraocular lens).

3.7. Prostate Diseases

For Newborns with AXA Benefit the Waiting Period after 24 (twenty-four) months shall not apply.

4. Coverage shall become effective after 48 (forty-eight) months have elapsed

Expenses incurred from the Illnesses described below shall be covered after 48 (forty-eight) months of continuous coverage under this Policy:

4.1 HIV and AIDS

Expenses incurred for Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) shall be covered, provided that the Insured is diagnosed positive under serological tests after the period stipulated in this coverage.

AXA Time Insured under the Individual Policy may be acknowledged to reduce Waiting Periods for this coverage, provided that the Insured has agreed upon a continuous coverage under an Individual Mayor Medical Expenses Policy with this Company.

For Newborns with AXA Benefit, HIV or AIDS shall be covered, provided that the Insured Mother has been provided coverage for said Diseases.

4.2 Bariatric Surgery

Expenses shall be covered once the Waiting Period of 48 months have elapsed, **for this coverage, any kind of Acknowledged Time Insured shall not apply.**

It shall be authorized as one-time expense in the life of the Insured and only for the following procedures:

- Sleeve gastrectomy (Sleeve or gastric sleeve)
- Placement of adjustable gastric band (Lap-band)
- Gastric bypass
- Switch duodenal

Expenses incurred shall be covered, provided that the Insured meets the following 4 (four) criteria:

- First bariatric surgery in the life of the Insured
- Body mass index (BMI) over 40 (forty)
- To be under the age of 40 (forty)
- To be diagnosed with any of the following: Diabetes Mellitus type 2, high blood pressure, musculoskeletal disorders and/or severe disability due to overweight

The following medication shall be covered for 1 (one) year for postoperative care: calcium, vitamin D, folic acid, vitamin B12 and iron.

Preoperative and postoperative consultations shall not be covered.

IV. Additional coverages subject to charge

Expenses incurred for Treatments medically necessary, prescribed and justified by a Physician, shall be covered under the Additional coverages subject to charge and as of the Addition Date of the coverages; provided that these coverages are agreed upon at the request of the Contracting Party or Policyholder.

The respective expenses shall be covered as per Benefit Payment Period clause and limits and specifications specified in the Policy Dec Page:

1. Out-of-hospital Medicines (MFH)

By purchasing this additional coverage and as of the Addition Date thereof, the costs of medicines bought out of the Hospital, Clinic or Sanatorium shall be covered only in the Mexican territory and by Reimbursement Payment.

For this coverage to apply, the following requirements must be met: the product to be covered must comply with the definition of Medicines provided in these general conditions, it must be prescribed and justified by the treating Physician, have a sanitary register in Mexico and must be listed and authorized by the Cofepris for treating the Accident or Illness covered.

The respective prescription must contain the medical indication for use, frequency, duration and dosification as stipulated by the regulations of health supplies of General Health Law.

Prescription must meet provisions set forth in article 28 of the health supplies Regulations.

The limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured

The Sum Insured as agreed and stated in the Policy Dec Page.

Deductible, Coinsurance and Coinsurance Cap

The conditions agreed and stipulated in the Policy Dec Page shall apply. The Deductible and Coinsurance shall apply as per provisions set forth in clause 28. Claim Payment of these general conditions.

Interaction with other coverages

Age

The age limit to acquire this coverage shall be from the first day of birth to Age 64 (sixty-four). For this coverage there is no age limit for renewals.

Specific Exclusions:

a. **Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.**

b. **This coverage may not be agreed where the Claim Payment Period is of 4 (four) months.**

2. Extended Maternity (MATE)

By purchasing this additional coverage and as of the Addition Date thereof, the Company shall substitute the payable amount of the Basic Maternity Financial Support coverage with the amount agreed for this coverage.

For this coverage to become effective, 10 (ten) months of continuous coverage the of Insured must have elapsed with the same option of Sum Insured at the time of Delivery or Caesarean Section.

The Company may pay in advance to the Insured the amount corresponding to the Maternity financial support from the 29 (twentieth nine) week of gestation, provided that:

The Company may pay in advance to the Insured the amount agreed for this additional coverage from the 29 (twentieth nine) week of gestation, provided that:

- The Insured furnishes to the Company the interpretation of the ultrasound image.
- at least 10 (ten) months of continuous coverage of the Insured mother have elapsed hereunder at the time of requesting such benefit.

The limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured, Deductible and Coinsurance

a. The Sum Insured is compensatory and neither Deductible nor Coinsurance apply

b. In case an increase of Sum Insured is requested for this coverage, a new 10 (ten) months Waiting Period will run as of said modification in order to obtain the Benefit of the new Sum Insured

c. Failure to comply with the Waiting Period will result in the payment of the Sum Insured for Maternity in force 10 (ten) months before delivery or caesarean section giving rise to indemnity

d. In case modification of a minor Sum Insured has been requested, the Sum Insured in force at the time of birth shall be paid

In no event shall expenses additional to the amount shown on the Policy Dec Page be covered. The Sum Insured shall not be accrued with the Maternity Financial Support coverage.

Age

The age limit to acquire this coverage shall be from the first day of birth to age 45 (forty-five). For this coverage there is no age limit for renewals.

Specific exclusions:

a. Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.

b. In case Guaranteed Conversion coverage (CGAR) is agreed upon, this coverage shall become null and void.

3. Preexistence (PRE)

By purchasing this additional coverage and once the Insured has 2 (two) years of continuous coverage, the Company shall pay the expenses incurred from Pre-existing Diseases that have been declared in the Insurance Application form, provided that within said period:

a. No medical Treatment has been provided.

b. No expenses have been incurred it care.

c. Not expressly excluded with an Endorsement in the Policy.

The limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured

The Sum Insured for this coverage is $1,000,000.00 (one million pesos 00/100 Mexican currency).

Deductible, Coinsurance and Coinsurance Cap

The conditions agreed and stipulated in the Policy Dec Page shall apply. The Deductible and Coinsurance shall apply as per provisions set forth in clause 28. Claim Payment of these general conditions.

Interaction with Coverages

In case Guaranteed Conversion coverage (CGAR) is agreed upon, it shall apply after exceeding the Guaranteed Conversion Deductible, applying the limits and conditions of this coverage.

This coverage may not be agreed together with the Guaranteed Continuity coverage (CONT).

Age

The age limit to acquire this coverage shall be from the first day of birth to Age 64 (sixty-four). For this coverage there is no age limit for renewals.

Specific Exclusions:

a. **Every expense incurred from a Pre-existing Disease shall be excluded when Treatment has been provided within a 2 (two) years period or expenses have been incurred for the Pre-exiting Disease care in question.**

b. **Pre-Existing Diseases stipulated in the exclusion Endorsements of this Policy shall not be covered.**

c. **Expenses shall be excluded when complementary to a Loss claimed under other insurance Policies of other companies within the Waiting Period.**

d. **Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.**

4. Zero Deductible in case of Accident (DED0)

By purchasing this additional coverage and as of the Addition Date thereof, the Company shall modify the Deductible agreed in the basic coverage to zero pesos (0$) in case of an Accident, provided that the total amount of the covered expenses is over $2,000 (two thousand pesos 00/100 Mexican currency).

Age

The age limit to acquire this coverage shall be from the first day of birth to Age 64 (sixty-four). For this coverage there is no age limit for renewals.

Territory Limit

This benefit applies only to the Mexican Territory.

In case this coverage is cancelled and the payment of complements of the Accident is furnished, the current Deductible will be charged.

Specific Exclusions:

a. **Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.**

b. **Accidents causing knee, spine and/or nose problems are excluded from this additional coverage, excepting fracture, in which case, the Insured must give notice to the Company within 30 (thirty) calendar days after the occurrence of the Accident; attaching the x-ray or study that proves there is a Fracture.**

c. **In case Guaranteed Conversion coverage (CGAR) is agreed upon, this coverage shall become null and void.**

5. Not Covered Major Medical Expenses Incurred for Medical Emergency Resulting from Complications (CGMM)

By purchasing this additional coverage and as of the Addition Date thereof, the Company shall cover in Mexican Territory, the medical expenses incurred for any Medical Emergency resulting from complications of the Treatment of the following concepts:

a. Therapeutic procedures or treatments of aesthetic or plastic nature

b. Treatments for baldness, obesity, weight loss, anorexia, bulimia

c. Therapeutic procedures or treatments for fertility, sterility, control, birth control, infertility and sexual impotence, evident before fertilization

d. Therapeutic procedures on the nose or accessory sinuses of the nose

e. Dental, alveolar, gingival or maxillofacial treatments not resulting from a covered accident

Once the pathological or traumatic condition of the Insured is stabilized and controlled, the Medical Emergency will cease; therefore, the effects of this coverage benefit will also cease.

The limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured

The Sum Insured for this cover is $800,000.00 (eight hundred thousand pesos 00/100 Mexican currency).

Deductible of basic coverage, Coinsurance and Cap Coinsurance

The Deductible and Coinsurance shall apply as per provisions set forth in clause 28. Claim Payment of these general conditions.

Age

The age limit to acquire this coverage shall be from the first day of birth to Age 64 (sixty-four). For this coverage there is no age limit for renewals.

Specific exclusions:

a. **Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.**

b. **In case there is no Medical Emergency, the conditions of the basic coverage shall prevail, which exclude the concepts referred to in this coverage.**

c. **In case Guaranteed Conversion coverage (CGAR) is agreed upon, this coverage shall become null and void.**

6. Coverage in Mexican Territory (CoNa)

By purchasing this additional coverage and as of the Addition Date thereof, the Insured may receive medical care in any part of the Mexican Territory (within the Mexican Republic), applying the conditions and limits agreed in this Policy, eliminating the increased Coinsurance as stipulated in clause 28. Claim Payment.

The limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured

The Sum Insured of the basic coverage stipulated in the Policy Dec Page shall apply.

Deductible, Coinsurance and Cap of Basic coverage

The Deductible and Coinsurance shall apply as per provisions set forth in clause 28. Claim Payment of these general conditions.

Interaction with other Coverages

In case Guaranteed Conversion coverage (CGAR) is agreed upon, it shall apply after exceeding the Guaranteed Conversion Deductible, applying the limits and conditions of this coverage.

Age

The age limit to acquire this coverage shall be from the first day of birth to Age 64 (sixty-four). For this coverage there is no age limit for renewals.

Specific exclusions:

a. **Expenses incurred from Pre-existence Diseases at the time of acquiring this additional coverage.**

b. **Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.**

7. Guaranteed Continuity (CONT)

By purchasing this additional coverage, the Company shall provide an Individual Policy with conditions equal to a group Policy, as per current products in file with the National Insurance and Bonding Commission (Comisión Nacional de Seguros y Fianzas), acknowledging Time Insured under the Group Major Medical Expenses insurance Policy of this Company, by way of the Continued Warranty Endorsement, for the purpose of covering medical expenses incurred for Accidents or Illnesses that have been diagnosed or paid as of Acknowledged Time Insured of the Group Policy with AXA provided that:

- Guaranteed Continuity Benefit is requested in writing, within 45 (forty-five) calendar days after the Deletion of the Insured from the Group Policy of this Company
- The Insured has been added to the group Policy, subject to a maximum age limit of 65 (sixty-five) years

The limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured

The Sum Insured as stated in the Policy Dec Page.

Deductible, Coinsurance and Coinsurance Cap

The Insured must pay again the current Deductible, Coinsurance and Cap Coinsurance of this Policy, regardless these have been covered in the group Policy.

Specific Exclusions:

a. Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.

b. Pre-existing Diseases on the date of Acknowledged Time Insured of AXA Group Policy, which is specified in the Guaranteed Continuity Endorsement.

c. Illnesses expressly excluded by Endorsements included in this Policy.

8. Guaranteed Conversion (CGAR)

By purchasing this additional coverage and as of the Addition Date thereof, it shall be binding on the Company to pay the amount of medical and hospital expenses incurred by the Insured, once the Guaranteed Conversion Deductible has been exceeded for medical care provided due to any of the Accidents or Illnesses covered under this Insurance Contract.

The Company will provide the following benefits under this agreed coverage:

- The Company shall pay for the medical and hospital expenses incurred by the Insured as per conditions stipulated and agreed under this Policy, once the Guaranteed Conversion Deductible stated on the Policy Dec Page has been exceeded.
- Upon expiration of the Group Medical Expenses Policy, the Insured may request cancellation of this coverage replacing the Guaranteed Conversion Deductible with the Deductible agreed and stated on the Policy Dec Page, without undergoing the medical selection process.

- The Company will acknowledge claims for Illnesses filed since this coverage was acquired to continue with the Claims payment.

For obtaining this coverage, it is an essential requirement that the Insured provides documentary evidence that he/she is insured under a Group Mayor Medical Expenses Policy, which Insurance Company and product are on file with the National Insurance and Bonding Commission, as well as of the amount of Sum Insured agreed therein; the sum insured of the group may not be less than $500,000 (five hundred thousand pesos 00/100 Mexican currency) in order to acquire said coverage.

In case the Contracting Party of the group Policy modifies the conditions thereof, the Insured must notify the Company within 90 (ninety) calendar days following said modifications, through the form provided by the Company for such purpose. In case modifications correspond to a lower Sum Insured than as permitted, and/or the product and/or the insurance company are not on file with National Insurance and Bonding Commission, request of deletion from this coverage must be made within the same period of time, after said period, the Company shall not be bound.

In case of deletion of the Insured from the Group Policy, the official documents will be necessary to exclude the Guaranteed Conversion coverage and to prove the deletion of the Insured from the Group Policy. Deletion must be requested with 90 (ninety) calendar days following the date of separation from the employment or educational institution, after said period, the Company shall be released form any obligation related to the Guaranteed Conversion benefit.

In case the Group cancels the benefit of the group insurance, it will be necessary to delete the Guaranteed Coverage that the Contracting Party of the Group Policy submits the official document specifying the deletion of the whole group from said Policy; this will not apply in case of deletion of one or some Insureds of the group.

In no event and under no circumstances shall this coverage apply for the payment of medical or hospital expenses incurred by the Insured from direct or indirect Accidents, or Illnesses, occurring or diagnosed or for which an expense has been incurred prior to the purchase of this Coverage.

Payment of medical or hospital expenses incurred by the Insured that involves the agreed group Policy of this or any other Insurer does not bind the Company to pay medical or hotel expenses in excess of the Guaranteed Conversion Deductible involving in this coverage, as payment or reimbursement thereof is subject to the terms and conditions of these general conditions

The effects of cancellation of this coverage are:

a. The Guaranteed Conversion coverage (CGAR) is rendered unenforceable and the agreed individual Insurance Contract remains in force, being subject to the terms and limitations stated in these general conditions, which Sum Insured and Claims Payment Period shall be those agreed and stipulated on the Policy Dec Page. For purposes of Deductible and Coinsurance application, provisions of clause 28. Claims Payment shall be effective

b. The Company shall continue to pay justified medical and hospital expenses incurred as of inception date of this coverage, based on the terms and limitations stated in these general conditions

c. The Company shall acknowledge the Time Insured under the coverage that has been cancelled to reduce Waiting Periods based on the terms and limitations stated in these general conditions, including the Maternity Financial Support, AIDS or HIV, Bariatric Surgery. The Time Insured shall be acknowledged to reduce the Waiting Periods, in case that the Insured has, at the time of purchasing the Guaranteed Conversion coverage (CGAR), the Preexistence and Extended Maternity coverages

The Insured should request in writing cancellation of this coverage within 90 (ninety) calendar days following the separation from the group or deletion from the Group Policy, by submitting an official proof of separation. Failure of the Insured to comply with this obligation shall release the Company from any obligation related to the Guaranteed Conversion benefit.

The limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured

The Sum Insured is as agreed in the basic coverage and as stated on the Policy Dec Page.

Deductible, Coinsurance and Cap Coinsurance

The conditions agreed and stipulated in the Policy Dec Page shall apply. The Deductible and Coinsurance shall apply as per provisions set forth in clause 28. Claim Payment of these general conditions.

Interaction with other Coverages

This coverage may not be agreed simultaneously with the Guaranteed Continuity coverage (CONT).

Age

The age limit to acquire this coverage shall be from the first day of birth to Age 64 (sixty-four). For this coverage there is no age limit for renewals.

Specific exclusions

a. **Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.**

b. **In case this coverage is acquired, the Maternity Financial Support, Extended Maternity (MATE) and Zero Deductible in case of Accident (DED0) coverages shall become null and void.**

9. Medical Emergency out of Mexico (EMER)

By purchasing this additional coverage and as of the Addition Date thereof, medical expenses incurred by the Insured shall be covered in case of any Medical Emergency resulting from an Accident or Illness covered whilst the Insured is traveling outside the Mexican Republic.

To acquire this coverage, it is essential that the Insured furnishes evidence to the Company of his residence in the Mexican Republic and that this is the normal place of residence of the Insured. This coverage shall become null and void in case the Insured changes his domicile or residence to any place out of the Mexican Republic.

In addition, the following are deemed medical Emergencies:

- Fractures and sprains
- Hypotension
- Unintentional poisoning
- Neurological Alteration
- 2nd (second) degree and 3rd (third) degree burns
- Body temperature over 38 (thirty-eight degrees) in minors 12 (twelve) years old

Once the pathological or traumatic condition of the Insured is stabilized and controlled, the Medical Event shall cease and thus the effects of this coverage.

The Company shall settle the claim in Mexican Currency according to the Exchange rate in force on the date and place payment of the covered expenses should be made.

Covered expenses:

Expenses incurred for the following will be covered:

a. Semiprivate room and meals of the Insured

b. Fees for surgical intervention, medical Consultations and professional medical services such as anesthesiologists and nurses

c. In-hospital supplies: Medicines, medical material, anaesthesia equipment and operating room

All:

- supplies must be related to the Treatment of an Accident or Illness covered
- indications for which the use of the supply was approved must specified by the FDA (Food and Drug Administration) of USA http://www.fda.gov/AboutFDA/EnEspanol/
- supplies must be authorized by the law of the country where the medical care is received

d. Diagnostic services: lab and imaging tests

e. Land Ambulance service: To or from the hospital in the locality, provided always it is medically necessary

f. Prosthesis and orthopedic apparatus necessary for medical Treatment, except for replacements

This coverage applies only under the Reimbursement Payment Scheme.

The limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured

The Sum Insured for this coverage is USD 100,000 (one hundred thousand U.S. Dollars).

Deductible

The Deductible for this coverage is USD 100 (one hundred U.S. Dollars).

Coinsurance

No Coinsurance applies.

The Sum Insured and Deductible corresponding to this coverage are independent and not cumulative in respect of other coverages of these general conditions.

Payment of Fees

This shall be paid based on the Table of UCR (Usual, Customary & Reasonable).

Age

The age limit to acquire this coverage shall be from the first day of birth to Age 64 (sixty-four). For this coverage there is no age limit for renewals.

Under no circumstances shall this coverage be agreed by persons which domicile or Permanent Residence is out of Mexico, that is to say, out of the Mexican Republic.

Specific exclusions:

a. **Complications of pregnancy and of the Newborn(s).**

b. **Delivery and caesarean section after 28 (twenty-eight) week of gestation.**

c. **Any type of rehabilitation and/or Nursing service out-of-hospital.**

d. **Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.**

e. **In case Guaranteed Conversion coverage (CGAR) is agreed upon, this coverage shall become null and void.**

f. **1. Out-of-hospital Medicine even though additional coverage subject to charge is agreed 1. Out-of-hospital Medicine (MFH).**

10. Illnesses covered out of Mexico (ECE)

By purchasing this additional coverage and as of the Addition Date thereof, the Insured shall be entitled to extend the coverage territory (territory limit) to a foreign territory (out of the Mexican Republic) for the Insured´s medical care expenses incurred out of Mexico, resulting from the Diseases described hereinbelow, which diagnosis and first expenses arise from the date of acquiring this additional coverage and after the Waiting Period stipulated for the following disease in these General conditions has elapsed:

a. Cancer

Expenses incurred from the Treatment of the following type of metastatic cancer as per de TNM classification of the National Comprehensive Cancer Network (NCCN) guidelines, confirmed by the respective studies: cancer in the pancreas, liver, and nervous system, or cancer located in the lymphatic or circulatory systems, leukemia and malignant melanoma.

Any type of cancer not stipulated in the paragraph above shall be excluded.

b. Cerebrovascular Diseases and Brain Disorders

Coverage is provided for surgical and medical treatments derived from benign and malignant tumors of the central nervous system, as well as tumors or malformations of the circulatory system located at the central nervous system, ischemia, thrombosis and brain hemorrhage.

Excluded herefrom are tumors in the presence of human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS); transient ischemic attack, as well as Diseases other than those mentioned in the above paragraph.

c. Coronary vessel disease requiring surgery

Coverage is provided for open chest surgery for the placing of bypass for myocardial revascularization. The need for this type of surgical operations must be demonstrated by coronary angiography.

Excluded herefrom are any surgical procedures such as angioplasty with stenting and the complications thereof, as well as thrombolysis.

d. Organ Transplants

Only surgical procedure shall be covered for transplants of the following organs: heart, lung, pancreas, kidney, liver and bone marrow, **excluding postoperative expenses.**

Expenses incurred by the donor for Organ Transplants are covered. In case of living donors, covered expenses shall be those medical expenses incurred by the donor during the donation surgery, excluding preoperative and postoperative donation expenses and any gratuity or compensation received by the donor himself. In case of cadaveric donors, only recipient expenses shall be covered.

e. Myocardial infarct

f. Kidney Diseases

g. Spine Disorders

To get the benefit insured by this coverage, it shall be binding on the Insured to provide to the Company the medical report, clinical record and the result of tests performed, at least 10 (ten) working days before the date of admission to the Hospital so that the Company provides authorization.

In case of Medical Emergency, it shall be binding on the Insured to give notice thereof within the 24 (twenty-four) hours following the admission to the Hospital.

This coverage shall not be paid through Reimbursement Payment.

h. Second Medical Opinion in USA

This coverage provides access to a program of specialized Medical Consultations for Insureds who suffer any serious illness through medical consultant network in USA service providers for the purpose of having an expert medical opinion related to the covered serious illness.

In order to get the benefit insured by this coverage, the Insured should comply with any of the following requirements:

- That any of the major illnesses mentioned in item a. a g. above as insured in this coverage is involved and no Emergency medical aid is required, permitting the necessary arrangements to be made to coordinate this benefit.

In order to request the Second International Medical Opinion service, the Insured should submit to the Company the corresponding initial form duly filled out and signed for:

- Ratifying the diagnosis
- Verifying treatment
- Alternatives to treatment

To make use of the International Second Medical Opinion service, it is necessary to submit the following:

- ID Card identifying the Insured
- Official photo ID
- Full clinical record duly filed out by the treating Physician, including: current Accident, or Illness, Non-pathological history, pathological history with diagnosis, evolution period and Treatment
- Clinical summary of attending Physicians. If the Insured has been hospitalized, copy of clinical record
- Results of all tests performed. In case of special studies, such as X-rays, tomographies, magnetic resonance, ultrasound, plates and others
- International Second Medical Opinion service application duly filled out

In case the Physician who will provide the second medical opinion needs additional special studies, the corresponding expenses shall be incurred according to traditional procedures stated for Direct Payment and Reimbursement Payment.

the answer of the second medical opinion shall be provided to the Insured in the original form issued by the Consulting Physician.

The limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured

The Sum Insured shall be the same agreed Sum Insured for the Basic Coverage as stated on the Policy Dec Page both in Mexican territory and out of Mexico.

Deductible, Coinsurance and Cap Coinsurance

The Deductible and Coinsurance shall apply as stated on the Policy Dec Page regardless expenses were incurred in Mexican territory or out of Mexico. The Deductible and Coinsurance shall apply as per provisions set forth in clause 28. Claim Payment of these general conditions.

Payment of fees

This shall be paid based on the Table of UCR (Usual, Customary & Reasonable)

Age

The age limit to acquire this coverage shall be from the first day of birth to age 64 (sixty-four). For this coverage there is no age limit for renewals.

To acquire this coverage, it is essential that the Insured furnishes evidence to the Company of his residence in the Mexican Republic and that this is the normal place of residence of the Insured. This coverage shall become null and void in case the Insured changes his domicile or residence to any place out of the Mexican Republic

At the time of purchasing this coverage, the Emergency out of Mexico coverage is included.

Specific Conditions:

a. **Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.**

b. **In case Guaranteed Conversion coverage (CGAR) is agreed, Illnesses covered out of Mexico (ECE) shall not apply.**

c. **In no event shall the Company pay medical or hospital expenses of the Insured where living out of Mexican Territory.**

d. **Out-of-hospital Medicines, even though additional coverage subject to charge is agreed 1. Out-of-hospital Medicine (MFH).**

11. Medical Care out of Mexico (ATEX)

By purchasing this coverage and as of the Addition Date thereof, the Insured shall be entitled to extend the coverage territory to a foreign territory (out of the Mexican Republic) applying the conditions and limits agreed and stipulated for this Policy.

the limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured

The Sum Insured of the basic coverage stipulated in the Policy Dec Page shall apply.

Deductible, Coinsurance and Cap Coinsurance

The Deductible and Coinsurance shall apply as stated on the Policy Dec Page regardless expenses were incurred in Mexican territory or out of Mexico. The Deductible and Coinsurance shall apply as per provisions set forth in clause 28. Claim Payment of these general conditions.

Payment of fees

This shall be paid based on the Table of UCR (Usual, Customary & Reasonable).

Age

The age limit to acquire this coverage shall be from the first day of birth to age 64 (sixty-four). For this coverage there is no age limit for renewals.

To acquire this coverage, it is essential that the Insured furnishes evidence to the Company of his residence in the Mexican Republic and that this is the normal place of residence of the Insured. This coverage shall become null and void in case the Insured changes his domicile or residence to any place out of the Mexican Republic.

In no event shall the Company pay medical or hospital expenses of the Insureds if living out of the Mexican Territory.

At the time of acquiring this coverage, the Medical Emergency coverages out of Mexico (EMER) and Illnesses Covered out of Mexico (ECE) will be included.

Specific Exclusions

a. **Regarding this additional coverage, each and every exclusion and limitation of expenses stipulated in Section V. Exclusions (expenses not covered) of these general conditions shall apply.**

b. **By purchasing this coverage, the following coverages shall become null and void out of Mexico: Coverage in Mexican Territory (CoNa), Illnesses covered out of Mexico (ECE), Medical Emergency out of Mexico (EMER) and VIP Customer (DIST).**

c. **In case Guaranteed Conversion coverage (CGAR) is agreed upon, this coverage of Medical Care out of Mexico (ATEX) shall become null and void.**

12. VIP Customer (DIST)

By purchasing this additional coverage and as of Addition Date thereof, the Company provides the following Benefits:

a. Upgrade to Next standard room level in Mexican territory

According to this coverage, an upgrade from a private standard room to a suite room is granted only in Mexican territory, provided that the Hospitalization is due to an Accident or Illness covered by these general conditions. **This benefit is subject to availability of the suite room within the Hospital.**

This benefit will cover whichever is the less:

- Maximum 2 (twice) the price of the standard single room; or
- The suite room, provided that said suite is the next higher room of the private standard room

In case Guaranteed Conversion coverage (CGAR) is agreed upon, it shall apply after exceeding the Guaranteed Conversion Deductible, applying the limits and conditions of this coverage.

This benefit does not apply to:

Financial Maternity Support, 2. Extended Maternity (MATE), Medical Emergency out of Mexico (EMER), Illnesses covered out of Mexico (ECE), Medical Care out of Mexico (ATEX).

b. Admission Kit

According to this coverage, it is stated that the Company shall cover the admission kit considered as the first personal effects delivered to the patient at the time of hospital admission

This benefit applies, provided that Hospitalization results from or is a consequence of an Accident or Illness covered under these general conditions.

In case Guaranteed Conversion coverage (CGAR) is agreed upon, it shall apply after exceeding the Guaranteed Conversion Deductible, applying the limits and conditions of this coverage.

c. MXN 500 (five hundred pesos 00/100 Mexican Currency) per day for meals of the companion, for a maximum of 30 (thirty) days, provided that these expenses are incurred during hospitalization of the Insured resulting from Accident or Illness covered by the Policy.

This benefit shall be covered only through Reimbursement Payment.

In case Guaranteed Conversion coverage (CGAR) is agreed upon, the benefit applies without any need to exceed the Guaranteed Conversion Deductible coverage.

d. MXN 100 (one hundred pesos 00/100 Mexican Currency) per day of indemnity for parking expenses, maximum 30 (thirty) days, provided that these expenses are incurred during hospitalization of the Insured, resulting from an Accident or Illness covered by the Policy.

Said benefit shall be covered only through Reimbursement Payment.

In case Guaranteed Conversion coverage (CGAR) is agreed upon, the benefit applies without any need to exceed the Guaranteed Conversion Deductible.

e. Doctor Home Visit (Home Consultation)

At the request of the Beneficiary, AXA Assistance will make arrangements to send a General Physician to the Permanent Residence of the Beneficiary or to the place where the Beneficiary is at the time of making the request.

The Beneficiary will pay only a preferential price of MXN150 (one hundred fifty pesos 00/100 Mexican Currency) directly to the visiting Physician in each home visit, once the medical consultation finishes.

AXA Assistance shall provide this service in the main cities of the Mexican Republic, specified in section VII. Assistance Services provided by AXA Assistance; in all other places, AXA Assistance will do everything possible to help the Beneficiary contact a Physician or Hospital as soon as practicable.

Age

The age limit to acquire this coverage shall be from the first day of birth to Age 64 (sixty-four). For this coverage there is no age limit for renewals.

f. Myopia Surgery

Expenses incurred from illnesses shown below shall be covered after 48 (forty-eight) months of continuous cover under this Policy counted from the date this coverage is agreed:

- Myopia. Expenses incurred from myopia surgery for any of the Treatments (including intraocular lens) and/or bilateral surgery.

5 (five) diopters due to myopia are necessary at least in one eye.

The limits and conditions applicable to this coverage shall be those in force at the time of incurring in the expenses and according to the following:

Sum Insured

The Sum Insured shall be $30,000.00 (thirty thousand pesos 00/100 Mexican currency) per Insured for one or both eyes and shall be a single sum insured in the life time of the Insured.

Deductible and Coinsurance

The Deducible and Coinsurance as stated in the Policy Dec Page.

Age

Age limit of Insureds as of age 21 (twenty-one)

Only and exclusively shall medical and hospital expenses be covered where incurred from any of the following complications arising from myopia surgical procedures:

- Dry eye syndrome: eye drops Treatment shall be covered only for the first 2 (two) years after surgery.
- Corneal opacity resulting from an abnormal scarring procedure: Corneal transplant is covered subject to a Sum Insured of $200,000 (two thousand pesos 00/100 Mexican currency) per Insured and shall be one-time expense in the Life of the Insured. Deductible and Coinsurance stipulated in the Policy Dec Page shall apply.

In case Guaranteed Conversion coverage (CGAR) is agreed upon, it shall apply after exceeding the Guaranteed Conversion Deductible, applying the limits and conditions of this coverage.

For this benefit, any kind of Acknowledged Time Insured shall not apply.

g. Keratoconus

Expenses incurred for keratoconus in Insureds over 18 (eighteen) years old shall be covered, only in stages III or IV, provided always the Illness has been diagnosed after a 48 (forty-eight) months Waiting Period.

Only Treatments with intracorneal ring segments or keratoplasty (corneal transplant) shall be covered.

In case Guaranteed Conversion coverage (CGAR) is agreed upon, it shall apply after exceeding the Guaranteed Conversion Deductible, applying the limits and conditions of this coverage.

For this coverage, AXA Time Insured under a Group and Individual Policy shall be considered to reduce Waiting Periods.

V. Exclusions (expenses not covered)

This Insurance Contract does not cover expenses for medical care to the Insured in respect of Illnesses, medical tests, medical or surgical Treatments or their complications and consequences, because of the following:

1. **Preexisting Disease, except as provided in the additional coverage under item 3. Preexistence (PRE) of section IV. Additional coverages subject to charge.**

2. **Expenses for any Accident or Illness first manifesting itself during any uncovered period, as well as expenses incurred during such period.**

3. **Neither the bodily injuries deliberately caused by the Insured nor the Treatments where the first medical care and/or first expense occurs or is incurred respectively within the first 90 (ninety) calendar days following the date on which the Accident occurs will be considered Accidents.**

4. **Prematurity, fetal immaturity, malformations and congenital diseases of Insureds born out of the period of coverage of this Policy, except as provided in coverage 1.3 Newborn coverage with AXA benefit with regard to congenital diseases for children born out of the Policy Period.**

5. **Abortion, whatever its cause and complications may be.**

6. **Termination of pregnancy during the first 12 (twelve) weeks, whatever its cause and complications may be.**

7. **Fees for the storage of stem cells in a stem cell bank, or expenses for collecting, refrigerating and preparing stem cells for transplantation purposes.**

8. **Expenses for cryopreservation of umbilical cord.**

9. **Surrogacy expenses incurred by the biological mother or pregnant woman, including all newborn expenses.**

10. **Expenses for fertility, infertility and/or birth control and/or assisted reproduction Treatments or procedures or any of their complications, whatever their causes may be.**

11. **Expenses for complications of pregnancy, delivery, caesarean section or puerperium, when getting pregnant results from an infertility and/or sterility Treatment or after undergoing an assisted reproduction treatment, except as provided in coverage 5. Not covered major medical expenses incurred for Medical Emergency resulting from complications (CGMM).**

12. **Expenses for complications of pregnancy, delivery, caesarean section or**

puerperium because of Illnesses and medical procedures of the fetus.

13. **Congenital diseases, Illnesses and/or complications of premature newborns resulting from alcoholism or drug addiction of either parent.**

14. **Congenital diseases, genetic diseases, Illnesses and/or complications of premature newborns resulting from infertility and/or sterility Treatments underwent by either parent, and assisted motherhood, except as provided in the additional coverage under item 5. Not covered major medical expenses incurred for Medical Emergency resulting from complications (CGMM) of section IV. Additional coverages subject to charge.**

15. **Organ donation and its complications, when the Insured is the donor, or expenses for medical or surgical complications of organ donors, and expenses of organ donation candidates, except as provided in coverage 7. Organ Transplant.**

16. **Treatments for Illnesses resulting from the intake of alcohol or toxic substances not prescribed by a Physician, and their respective detoxification Treatments.**

17. **Treatments for Illnesses and/or Accidents resulting from drug addiction, use of illegal drugs and/or toxic substances not prescribed by a Physician, and their respective detoxification Treatments.**

18. **Procedures or Treatments of plastic, cosmetic or aesthetic nature or for baldness, cold caps for alopecy Treatment following chemotherapy, butt implants, vacuum pumps and prosthesis for erectile dysfunction, except as provided in the additional coverage under item 5. Not covered major medical expenses incurred for Medical Emergency resulting from complications (CGMM) of section IV. Additional coverages subject to charge.**

19. **Expenses for hairdressing, wigs, barbershop and pedicurist, and purchase or renting costs of devices or services for personal comfort.**

20. **Dietary, medical and/or surgical Treatments for anorexia and bulimia and their complications, except as provided in the additional coverage under item 5. Not covered major medical expenses incurred for Medical Emergency resulting from complications (CGMM) of section IV. Additional coverages subject to charge.**

21. **Surgical Treatments for medical or surgical procedures or dietary Treatments for correction and/or management of obesity or weight loss, including bariatric surgery for diabetes Treatment, except as provided in coverage 4.2 Bariatric surgery and the additional coverage under item 5. Not covered major medical expenses incurred for Medical Emergency resulting from complications (CGMM) of section IV. Additional coverages subject to charge.**

22. **Tests and/or Treatment of any kind to correct sleep disorders, sleep apnea,**

snoring and their complications.

23. **Medical expenses for:**

    a. **Psychiatric or psychological treatments.**

    b. **Mental derangement treatments.**

    c. **Conduct disorder treatments.**

    d. **Depressive disorder treatments.**

    e. **Hysteria, neurosis, psychosis treatments or treatments for any of their clinical manifestations.**

The Company will not pay expenses incurred for the above Treatments or their complications, even if they result from any Illness or Accident covered by this Insurance Contract.

Coverage will in no event be provided for medical and hospital expenses incurred for Illnesses listed in the last version of the DSM Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

24. **Admission Package, except as provided in coverage 12. VIP customer (DIST).**

25. **The following therapies, whatever their origin or Illness giving rise thereto may be:**

    a. **Psychomotor rehabilitation, except as provided in coverage 4. Rehabilitation therapies.**

    b. **Neuro feed-back rehabilitation.**

    c. **Neurostimulation therapy.**

    d. **Early stimulation.**

    e. **Cognitive rehabilitation.**

    f. **Learning therapy.**

    g. **Occupational therapy.**

    h. **Recreational therapy.**

    i. **Vocational therapy.**

    j. **Neurolinguistic programming.**

k. Language therapy.

The Company will not pay expenses incurred for the above Treatments and/or therapies or their complications, even if they are medically justified and result from any Illness or Accident covered by this Insurance Contract.

26. Treatments or procedures for treatment of sexual impotence or dysfunction, even when caused by Illnesses or Accidents which expenses are covered.

27. Therapeutic Treatments or procedures to correct astigmatism, presbyopia, hypermetropia, myopia, keratoconus or any other eye refraction disorder, as well as purchase of eyeglasses, contact lenses and intracorneal rings, except as provided in item b) Expenses covered subject to Waiting Period of section III. Basic coverage.

28. Intraocular lenses, except as provided in item b) Expenses covered subject to Waiting Period and coverage 12. VIP customer (DIST) of section III. Basic coverage.

29. Strabismus for newborns without AXA benefit.

30. Dental, alveolar, gingival and maxillofacial treatments because of Illness, even when caused by complications of Illnesses which expenses are covered.

31. Alternative medicine treatments, which benefit is still uncertain and/or performed for preventive purposes and/or by persons not meeting the definition of Physician in these general conditions, except as provided in coverage 14. Alternative Medicine of these general conditions.

32. Expenses for the purchase of Medicines, devices and/or supplies that have no health registration with the Cofepris or that have not been licensed for sale in Mexico, even when prescribed or justified by the treating Physician or even when the Insured has an import permit.

33. Medical expenses for Medicines of any kind taken by the Insured to treat Illnesses or symptoms other than those specified in the therapeutic indications of the Medicine at issue.

34. Illnesses, injuries and/or Treatments resulting from attempted suicide and/or deliberate mutilation or self-inflicted injuries, even when committed in a state of mental derangement.

35. Injuries sustained by the Insured when traveling in a car (as driver or passenger), motorcycle or any other similar vehicle, in races, endurance or speed trials, motorcycling or sports involving motor vehicles in any of their forms.

36. Illnesses or injuries sustained by the Insured while participating in any championship sponsored by national or international federations, and Accidents or Illnesses resulting from playing professional sports of any kind.

37. Injuries sustained by the Insured when traveling as pilot, passenger, mechanic or crew member of a commercial airliner lawfully established and licensed to provide regular passenger transportation services, subject to a regular flight schedule, frequency of flights and timetables, as well as flights in ultralight aircraft with or without engine.

38. Medical fees when the Physician is the Insured himself or a family member of the Insured; family member being understood as parents, children or spouse.

39. Fees of physicians, physiotherapists, chiropractors or acupuncture specialists or homoeopathists not holding a professional certificate accrediting them as Physicians legally authorized to perform such Treatments.

40. Any expense not directly related to the medical and/or surgical Treatment of the covered Illness or Accident.

41. Personal costs of the Insured or the Insured´s companions in any Hospital, Clinic or Sanatorium, excepting extra bed and as provided in coverage 12. VIP customer (DIST).

42. Healthy newborn care (crib, physiological crib, incubator, pediatrician).

43. The following formulas or preparations and products, even if medically prescribed:

a. Milk formulas.

b. Food supplements and complements.

c. Vitamin medicines and multivitamin products.

d. Cosmetic and dermatologic products.

e. Medicines out of the Hospital, except as provided in coverage 1. Out-of-hospital medicines (MFH).

f. Covered medicines without a valid medical prescription.

g. Biological medicines and supplies used in connection with cell therapy.

h. Medicines not related to the covered Illness or Accident.

i. Naturist formulas.

44. Expenses incurred out of the Mexican Republic, except as provided in coverage 9. Medical emergency out of Mexico (EMER), coverage 10. Illnesses covered out of Mexico (EE), and coverage 11. Medical care out of Mexico (ATEX)

45. Expenses for Medicines purchased out of the Hospital in a foreign country, even if the following coverages are agreed: coverage 9. Medical emergency out of Mexico (EMER), coverage 10. Illnesses covered out of Mexico (EE), and coverage 11. Medical care out of Mexico (ATEX)

46. Replacement of orthopedic devices, prosthesis and functional aids, except as provided in the basic coverage, and orthopedic devices, prosthesis and functional aids already existing prior to purchasing an AXA individual insurance Policy, whatever the nature or cause of such replacement may be.

47. Hearing aids and/or auxiliary devices intended to improve hearing; hearing aid being understood as the special part or implant intended to improve or restore hearing, except as provided in 1.3 Newborn coverage with AXA benefit.

48. Buying or renting of orthopedic shoes, insoles and orthopedic flaps, even if medically prescribed or justified by a Physician.

49. Relaxation therapies, therapeutic massages or medical indications to get rest, and initial medical tests to verify the health condition, known as medical check-ups.

50. Any expense not expressly specified in section III. Basic coverage of these general conditions.

51. Injuries occurring while taking part in military activities, acts of war, fights, rebellion or insurrection, or while voluntarily participating in riots, including, among others, protests, meetings, public demonstrations and strike actions or solidarity strikes.

52. Clothing credited with therapeutic properties, such as shoes, socks, blouses, underwear, stockings, shirts and undershirts.

53. Medicines, medical devices and/or supplies taken during the hospital stay that have no health registration in the Mexican territory or a specific and valid import permit issued by the Cofepris.

54. Medicines brought from a foreign country that have no health registration in Mexico.

55. Nursing care services for oral administration of Medicines and general nursing

This translation into english is a professional courtesy only. In case of controversy, the Spanish wording shall prevail.

care, such as personal hygiene, oral feeding, accompaniment, male/female assistants and nurses not legally authorized to practice his/her profession, except as provided in coverage 3. Homecare, item a) Nursing care.

56. **Illnesses the existence of which is certified by means of a medical record, where the Insured has incurred expenses verifiable by documents in order to be diagnosed or receive medical Treatment for the Illness or Illnesses that have been diagnosed within the first 30 (thirty) days of the Policy Period. This period of time will not take effect with regard to renewals.**

    This 30 (thirty) day period will not take effect in case of Accidents or Medical Urgencies.

57. **Medical expenses for magnetic therapy Treatments.**
58. **Expenses related to hyperbaric camera Treatments, even if prescribed by a Physician, except as provided in coverage 16. Hyperbaric Medicine.**
59. **Import costs for cadaveric corneas, tendons, ligaments, skin and bones.**
60. **Expenses for Treatments or Medicines in testing stage.**
61. **Expenses for Treatments based on Medicines that have no health registration or have not been licensed for sale in Mexican territory; respecting cancer, Medicines not specified in the National Comprehensive Cancer Network (NCCN) Therapeutic Guidelines.**
62. **Administrative expenses, transportation and import costs of organs, cells and tissue for transplantation purposes.**
63. **Gene therapy Treatment.**

VI. General clauses

1. Insurance Contract Coverage

Effective date of the Insurance Contract

Date from which each Insured is covered by the Insurance Contract according to the following:

a. Accident. The Insured enrolled in the Policy will be covered against any covered Accident as of the Addition Date of the Insured in the Policy

b. Illness. In case of any covered Illness, unless otherwise provided, it will be covered 30 (thirty) days after the Addition Date of the Insured in the Policy. This 30-day period will not take effect with regard to renewals or Medical Emergencies

c. The Sum Insured indicated on the Policy Dec Page will apply to each Accident or Illness covered by this Insurance Contract, per Insured and for the agreed Claim Payment Period. Such sum will not be reinstated in any case

2. Hospital plan

The Contracting Party or Insured Policyholder is free to elect upon agreeing the insurance coverage the Hospital Plan that best satisfies his/her needs, and will have access to the hospitals included in such plan at the time of requiring medical assistance or medical Treatment according to the benefits derived from the agreements executed by the Company and the Hospital, Clinic or Sanatorium. There are 3 (three) Hospital Plans indicated in descending order of rank: Diamante, Esmeralda and Zafiro.

The agreed Hospital Plan is indicated on the Policy Dec Page.

The Hospital, Clinic or Sanatorium plan may be changed or modified by the Company at any time without prior notice. The Insured´s right and will to freely choose or select the Hospital, Clinic or Sanatorium to receive medical assistance is not restricted by such listing.

3. Reduction or elimination of Waiting Periods

Benefit granted by the Company to the Insured on the basis of the time in which the Insured remains continuously and uninterruptedly covered by a similar Major Medical Expenses Insurance Policy issued by this or other company lawfully authorized. This benefit is intended solely for reducing the Waiting Periods.

a. This benefit applies as follows:

Time insured under an AXA Individual Policy

This benefit is intended solely for eliminating or reducing Waiting Periods applicable to Illnesses covered by these general conditions. Such Waiting Periods are set forth in section III. Basic coverage, item b) Expenses covered subject to Waiting Periods, providing the following coverages:

- Maternity financial support
- Newborn with AXA benefit

- Complications of pregnancy, delivery, caesarean section and puerperium
- Illnesses of 12 (twelve) and 24 (twenty-four) months
- HIV and AIDS

This benefit does not take effect for bariatric surgery, extended maternity (MATE), preexistence (PRE) and additional coverage subject to charge item 12. VIP customer (DIST), item 12.6. Myopia surgery.

b. AXA Time Insured

This benefit is intended solely for eliminating or reducing Waiting Periods applicable to Illnesses covered by these general conditions. Such Waiting Periods are set forth in section III. Basic coverage, item b) Expenses covered subject to Waiting Periods, **excepting the following coverages:**

- **Maternity financial support, newborn with AXA benefit and complications of pregnancy, delivery, caesarean section or puerperium.**
- **Bariatric surgery.**
- **HIV or AIDS.**
- **Preexistence (PRE) of section IV. Additional coverages subject to charge.**
- **Myopia surgery in case the additional coverage subject to charge 12. VIP customer (DIST) is agreed.**
- **Extended maternity.**

c. Acknowledged time insured

This benefit is intended solely for eliminating or reducing Waiting Periods applicable to Illnesses covered by these general conditions. Such Waiting Periods are set forth in section III. Basic coverage, item b) Expenses covered subject to Waiting Periods, **excepting the following coverages:**

- **Maternity financial support, Newborn and Complications of pregnancy, delivery, caesarean section or puerperium.**
- **Bariatric surgery.**
- **Myopia surgery in case the additional coverage subject to charge 12. VIP customer (DIST) is agreed.**
- **HIV or AIDS.**
- **Preexistence (PRE).**

4. Guaranteed Conversion deductible

Fixed amount applicable to expenses first incurred in respect of each Claim, payable by the Group Policy and/or by the Insured.

The general deductible is replaced by this deductible in case the Guaranteed conversion coverage (CGAR) is agreed.

In case this coverage is deleted, the applicable Deductible will be the basic Deductible indicated on the Policy Dec Page and not the deductible of such coverage.

5. Benefit period

Expenses incurred for each covered Accident or Illness during the Policy Period will be paid by the Company according to conditions of the insurance plan in effect at the time such expenses are incurred to restore the Insured´s health, subject to the following limit, whichever occurs first:

a. The Sum Insured becomes exhausted, that is to say, the amount of expenses covered by this Insurance Contract exceeds the Sum Insured indicated on the Policy Dec Page

b. The agreed Claim Payment Period runs out

c. The amount of expenses incurred during the Policy Period and up to 5 (five) calendar days following expiration of the Policy Period. If the Insured requests the renewal of his/her Medical Expenses Individual Insurance Policy for the period immediately following expiration of this Policy or a change of insurance plan or product and it is accepted by the Company, the benefit period will take effect in the terms established in this clause, provided that the new insurance plan covers the Accident or Illness under the Basic Coverage

d. Health or vitality is regained after the covered Accident or Illness sustained by the Insured

e. In case the Insurance Contract is cancelled, the expenses incurred up to 5 (five) calendar days following the cancellation date of the Insurance Contract

6. Grace period

30 (thirty) day period following inception date of the Policy Period for payment of premium, granted to the Contracting Party to settle the total premium or the respective fraction thereof.

The Insurance Contract will automatically cease to be effective at 12:00 (twelve) hours of the last day of such grace period in case of failure to pay the premium or the respective fraction thereof (with regard to installment plans) within the period indicated to such effect on the Policy Dec Page.

In case of Claim occurring within such grace period, the Company will deduct from the indemnity payment the total outstanding premium or the unsettled fractions thereof until collecting the total premium corresponding to the period of the agreed insurance.

Within the grace period, payment of medical expenses incurred for any Claim will not be made via Direct Payment; instead, such payment will be made on a Reimbursement basis.

7. Uncovered Period

Period in which the Insured may not enjoy the benefits of this Insurance Contract. It results from failure to pay the insurance premiums.

8. Insurance Contract rectifications and notifications

a. Insurance Contract rectification

If the contents of the Policy or the amendments thereto do not conform to the offer, the Contracting Party or Insured Policyholder will request the respective rectification within 30 (thirty) calendar days following inception date of the Policy Period. Once this period has elapsed, the stipulations of the Policy or the amendments thereto will be considered accepted (Article 25 of the Insurance Contract Law).

Only the rectifications previously agreed by the Contracting Party and the Company and made in writing by means of Endorsement will take effect.

The agents or persons not specifically approved by the Company are not entitled to make modifications or rectifications to the Insurance Contract and Endorsements thereto.

b. Notifications

Every notification among the Company, the Insured and/or the Contracting Party will be forwarded in writing to the addresses indicated on the Policy Dec Page. Any change of address during the Policy Period will be notified in writing by the Contracting Party or Insured Policyholder to the Company. Notifications received by the Contracting Party or Insured Policyholder from the Company will be forwarded to the last address made known in writing by the former to the Company,

9. Premiums

Monetary compensation provided for in the Insurance Contract and payable by the Contracting Party to the Company either in one single payment or installments as set forth on the Policy Dec Page.

The total premium of the Policy is equal to the sum of the premiums of all the Insureds for the agreed coverages, according to their occupation, place of residence, gender and age attained on the inception date of the Policy Period or the Addition Date of the Insured.

The premium will be updated in every renewal according to the age attained by each Insured and subject to rates applicable at the time according to the insurance products registered by the Company with the National Insurance and Bonding Commission. The increase in premiums on every renewal will be that resulting from calculating and updating the premium parameters based on consistent, reliable and sufficient information, pursuant to provisions in the technical note to that effect.

The premium indicated on every receipt becomes due on inception of each agreed period as indicated on the Policy Dec Page. If the premium or any portion thereof, in case of installment payments, is not paid within the period indicated on the Policy Dec Page, the effects of the Insurance Contract will cease automatically at 12 (twelve) hours on the last day of such period, according to provisions in article 40 of the Insurance Contract Law.

Any due and outstanding premium will be deducted from any amount payable to the Insured.

Place of payment

The agreed premiums may be paid to a bank deposit reference number or by wire transfer of funds to AXA Seguros, S.A. de C.V.; to this effect, the Contracting Party will obtain and keep the voucher of this operation for further reference and clarification.

Premium payments may also be made through direct debit; the Contracting Party´s bank statement or the issuing bank´s receipt will serve as proof of payment.

10. Cancellation of contract

This Insurance Contract will be cancelled in case the Contracting Party fails to pay the corresponding premium within the agreed period.

If the Insurance Contract is cancelled by the Contracting Party within the first 30 (thirty) days of the Policy Period, the Company will refund 100% (one hundred percent) of the net premium corresponding to the time remaining before expiration of the Policy Period, but not to include Policy fees.

If the Insurance Contract is cancelled by the Contracting Party after 30 (thirty) calendar days following inception date of the Policy Period, the Company will refund 60% (sixty per cent) of the net premium corresponding to the time remaining before expiration of the Policy Period (unearned premium), but not to include Policy fees.

The cancellation request will be submitted at the Company´s offices nearest to the Contracting Party´s address, call 800 900 1292 for information on the nearest office.

At the time the cancellation request is submitted, prior identification of the Contracting Party, the Company will provide the respective folio number. The unearned premium will be refunded through electronic transfer or money order within 20 (twenty) calendar days as of the day following that on which the cancellation request is submitted.

11. Termination of obligations

By this clause, the Contracting Party or Insured Policyholder and the Company acknowledge and ratify that, according to provisions in the Insurance Contract Law, this Insurance Contract is ruled by the principle of good faith.

Consequently, the Contracting Party and/or Insured Policyholder expressly agree that the Company´s obligations will terminate in full right without need of any judicial action according to provisions in article 70 of the Insurance Contract Law, when, based on the analyzed information or documents submitted by the Contracting Party or Insured Policyholder to support any claim for payment or reimbursement, it is reasonably presumed that for the purpose of making the Company incur an error, the Contracting Party or Insured Policyholder and/or their representatives conceal or alter any fact directly or indirectly affecting in any way the obligations assumed by the Company according to this Insurance Contract, such as:

a. Concealment, omission or misrepresentation of circumstances related to the filing of the Claim and/or the its consequences; or

b. Forgery or alteration of public or private documents constituting the basis of the claim; or

c. Use and/or submission of forged or altered public or private documents in support of the existence or updating of the covered risk or any claim for payment or reimbursement, or in support of or to justify any situation or circumstances related to the Claim

To this effect, formal written notice of termination of the obligations under the Insurance Contract will be given by the Company to the Insured Policyholder and/or Contracting Party within 30 (thirty) working days following the date on which the Company has the elements, documents or information related to this situation.

Once notice is given, the Company will be released from any payment obligation or responsibility of any kind in connection with the claim giving rise to the termination of obligations.

However, the Company will fully meet its obligations according to the maximum limits of liability, Sums Insured and all other terms and conditions agreed in this Insurance Contract, including payment of obligations that arise or are likely to arise from losses and Claims legitimately filed and claimed prior to termination of the Company´s obligations, provided that these obligations are other than those giving rise to such termination of obligations.

The Company will in no event pay for losses occurring after the date of notice of termination of the Company´s obligations, even if the loss refers to a Claim different to that causing the advance termination.

The above will also apply in case the Contracting Party or Insured Policyholder or their representatives obtain illicit gain to the detriment of the Company by incurring any of the cases provided for in this clause.

In any case, the Company will be entitled to retain the premium earned until termination of obligations; however, it will refund the Contracting Party or Insured Policyholder 60% (sixty per cent) of the net premium corresponding to the time remaining before expiration of the Policy Period (unearned premium), but not to include Policy fees. Premium will be refunded to the Contracting Party through electronic transfer or money order within 20 (twenty) calendar days following the date on which the Company gives notice of termination of the obligations under the Insurance Contract.

12. Disclosure of commissions

The Contracting Party may request in writing during the Policy Period to be informed by the Company of the percentage of premium that corresponds to the intermediary or legal entity, whether by commission or direct compensation, because of their intervention in the execution of this Insurance Contract. The Company will provide such information in writing or by electronic means within a period not exceeding 10 (ten) working days after receiving such request.

13. Additions

At the request of the Contracting Party or Insured Policyholder and upon acceptance by the Company, any person meeting the requirements established by the Company may be included in the Insurance Contract, according to the evidence of insurability the Company is entitled to request.

Children born with AXA benefit will be covered from their date of birth to expiration date of the Policy, provided that the Insured Mother giving birth has been uninterruptedly covered by this Policy for at least 10 (ten) months at the time of delivery or caesarean section and notice is given to the Company within 30 (thirty) calendar days following birth.

In both cases, the Company will charge the Contracting Party a pro rata premium for the period from the addition date to expiration date of the Policy and issue the respective receipt.

In case of any increase in benefits under this Insurance Contract, the Company will charge the refunding to the Contracting Party a pro rata premium for the period from the date benefits are increased to expiration date of the Policy and will issue the respective receipt.

Once the addition of the Insured is accepted, payment of the respective premium will be made.

14. Deletions

The deletion of any Insured(s) from the Policy or reduction of benefits will be requested in writing and duly signed by the Contracting Party or Insured Policyholder. Deletion will take effect on the request date and, consequently, the insurance benefits for the deleted Insured will also cease from that date, the Contracting Party being refunded 60% (sixty per cent) of the net premium for the time remaining before expiration of the Policy Period (unearned premium), but not to include Policy fees.

15. Change of insurance plan

The Company gives the Contracting Party or Insured Policyholder the choice to terminate the Insurance Contract during the Policy Period and execute a new Insurance Contract making some modifications to the insurance product originally agreed.

The Contracting Party or Insured Policyholder may modify any of the following issues by changing the insurance plan:

- Sum Insured
- Deductible
- Coinsurance
- Hospital Plan
- Claim Payment Period
- Table of Medical Fees
- Addition or deletion of additional coverages subject to charge

The Contracting Party or Insured Policyholder will request in writing to the Company such changes by filling out and signing the Change Request Form and Medical Questionnaire Form in order for the Company to perform the medical selection process.

The Company is free to decline or accept such change of insurance plan according to the current change of insurance plan Policy.

When a change of insurance plan is requested by the Insured, the Company will not ensure:

- That the change is made without requesting Insurability requirements.
- The Waiting Periods of the previous insurance plan.
- The expenses not covered (exclusions).

16. Change of insurance product

The Company gives the Contracting Party or Insured Policyholder the choice to terminate the Insurance Contract during the Policy Period and execute a new Insurance Contract for a different insurance product currently in effect and registered by the Company with the National Insurance and Bonding Commission (CNSF). This Insurance Contract will be subject to different insuring terms and general conditions.

The Contracting Party or Insured Policyholder will request to terminate the Insurance Contract currently in effect, fill out and sign the Insurance Application Form and Medical Questionnaire Form in order for the Company to perform the medical selection process of the new insurance product.

The Company is free to decline or accept the change of insurance product according to the current change of insurance product Policy.

In case the change of insurance product is accepted, the Company will give written notice of such acceptance, remaining unchanged the Addition Date of the previous Policy and the Addition Date of the additional coverages subject to charge.

The Insured expressly accepts that, upon requesting to change the insurance plan, the Insurance Contract is terminated to execute a new Insurance Contract subject to conditions other than those originally agreed.

17. Medical examination

For the purpose of determining fairly and objectively any Preexisting Disease, the Company may ask the Insured to submit to a medical examination as a part of the risk selection process.

The Insured submitting to the medical examination referred to in the above paragraph will not be subject to provisions in the Preexistence clause in case the medical examination results do not test positive for the Illness for which the medical examination is originally performed.

In case the Insured reports the existence of any Illness that manifests itself before execution of the Insurance Contract, the Company is free to decline or accept the reported risk.

18. Renewal

This Insurance Contract will be considered renewed for a period of one year if notice of the Contracting Party´s intention of not renewing it is not given in writing within the last 30 days of the Policy Period.

The renewal is not understood as an extension of the Policy Period, that is to say, it gives no choice to keep unchanged the terms and conditions of the Insurance Contract.

In every renewal the Insured´s time insured with this Company will be preserved and the insuring terms of such renewal will be consistent with the insuring terms originally agreed and duly registered and approved by the National Insurance and Bonding Commission.

In like manner, the Company undertakes to renew the Insurance Contract with an insurance product containing sufficient, homogeneous and reliable statistical data in the terms provided in the standards of the actuarial practice.

The premium payment confirmed by the receipt issued as usual by the Company will be sufficient proof of renewal.

It is agreed by the Company that no Insured may be deprived of the benefit of renewing this Insurance Contract because of a high loss ratio, provided that there is no fraud or bad faith according to provisions in the Omissions or Misrepresentations clause.

19. Reinstatement

In case of cancellation of this Insurance Contract for nonpayment of premium, it will be reinstated at the request of the Contracting Party if within 30 (thirty) days following termination of the grace period indicated in clause 10. Premiums the Contracting Party pays the full premium or any portion thereof if installment payments are agreed.

The Insurance Contract may be reinstated without any change to the Policy Period originally agreed, according to current acceptance and reinstatement policies.

The Contracting Party is required to pay the premium for the uncovered period that corresponds to the reinstatement cost in order for the Company to reinstate the Insurance Contract.

The effects of this insurance will be reinstated as of the time and date indicated on the payment receipt. If the time is not indicated on the payment receipt, insurance will be deemed reinstated at 00:00 hours on the date of payment.

Losses occurring during the Uncovered Period will in no event be covered by the Company, and the Accidents, Illnesses and their complications discovered during this period will not be covered either.

20. Statute of limitations

All actions arising out of this Insurance Contract will become time-barred in 2 (two) years according to provisions in Article 81 of the Insurance Contract Law as of the date of the occurrence giving rise thereto, except as provided in Article 82 of the Insurance Contract Law.

The statute of limitations will be interrupted upon filing a claim with the Company Customer Complaints Unit (Unidad Especializada de Atención de Consultas y Reclamaciones de la Compañía) pursuant to provisions in article 50 bis of the Law for the Protection and Defense of Users of Financial Services.

21. Scope of coverage (territory limit)

Medical expenses must be incurred in the Mexican Republic.

In case any of the following additional coverages is acquired: Medical emergency out of Mexico (EMER), Illnesses covered out of Mexico (ECE) and Medical care out of Mexico (ATEX), the medical expenses incurred out of the Mexican territory will be covered according to provisions in these general conditions for such additional coverages.

Regarding the Illnesses covered out of Mexico (ECE) and Medical care out of Mexico (ATEX) coverages, the Insured will give prior notice to AXA and pay an additional premium in case the Insured stays out of Mexico for a period longer than three months but not exceeding 12 consecutive months (within the Policy Period). If the Insured fails to give notice as above or exceeds the above period of time, the effects of this Insurance Contract will automatically cease.

For the purpose of this Insurance Contract, only the Insureds permanently living in the Mexican Republic will be covered by this insurance.

The Contracting Party or Insured Policyholder is required to notify the Company of the place of residence of the Insureds in case they no longer live in the same address, and of any change of residence.

The Company may request the documents it may deem necessary to confirm the place of residence or length of stay out of Mexico at the time the Insured requests assistance services out of Mexican territory.

22. Currency

The amounts in this Insurance Contract are denominated in Mexican currency. The amounts indicated in this document are denominated in the currency or unit of value chosen at the time of effecting this Insurance Contract.

All payments in this Insurance Contract will be made in Mexican currency at the rate of exchange published by the Banco de México in the Official Journal of the Federation on the day payments are made according to provisions in article 8th of the Monetary Law applicable at the time payment is made.

The currency used at the time of issuing this Insurance Contract will not be modified, that is to say, there will be no currency conversion in respect of Sum Insured or premium.

23. Omissions or misrepresentations

The Contracting Party or Insured Policyholder is required to report in writing to the Company, in the pertinent questionnaire, all material facts relevant to assess the risk, which are likely to influence the agreed conditions, as they are known or should be known at the time of executing the Insurance Contract, according to provisions in article 8th of the Insurance Contract Law.

In case the Insurance Contract is executed by any representative of the Insured, all material facts known or that should be known by the representative or the represented party will be reported, according to provisions in article 9th of the Insurance Contract Law.

If the insurance is proposed by another party, the proposer will report all material facts known or that should be known by the third party Insured or his/her insurance intermediary, according to provisions in article 10th of the insurance Contract Law.

Any Omission or Misrepresentation of the facts referred to in articles 8th, 9th and 10th of the Insurance Contract Law will entitle the Company to consider the Insurance Contract terminated in full right, even if such omission or misrepresentation does not contribute to the Loss.

The Company will give official notice to the Insured or the Insured´s beneficiaries of termination of the Insurance Contract within 30 (thirty) calendar days following the date on which the Company has knowledge of the omission or misrepresentation.

24. Increase of hazard

For the purpose of this Insurance Contract, an increase of hazard takes place when a situation or condition other than that reported in the Insurance Application Form to assess the risk occurs.

In consideration of the above, the Insured is required to inform the Company of any essential increase of hazard concerning the risk and occurring during the period of insurance, within 24 (twenty four) hours after the Insured has knowledge thereof. If the Insured fails to give notice of or causes any increase of hazard, causes any increase of hazard, the Company´s obligations will cease in full right according to provisions in Articles 52, 53 section I, 54, 60 and 70 of the Insurance Contract Law.

The Company´s obligations will cease in full right because of any essential increase of hazard in case the Contracting Party(ies), Insured(s) or beneficiary(ies), in the terms of article 492 of the Insurance and Bonding Institutions Law and its general provisions, is (are) convicted by final judgement for any crime associated or arising from provisions in Articles 139 to 139 quinquies, 193 to 199, 400 and 400 Bis of the Federal Criminal Code and/or any other article relating to organized crime in Mexican territory; such judgement may be rendered by any local or federal competent authority, or in case the name of the Contracting Party(ies), Insured(s) or beneficiary(ies), their activities, property insured by the Policy or their nationalities are published in any official list relating to crimes associated with provisions in the above articles, whether national or foreign, issued by any government with which the Mexican government has executed an international treaty on the above subject, the above according to the terms of section X, Twenty-Ninth provision, section V, Thirty-Fourth provision or Fifty-Sixth provision of the Resolution for which the General Rules referred to in article 140 of the General Law of Insurance Institutions and Mutual Societies are issued.

25. Jurisdiction

In case any dispute arises, the Contracting Party or Insured Policyholder will enforce his/her rights with:

a. The Company Customer Complaints Unit.

b. The National Commission for the Protection and Defense of Users of Financial Services (Comisión Nacional de Protección y Defensa al Usuario de Servicios Financieros – Condusef), in which event the Contracting Party or Insured Policyholder will determine, at his/her choice, the jurisdiction by territory according to the address of any of its branch offices, as per provisions in articles 50 Bis and 68, 70, 71 and 72 Bis of the Law for the Protection and Defense of Users of Financial Services, and 277 of the Insurance and Bonding Institutions Law.

If the parties hereto do not submit to arbitration by the Condusef or by whomever is proposed by the Condusef or the Company, the rights of the Contracting Party or Insured Policyholder will be preserved to assert them at competent courts with jurisdiction of any of the regional branch offices of the Condusef. In any case, it is up to the Contracting Party or Insured Policyholder to appeal either to the above administrative bodies or directly to such courts.

In case the Contracting Party or Insured Policyholder so decides it, he/she will assert his/her rights according to provisions in clause 31. Medical arbitration of these general conditions.

Contact data:

Customer Complaints Unit of AXA Seguros (UNE by its initial in Spanish):

Telephones:

In the Mexican Republic: 800 737 76 63 (option 1)

In Mexico City: (55) 5169 2746 (option 1)

Address:

Félix Cuevas 366, col. Tlacoquemécatl, alc. Benito Juárez, 03200, at the Customer Service Counter of AXA.

Send an e-mail to axasoluciones@axa.com.mx or log onto axa.mx/web/servicios-axa/quejas.

Office hours: Monday to Thursday 8:00 to 17:30 hours and Friday 8:00 to 16:00

Condusef

Telephones:

In Mexican territory: 800 999 8080

In Mexico City: (55) 53 40 0999

Address:

Av. Insurgentes Sur # 762, col. del Valle, México, D.F., C.P. 03100.

For other customer service offices in the country, visit

www.condusef.gob.mx/index.php/oficinas-de-atención

Electronic registration of comments: asesoria@condusef.gob.mx

26. Age

a. The age limit for purchasing this insurance is from the first day of birth to 64 (sixty-four) years old. No age limit applies to renewals under this Insurance Contract.

b. In case the Insured´s age falls out of the applicable age limit because of a misreporting of the Insured´s age at the time of execution or renewal of this Insurance Contract, the benefits under this Policy will be terminated according to provisions in article 171 of the Insurance Contract Law.

c. When there is proof that the Insured´s age was misreported and, consequently, the paid premium is less than what it actually should have been paid, the Company´s liability will be reduced in the proportion that the paid premium bears to the premium indicated on the rate table for the actual age on the execution date of the Insurance Contract. In calculating the above, the rates current on the execution date of the Insurance Contract will apply, according to provisions in article 172 of the Insurance Contract Law. The respective premium adjustment will be made upon verifying the actual age.

d. In case the age misreporting is attributable to the Company, premium will be computed on the basis of the actual age. If premium for the actual age is less than the premium paid, premium will be refunded.If the premium is greater, it will be adjusted as of the discovery date of such misreporting.

27. Losses

The Company will be entitled to demand from the Contracting Party or Insured Policyholder information of any kind on the facts related to the loss, relevant to determine the circumstances and consequences of its occurrence.

In every claim, the Contracting Party or Insured Policyholder will be required to prove the Loss occurrence to the Company and submit, duly filled out, the documents received to such effect. The medical reports and tests in connection with the claimed Illness or Accident and the original receipts of costs incurred will have to comply with the tax provisions applicable on the issuance date of such documents; sales notes in no event will be acceptable. Failing to comply with these requirements will release the Company from any obligation arising from the claim, according to the following:

a. The claimant is bound to give written notice to the Company of any Illness resulting from an Accident or Illness within 5 (five) working days following its occurrence, except in case of force majeure or acts of God, in which event the claimant will give notice to the Insurance Institution as soon as the impediment ceases to exist.

b. In order for the psychological support coverage to come into effect in case of robbery or rape, it is an essential requirement for the claimant to attach a simple copy of the report on facts filed with the competent Public Prosecutor.

The Company will be released from any obligation resulting from the claim in case:

a. The Contracting Party or Insured Policyholder prevents the Company from gathering information or making enquiries to determine the circumstances and consequences of the Loss.

b. The Insured fails to submit the information or documentation requested by the Company on the facts related to the Loss, relevant to determine the circumstances and consequences of its occurrence, within the period of time provided in clause 20. Statute of Limitations of these conditions, according to provisions in articles 69 and 70 of the Insurance Contract Law.

28. Loss payment

Provided that the incurred medical expenses exceed the agreed Deductible, payment amount will be determined as follows:

a. All covered medical expenses resulting from one single Loss will be added up and adjusted according to the limits and conditions provided in the Insurance Contract. In case of Bilateral Organs, a single deductible will apply if at the time of the initial diagnosis the bilateral health condition and/or the need for Treatment on both sides are confirmed. Separate deductibles will apply to each side if the initial diagnosis and/or Treatment are established in different times.

b. The agreed Deductible will be first deducted from the resulting amount indicated in the above paragraph, then, the agreed Coinsurance, according to the percentage and Coinsurance Cap indicated on the Policy Dec Page, will be deducted.

c. Indemnity will be paid by the Company to the Insured or to whom it may concern within 30 (thirty) calendar days following the date of receipt of all proofs required to support the claim.

d. In case the expenses incurred by the Insured for one single Loss are also covered by other insurance policies issued by this or other insuring institution, they will be considered to meet the Deductible amount and the Insured will submit to the Company the necessary documents to prove that such expenses are actually incurred.

Initial Lossses

Expenses will be covered according to the current agreed Conditions and limits indicated on the Policy Dec Page on commencement of the Company´s obligation. The Company´s obligation commences at the time the total payable expenses exceed the agreed Deductible amount.

Complementary Payments

Subsequent expenses will continue being paid subject to the current agreed Conditions and limits indicated on the Policy Dec Page at the time such expenses are incurred, provided that the Contracting Party or Insured Policyholder has not requested any change of insurance plan or product.

In case the Insured requests a change of insurance plan or product and such change is approved by the Company, subsequent expenses will continue being paid according to the Hospital Plan, Table of Medical Fees, Sum Insured, Deductible, Coinsurance, Coinsurance Cap, Loss Payment Period, additional coverages and Endorsements indicated on the Policy of the Period corresponding to the time when the new expense is incurred, considering the requested changes.

The above provisions will take effect, provided that the medical and hospital expenses are incurred within the Mexican territory, and the Insurance Contract is in effect and its premiums are currently paid or it complies with provisions in the benefit period or grace period clauses.

28.1. Application of Sum Insured

The Sum Insured takes effect from the date of the first incurred payable expense reported to the Company for each covered Accident or Illness and it will remain in effect for the period chosen by the Contracting Party or Insured Policyholder as indicated on the Policy Dec Page.

If a new Sum Insured is requested and it is accepted by the Company for Losses covered by the Policy preceding the change, the new Sum Insured as indicated on the Policy of the period corresponding to the time when the new expense is incurred will apply, deducting the amount incurred from the time the Loss is opened with this Company.

28.2. Application of Deductible

Initial Loss

The Deductible amount is determined at the time the expenses incurred exceed the Deductible indicated on the Policy. In other words, the applicable Deductible will be that in effect at the time the total payable expenses exceed such Deductible amount, and once such Deductible is exceeded it may not be reinstated and/or adjusted unless there is a change of insurance plan or product.

Complementary Payments

If a change of Deductible is requested and it is accepted by the Company for Losses covered by the preceding Policy, the amount paid for this concept under such Policy will be taken as Deductible; in other words, the Insured will have to meet the amount of the new Deductible and the Company will take into consideration the amount applied as Deductible under such preceding Policy; if the amount is greater, the amount for this concept will not be reimbursed. Regarding the Guaranteed Continuity coverage (CONT), the Deductible will have to be met, without considering any other amount paid for this concept.

In case the Guaranteed Conversion coverage (CGAR) is agreed, provisions in such coverage will apply, the Guaranteed Conversion Deductible being applicable and leaving without effect the basic coverage Deductible.

28.3. Application of Coinsurance

Initial Loss

The Coinsurance will apply to all payable expenses in respect of every covered Loss up to the Coinsurance Cap, after deducting the agreed Deductible. Such Coinsurance percentage and Coinsurance Cap are indicated on the Policy Dec Page. The applicable Coinsurance Cap will be that in effect at the time the amount for this concept is exceeded.

Complementary Payments

The Coinsurance will apply until it exceeds the Coinsurance Cap in effect at that time, including the Guaranteed Conversion coverage (CGAR).

If a change of Coinsurance is requested and it is accepted by the Company for Claims covered by the preceding Policy, the amount previously paid will be taken as Coinsurance until it exceeds the Coinsurance Cap in effect at that time. In case the Coinsurance applicable in the preceding Policy is greater, the difference will not be refunded.

Regarding the Guaranteed Continuity coverage (CONT), the Coinsurance will have to be fully met up to the Coinsurance Cap, without considering any amount previously paid for this concept.

The Coinsurance percentage and Cap may be modified according to the following:

a) In case the Insured decides to go to a Hospital, Clinic or Sanatorium of a Hospital Plan different to that agreed:

1. If the Insured decides to go to a Hospital, Clinic or Sanatorium of a Hospital Plan lower than that agreed, the coinsurance will be reduced by a number of percentage points according to the Hospital Plan where the bill receives medical care, and will apply to the payable expenses indicated on the hospital invoice, keeping unchanged the agreed Coinsurance Cap corresponding to the Agreed or Lower column according to the table of paragraph e) of this section. The maximum benefit that the Insured may enjoy is that corresponding to the agreed Coinsurance.
2. If the Insured decides to go to a Hospital, Clinic or Sanatorium of a Hospital Plan higher than that agreed, a percentage additional to the agreed Coinsurance will apply to the hospital bill and the Coinsurance Cap corresponding to the Higher/Different column according to the table of paragraph e) of this section will apply instead of the agreed Coinsurance Cap.

3. If the Insured decides to go to a Hospital, Clinic or Sanatorium of the agreed Hospital Plan, the agreed Coinsurance and Coinsurance Cap will apply.

The above is based on the following scheme:

Agreed Hospital Plan	Hospital Plan where the Insured receives medical care		
	Diamante	Esmeralda	Zafiro
Diamante	Agreed Coinsurance	The agreed Coinsurance is reduced by 5 percentage points	The agreed Coinsurance is reduced by 5 percentage points
Esmeralda	The agreed Coinsurance is increased by 10 percentage points	Agreed Coinsurance	The agreed Coinsurance is reduced by 5 percentage points
Zafiro	The agreed Coinsurance is increased by 20 percentage points	The agreed Coinsurance is increased by 10 percentage points	Agreed Coinsurance

b) All out-of-network Hospitals, Clinics or Sanatoriums will fall into the Diamante Hospital Plan for Coinsurance Cap and Coinsurance application purposes.

c) If the Insured receives medical care at a Zone different to the tariff zone indicated on the Policy Dec Page, a reduction or increase of Coinsurance percentage points will apply to the hospital bill according to the following table, except for Medical Emergencies:

Agreed Care Zone	Hospital Care Zone			
	Metropolitan area	Monterrey	Guadalajara	Other
Metropolitana	Agreed Coinsurance	Agreed Coinsurance	The agreed Coinsurance is reduced by 5 percentage points	The agreed Coinsurance is reduced by 5 percentage points
Monterrey	The agreed Coinsurance is increased by 10 percentage points	Agreed Coinsurance	Agreed Coinsurance	Agreed Coinsurance
Guadalajara	The agreed Coinsurance is increased by 15 percentage points	The agreed Coinsurance is increased by 10 percentage points	Agreed Coinsurance	Agreed Coinsurance
Other	The agreed Coinsurance is increased by 20 percentage points	The agreed Coinsurance is increased by 15 percentage points	The agreed Coinsurance is increased by 10 percentage points	Agreed Coinsurance

1. In case of reduction of Coinsurance percentage points, the maximum benefit the Insured may enjoy will be that corresponding to the agreed Coinsurance up to the Coinsurance Cap indicated in the Agreed or Lower column according to the table of paragraph e) of this section.

2. In case of increase of the agreed Coinsurance percentage points, the Coinsurance Cap will be modified according to that corresponding to the Higher/Different column according to the table of paragraph e) of this section.

d) If the Insured receives medical care in a zone and Hospital Plan different to those agreed, the combination (addition) of the tables provided in paragraphs a. and c. will apply.

e) A Coinsurance Cap will be paid in every case by the Insured, it will vary according to the percentage of the agreed Coinsurance and the Hospital Plan and/or Zone where the Insured receives medical care, as shown in the following table:

Agreed Coinsurance	Coinsurance Cap Hospital Plan or Zone where the Insured receives medical care	
	Agreed or Lower	Higher/Different
5%	$36,000	$95,000
10%	$40,000	$110,000
20%	$70,000	$130,000
30%	$90,000	$170,000

In case the Insured receives medical care in a Hospital, Clinic or Sanatorium or zone of higher level than that agreed, the Coinsurance Cap will be fixed in the Higher/Different level for all the Loss expenses, even if the Insured returns to his/her agreed zone or level.

28.4. Application of Loss Payment Period

The Loss Payment Period shall take effect from the date of the first incurred payable expense reported to the Company for each Accident or Illness covered and will last for the period that the Contracting Period or Insured Policyholder chooses as indicated on the Policy Dec Page, provided the Insurance Contract is in effect.

If a new Loss Payment Period is requested and it is accepted by the Company for Losses covered by the Policy preceding the change, the new Loss Payment Period will apply, deducting the time elapsed from the time the Loss is opened.

28.5. Previous Notice Benefit

Process by which the Insured notifies to the Company the events listed below, and the Insured may enjoy by this notice a benefit consisting of a reduction of 5 (five) percentage points on the agreed Coinsurance:

a) For all types of cancer, leukemia, lymphoma or melanoma, (surgery and/or chemotherapy and/or radiotherapy) diagnosed by pathology tests, with the exception of in situ skin carcinoma, the Insured must comply with the following:

- Notify the Company at the onset of the Illness, or 10 (ten) days after the diagnosis at the latest and,

For further Treatments of the same Illness, this benefit shall be applicable, provided that the first Treatment had the same benefit.

The benefit shall only be applicable for the scheduled Treatment, including medical fees. In case of radiotherapy and chemotherapy, this benefit will be provided even if this benefit did not apply to the first Treatment, provided that the Medicine and/or its application is scheduled and this procedure is performed by the Providers chosen by the Company.

b) For case of any Scheduling of Services with Hospitalization, the Insured will:

- Notify the Company at the onset of the Illness, or 10 (ten) days after diagnosis at the latest or,
- Notify the Company 7 (seven) days before being admitted to Hospital, and
- Ensure that he has not received any medical Treatment as a result of said Illness

Additionally note

- For vertebral column, shoulder, knee and hip, the benefit will be applicable, as long as the Insured has received a second medical opinion.

For further surgeries of the same Illness, this benefit shall be applicable, provided that this benefit applies to the first Treatment.

This benefit shall only be applicable for the scheduled hospital event, including medical fees, and if no Hospitalization is required, this benefit will be applicable to Medicines scheduled with Providers.

c) For Hospitalizations out of Mexico, the Insured will:

- Notify the Company at the onset of the Illness, or 10 (ten) days after the diagnosis at the latest, or
- Notify the Company 10 (ten) days before being accepted to a Hospital out of Mexico,º and
- Ensure that he has not received any medical as a result of from said Illness.

This only applies if the Insured has purchased the following Additional coverages subject to charge: Medical Care out of Mexico (ATEX) and Covered Illnesses out of Mexico (ECE).

For further surgeries of the same Illness, this benefit shall be applicable, provided that this benefit applies to the first Treatment.

This benefit shall only be applicable for the scheduled hospital event, including medical fees.

The diagnosis will be determined based on the initial medical information provided by the Physician who gave the final diagnosis, and on the tests that confirmed the Illness.

Application of Coinsurance for the Previous Notice Benefit:

Once the Insured has met the requirements mentioned above, the Coinsurance agreed and shown on the Policy Dec Page will be reduced by 5 (five) percentage points in respect of hospital costs.

In addition to the provisions in of V. Exclusions (expenses not covered) this coverage does not include:

- **Any procedure not approved by national or international health institutions.**

29. Interest in Arrears

In case the Company fails to meet the obligation to pay the Sum Insured within 30 (thirty) calendar days following the date on which it receives the documents and information which are the basis of the claim filed against it, in the terms of Article 71 of the Insurance Contract Law, the Company undertakes to pay the Insured or beneficiary Interests in Arrears as provided for in article 276 of the Law of Insurance and Bonding Institutions (Ley de Instituciones de Seguros y de Fianzas) for the period in default.

30. Tax Benefits

The premiums paid for medical expense insurance complementary to or separate from health care services provided by public social security institutions will be considered personal deductions in favor of the Insured, on the condition that the Beneficiary, the Beneficiary´s spouse or the person with whom the Beneficiary lives in concubinage is the taxpayer, or the Beneficiary´s first degree ascendants or descendants, according to provisions on Article 151, section VI of the Income Tax Act (Ley de Impuesto sobre la Renta), subject to the limits set forth in such Act.

Where claims are paid on a Reimbursement basis, the Insured confirms that at his/her choice he/she hired health care service providers (legal entities) on behalf of and for account of the Company, such as Hospitals, Clinics or Sanatoriums, drugstores, laboratories, medical equipment providers, including devices and Prostheses, up to the sums indicated in the Table of medical fees and the limits of coverage of this Policy.

The expenses incurred by the Insured on behalf of and for account of the Company and in favor of such providers will be reimbursed to the Insured, subject to the table of medical fees and the limits of coverage of this Policy.

The sums paid by the Insured in excess of the Company´s limits of liability or the expenses not covered by the Policy are tax-deductible expenses for the Insured in the terms of the tax legislation.

31. Medical Arbitration

In case notice is given by the Company of the inadmissibility of a claim because of a Pre-existing Illness, the Insured may request in writing to the Company, at the Company´s address, the appointment of a Physician who will act as arbitrator mutually selected by the Insured and the Company so that such expert decides by arbitration whether the expenses giving rise to the claim filed by the Insured result or not from a Preexisting Illness.

The Company agrees that in case the claimant appeals to the arbitration proceeding, he/she will appear before the Physician and submit to the arbitration proceeding and resolution that will be binding on the Insured who, by this fact, waives any other right to resolve the dispute.

The Arbitration proceeding will be resolved by the Physician selected by the Insured and the Company, and both will sign the arbitration agreement.

The rendered arbitration award will be binding on the parties and have res judicata effect. This proceeding will be free of charge for the Insured.

32. Submission of Contractual Documentation

The Company is required to submit the contractual documentation consisting of Policy, General Conditions, Endorsements and all other contractual documents via the electronic e-mail address provided by the Contracting Party at the time of executing the contract or through the means selected by the Contracting Party when buying insurance.

In case the Contracting Party requires a duplicate of the Policy or wants to read the general conditions, they may be downloaded from axa.mx; otherwise, the Contracting Party may call the phone number indicated on the Policy Dec Page so that the Company submits to the Insured such contractual documentation:

- By regular mail to the address registered at the time of purchasing the insurance, or
- At any of the Company´s branch offices.

33. Responsibility assumed by the Company

According to provisions in this Policy, it is understood that the Insured, upon freely and voluntarily selecting the Hospital, Clinic, Sanatorium, Laboratory, Imaging Center or Drugstore, the attending Physicians and in general any other health care service intended for the recovery and restoration of the Insured´s health, accepts that the relationship developed with any Provider of the services mentioned above is strictly personal; consequently, the contractual relationship arising out of this free and voluntary selection is developed only between the service Provider and the Insured; therefore, the Company does not in any way take responsibility for any deficiency or medical malpractice, or for any professional, legal or moral responsibility likely to arise between these parties. Provisions in this clause will apply to each and every concept and service arising from this Policy, including any additional benefit and agreed assistance service.

34. Subrogation

The Company, pursuant to article 163 of the Insurance Contract Law, shall be subrogated to the extent of the rights and actions that correspond to the Insured or Loss payee, up to the limit of expenses incurred and injuries in relation to this Policy, against third parties due to the Loss, that is, against the people that caused the lesions, Accidents, Illnesses that give rise to the medical and hospital expenses covered by the Company.

The subrogation shall be considered fulfilled simply by virtue of the payment that the Company makes to cover the medical and hospital expenses of the Insured, and said subrogation includes the actions due to liability both subjective and objective that may correspond to the Insured or Loss payee.

The Subrogation right shall not apply if the Insured is the spouse of or has a consanguinity or a second- or third-degree affinity relation with the person that may have caused the Loss, or if he is liable for the Loss.

VII. AXA Assistance Services

I. Definitions

The terms listed below as used in this section shall have the following meaning when capitalizaed:

a. Beneficiary(Ies)
Persons added to the Policy.

a. AXA Assistance Medical Team
Suitable medical and assistance staff arranging Assistance Services for a Beneficiary on behalf of AXA Assistance.

b. Insured Family
Insureds added to the Policy.

c. Insured Family Guest

Persons invited by the Insured Family, who are at the Insured Policyholder´s adrress at the time an Assistance EVent occurs.

d. Household Employees

Persons working at the domicile of the Insured Policyholder who have been hired by any Family member to carry out household chores and cleaning-related activities when an Assistance Event occurs.

e. Representative

Any person, whether or not a companion of the Beneficiary, making arrangements for the Beneficiary to facilitate Assistance Services.

f. Assistance Services

The Assistance Services arranged by AXA Assistance for the Beneficiaries in the terms of these general conditions, in case of any Assistance Event involving a Beneficiary.

g. Assistance Event

Every occurrence happening to the Beneficiary in the terms and subject to the limits of these general conditions, and all other described situations likely to enable the arrangement of Assistance Services.

h. Territory Limit

The Assistance Services described in these General Conditions may be arranged anywhere in the Mexican Republic from the Beneficiary's own Permanent Residence.

i. Trip

A person is on a trip when he/she is more than 100 (one hundred) kilometers away from the center of his/her city of Permanent Residence at the time of occurring an Assistance Event.

j. Country of Residence

For the purpose of this Insurance Contract, the Mexican Republic.

k. Permanent Residence (Domicile)

The Beneficiary's usual domicile in the Mexican Republic as shown on the Policy Dec Page or any other reasonable means of verification.

II. Assistance Services included in the Policy

24-hour Medical Helpline

a. Telephone Medical Assistance

At the request of the Beneficiary, AXA Assistance Medical Team will provide him/her telephone assistance on minor issues or any doubt related to the use of medicines or discomfort afflicting him/her. This service will be provided 24 (twenty-four) hours a day, 365 (three hundred and sixty-five) days a year.

AXA Assistance Medical Team will not make a diagnosis, but at the request of the Beneficiary he/she will be directed to Schedule the provision of land ambulance services.

b. Provision of land ambulance services (Medical Land Transportation)

AXA Assistance shall arrange the transportation of the Insured to the nearest hospital center in case AXA Assistance Medical Team considers Hospitalization is necessary and shall carry out transportation by the most appropriate means.

Inter-Hospital transportation or transportation from hospital to the Beneficiary´s Permanent Residence is also covered when recommended by AXA Assistance Medical Team.

This service is provided at no cost limited to 2 (two) events during the Policy Period, service subject to availability at the respective locality.

c. Doctor Home Visit (Home Consultation)

At the request of the Beneficiary, AXA Assistance will make arrangements to send a General Physician to the Permanent Residence of the Beneficiary or to the place where the Beneficiary is at the time of making the request.

The Insured shall pay directly to the visiting Physician for each home visit at the end of the medical Consultation.

AXA assistance will provide such service in the main cities of the Mexican Republic specified in clause 35 -Special Clause for Assistance Services provided by AXA Assistance; and in all other places AXA Assistance shall do everything possible to help the Beneficiary contact a Physician or Hospital as soon as practicable.

d. Telephone Nutritional Support

Nutritionists hired by AXA Assistance will provide the Insured with telephone nutritional assistance through a call center from 9:00 to 17:00 hours Monday to Friday, maximum assistance time:15 (fifteen) minutes per call. After this time, the Beneficiary will be referred to a nutritionist for a personal consult.

e. Telephone Psychological Support

Psychologists hired by AXA Assistance will provide the Beneficiary with telephone psychological assistance through a call center from 9:00 to 17:00 hours Monday to Friday, maximum assistance time:15 (fifteen) minutes per call. After this time, the Beneficiary will be referred to a psychologist for a personal consult

III. Additional Assistance services subject to charge

Trip Assistance Services (SAV)

By purchasing this additional coverage and as of the Addition Date thereof, Assistance Services described below shall be provided by AXA Assistance, company specialized in assistance programs.

Services described below will be scheduled by calling the phone numbers provided by the Company for such purpose.

1.1. Benefits

a. Transportation to a medical center

In case a Beneficiary sustains an Accident or Illness after the beginning of or during the Trip and AXA Assistance Medical Team in contact with the Physician attending the Beneficiary, recommends Hospitalization, AXA Assistance shall arrange:

a. Transportation of the Beneficiary to the nearest Hospital center, and

b. If it is necessary for medical reasons:

- The Beneficiary will be transported under medical supervision by the most suitable means of transportation (including but not limited to air ambulance, commercial airliner, or intensive, intermediate or standard care ambulance) to the hospital that best copes with the particularities of the wounds or Illness sustained by the Beneficiary.

- If the medical condition allows the Beneficiary to be transported, the AXA Assistance medical team will arrange the Beneficiary´s transportation under medical supervision by commercial airliner to the Hospital or medical center nearest to the Beneficiary´s Permanent Residence. The AXA Assistance medical team and the treating Physician will take the measures necessary for this transportation.

Beneficiaries: the Insured Family.

b. Round trip ticket and accommodation expenses for a family member

In case the Beneficiary is hospitalized because of an Accident or Illness occurring after the beginning of or during the trip and such Hospitalization is expected to last longer than 5 (five) days, AXA Assistance will arrange and provide the person designated by the Beneficiary with a round trip ticket (economy class, point of departure from the city of Permanent Residence of the Beneficiary) to accompany the Beneficiary.

AXA Assistance will also make accommodation arrangements for the person designated by the Beneficiary and pay up to USD 1,000 (one thousand dollars) per day for a 10 (ten) calendar day period.

c. Round trip ticket for a family member

In case the Beneficiary is hospitalized and such Hospitalization is expected to last longer than 10 (ten) days, the assistance company will provide the person designated by the Beneficiary with a round trip ticket (economy class, point of departure from the city of Permanent Residence of the Beneficiary) to accompany the Beneficiary

d. Trip ticket for a substituting professional

In case the Beneficiary becomes disabled to perform the entrusted work and such disability is expected to last longer than 5 (five) calendar days, according to the opinion of the treating Physician and the AXA Assistance medical team, as a result of an Accident or Illness (not caused by manual works after the beginning of or during the Trip), AXA Assistance will make arrangements for a round trip flight ticket (economy class) so that a substituting professional of the same company travels on a commercial airliner to replace the Beneficiary in all his/her entrusted activities.

e. Referral to interpreters and legal advisors, including payment and sending of a lawyer

At the request of the Beneficiary and in case of a civil or criminal suit brought against the Beneficiary following the beginning of or during the Trip, AXA Assistance will arrange and pay the fees of a lawyer who will take over the Beneficiary's defense, up to MXN 25,000 (twenty-five thousand pesos) as fees for lawyers, bails and bonds, subject to a maximum of 3 (three) events per year and Policy.

This benefit will be forfeited if the legal suit is due to the Beneficiary's professional activity or involvement in the traffic, possession or consumption of drugs or narcotics or intoxicants, or ingestion of alcoholic drinks, or in case the beneficiary absconds or abandons the legal proceedings brought against him/her.

f. Medical repatriation to the Beneficiary´s residence or to a rehabilitation center

In case the Beneficiary sustains an Accident or Illness of such a seriousness that Hospitalization is advised by the AXA Assistance medical team along with the Physician attending the Beneficiary, the assistance company will arrange and pay:

a. The transportation of the Beneficiary to the nearest Hospital center when necessary for medical reasons.

b. The transportation of the beneficiary under medical supervision by the most suitable means of transportation (including but not limited to air Ambulance, commercial airliner or Ambulance) to the hospital center that best copes with the wounds or injuries sustained by the beneficiary.

c. If the medical condition allows the Beneficiary to be transported, the AXA Assistance medical team will arrange the Beneficiary´s transportation or repatriation under medical supervision by commercial airliner to the Hospital or medical center nearest to the beneficiary´s Permanent Residence. The AXA Assistance medical team and the treating Physician will take the necessary measures for such transportation or repatriation.

g. Transmission of urgent messages to keep the Beneficiary´s family well informed

The assistance company, at the request of the Beneficiary, will take charge of transmitting urgent messages in connection with an Assistance Event.

h. Transportation of Mortal remains, transportation arrangements, including corpse preparation, necessary documentation and payment of transportation or local burial

In case of death of the Beneficiary, the assistance company will make all the necessary formalities (including any legal proceedings) and take over:

a. The transportation of the corpse or ashes to the burial site in the city of Permanent Residence of the Beneficiary; or

b. At the request of the Beneficiary's heirs or Representatives, the burial at the place where death occurs. The assistance company will bear such expenses up to the cost that would have been incurred had the corpse be transported as provided in the above paragraph.

i. Assistance for the replacement of stolen or lost baggage or documents, and reshipment of this property if recovered

In case of theft or loss of the Beneficiary's baggage or personal effects, the assistance company will assist the Beneficiary in reporting the facts and recovering such baggage or personal effects. If this property is recovered, the assistance company will be responsible for reshipping if to the place where the beneficiary is currently staying or to the Beneficiary´s Permanent Residence.

In case of theft or loss of documents necessary to continue the trip, such as passport, visa, flight tickets, etc., the assistance company will provide the necessary information and arrange the respective proceedings with the relevant local authorities in order to process the replacement of lost or stolen documents.

j. Medical assistance out of Mexico, up to USD 10,000 (ten thousand dollars)

Medical and Hospitalization expenses

AXA Assistance will provide and take responsibility for necessary medical services in case the Insured requires Hospitalization out of Mexico, up to the maximum limit of USD 5,000 (five thousand dollars) or amount equivalent in Mexican pesos per trip, and up to USD 10,000 (ten thousand dollars) or amount equivalent in Mexican pesos per year and for each Beneficiary of the Policy.

Costs of Prostheses, eyeglasses, contact lenses, hearing aids, dentures, plastic surgery, routine or periodical health checkups, medical and Hospitalization expenses incurred out of the Country of Residence, when prescribed or justified before commencing the trip or occurring after the Beneficiary's return are excluded.

k. Expenses incurred for urgent dental care, up to USD 500 (five hundred dollars)

In case of acute dental problems requiring urgent dental Treatment, emergency dental service will be provided for the Beneficiary up to USD 500 (five hundred dollars).

l. Hotel Expenses for Convalescence, up to USD 500 (five hundred dollars)

AXA Assistance will arrange the payment of expenses for extended stay at a hotel selected by the beneficiary immediately after being discharged from Hospital, because of a covered Accident or Illness occurring after the beginning of or during the Trip, in case such extension is prescribed by the local Physician and the AXA Assistance medical team. This benefit is limited to USD 100 (one hundred dollars) per day and up to 5 (five) calendar days per year.

Beneficiaries: the Insured Family.

m. Early return home by commercial airliner (economy class) in case of death of a first-degree relative

The assistance company will arrange and be responsible to pay additional expenses for the beneficiary´s early return home by commercial airliner (economy class) in case of death of a first-degree relative in the city of Permanent Residence, provided that the original return ticket cannot be used.

n. Sanitary Repatriation

In case the Beneficiary is anywhere out of the Mexican Republic where an epidemic outbreak occurs as declared by the World Health Organization, and requests the Company to be repatriated to a medical center at his/her usual residence, AXA Assistance in coordination with the treating Physician will decide on its convenience and make the transportation arrangement.

If the Insured cannot return to his/her Permanent Residence as a regular passenger, or cannot use the transportation means initially planned, AXA Assistance will arrange the Insured´s transportation by the necessary means according to the instructions of the treating Physician and will bear all the necessary costs for such transportation.

This benefit may be enjoyed only by means of previous scheduling with AXA Assistance by calling the telephone numbers indicated by the Company to such effect. **Reimbursement payment is not applicable**.

Trip Assistance Services are available 24 hours a day.

If the Guaranteed Conversion (CGAR) coverage is agreed, this benefit will take effect even if the Guaranteed Conversion deductible is not exceeded.

IV. Obligations of the Beneficiary

a. Request for Assistance

In case of an Assistance Event and before any action is taken, the Beneficiary will make a call for assistance to the telephone number provided by the Company to such effect and provide the following information:

- Address and telephone number where the Beneficiary or Beneficiary´s Representative may be contacted by AXA Assistance.
- Name and Policy number.
- Description of the ailment or condition and the assistance required.

The AXA Assistance medical team will have free access to the Beneficiary and his/her clinical record to learn about his/her condition. If such access is denied, AXA Assistance will have no obligation to arrange any assistance services.

b. Medical Land Transportation

To facilitate a better intervention of AXA Assistance in case of medical transportation, the Beneficiary or Beneficiary´s Representative will provide:

- Name, address and telephone number of the Hospital or medical center where the Beneficiary is admitted or place where the Beneficiary stays.

- Name, address and telephone number of the treating Physician and, where required, the data of the Beneficiary´s family doctor.

The AXA Assistance medical team or their representatives will have free access to the Beneficiary and his/her medical record for health assessment purposes. If such access is denied, the Beneficiary´s right to any assistance services will be forfeited.

In any case, the AXA Assistance medical team will decide on the appropriate time for such transportation and determine the most appropriate dates and means for such purpose, considering the circumstances of the case.

c. Impossibility to notify AXA Assistance

The services referred to in these conditions are the sole obligation of AXA Assistance and only in cases of absolute and proven urgency or impossibility of the Beneficiary to request such services in the terms of these conditions, such Beneficiary may turn directly to third parties for these services; in such case, AXA Assistance will reimburse to the Beneficiary the sums incurred, but only with respect to emergency land Ambulance. No reimbursement will be made in any other case.

In case of danger to life

In situations where life is in danger, the Beneficiary or Beneficiary´s representative will always act with the utmost diligence to transport the injured person to the hospital nearest to the place where the Accident or Illness occurs, by using the most appropriate and immediate means, or will take the appropriate measures; and, as soon as practicable, they will report the situation by calling to the telephone number provided by the Company to such effect.

Use of land Ambulance services without prior notification to AXA Assistance

Upon the occurrence of an Accident or Illness that makes necessary the provision of emergency land ambulance services without prior notification to AXA Assistance, the Beneficiary or Beneficiary´s Representative will make a call to the telephone number provided by the Company to such effect within a period not later than 24 (twenty-four) hours following the occurrence of such Accident or Illness.

In case such notification is not given as above, the Beneficiary will be considered by AXA Assistance the party responsible to pay the incurred costs and expenses.

V. General rules

a. Mitigation

The Beneficiary will contribute to prevent the effects of any Assistance Event from becoming worse.

b. Filing of claims

Any claim related to an Assistance Event will be filed within 90 (ninety) calendar days following the date of the event giving rise to such Assistance Event, and any right likely to be exercised against AXA Assistance or the service provider will become time-barred once such period elapses.

c. Assistance service provider

The parties providing services are mostly independent contractors selected by AXA Assistance and holding the appropriate qualifications and competencies according to the average levels in the area, at the time and in the circumstances under which the assistance services are arranged. AXA Assistance and the Company are responsible for the arrangement of services according to provisions in this Insurance Contract.

d. Subrogation

AXA Assistance will be subrogated to the extent of the limit of expenses incurred and sums paid to the Beneficiary, in all the rights and actions the beneficiary may exercise in respect of the events for which the assistance services are arranged.

VI. Specific exclusions applicable to Trip Assistance Services

I. Assistance Events occurring in trips or vacations taken by the Beneficiary against medical advice.

II. In case the Beneficiary absconds or abandons the legal proceedings brought against him/her.

III. Rejection of the lawyer appointed by AXA Assistance.

IV. Refusal by the beneficiary to attend any hearing with the competent authority.

V. The Beneficiary will not be entitled to reimbursement from AXA Assistance.

VI. Assistance Events arising from the Scheduling of Services

VII. Assistance Events arising from:

- **a. The Beneficiary's direct participation in war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), rebellion, civil war, insurrection, acts of terrorism, uprisings, demonstrations, riots, radioactivity.**
- **b. Illnesses or Accidents attributable to extraordinary natural phenomena, such as flood, tidal wave, earthquakes, volcanic eruption, cyclone, mudslide, snowfall, snow avalanche, tsunami, storm surge, hurricane, flash flood, windstorm, hydrometeorological phenomena and/or hailstorm.**
- **c. Self-inflicted injuries or participation of the Beneficiary in criminal acts.**
- **d. The Beneficiary´s participation in quarrels or fights, except as an act of self-defense.**
- **e. Playing of sports as professional, participation in official competitions and exhibitions.**

f. The Beneficiary´s participation in any kind or races, competitions, exhibitions or safety, speed or endurance contests and/or tests.

g. Radiation from nuclear transmutation or disintegration or radioactivity resulting from any kind of Accident caused by nuclear fuel.

h. The Beneficiary´s participation in criminal acts or acts contrary to the morality or good manners.

i. Transportation for natural or normal reasons related to pregnancy, delivery or scheduled caesarean section.

j. Mental Illnesses or disorders and depression.

k. Vision examinations to obtain or correct a prescription for corrective lenses, and surgical procedures, such as radial keratotomy or other type of surgeries intended to correct refractive errors.

l. Transplant of organs or limbs of any kind.

m. Illnesses or pathological states produced by deliberate ingestion or administration of intoxicants (drugs), narcotics or the use of Medicines without medical prescription.

n. Suicide or Illnesses and injuries resulting from attempted suicide.

o. Injuries resulting from practicing a manual profession.

p. Death or injuries caused by malicious intent or bad faith of the Beneficiary.

q. Minor injuries or Illnesses that do not make ambulance transportation necessary according to the treating Physician.

r. If the Beneficiary is arrested by any authority for any reason.

s. If the airport time schedule and/or the physical or meteorological conditions prevent the safe transportation.

t. No assistance services will be provided if the Beneficiary does not have an official ID.

u. Lack of approval by the treating Physician expressly certifying the Beneficiary´s clinical stability for his/her transportation.

v. Rescue operations or situations that prevent or hinder the Beneficiary from being rescued or put in danger the life of providers of assistance services because of being at remote, impassable places or regions making the access thereto difficult and dangerous, very distant from a town or road that allows

the safe and appropriate transit of an ambulance or tow truck, as well as any place or land whose morphology or circumstances demand the involvement of rescue experts of any kind.

VIII. Meaning of Abbreviations

- **MFH:** Out-of-hospital medicines
- **MATE:** Extended Maternity
- **PRE:** Preexistence
- **DED0:** Zero Deductible in case of Accident
- **CGMM:** Not Covered Major Medical Expenses Resulting from Complications
- **CoNa:** Coverage in National Territory
- **CONT:** Guaranteed Continuity
- **CGAR:** Guaranteed Conversion
- **EMER:** Medical Emergency out of Mexico
- **ECE:** Illnesses covered out of Mexico
- **ATEX:** Medical Care out of Mexico
- **DIST:** VIP Customer
- **SAV:** Trip Assistance Services
- **GMM:** Major Medical Expenses
- **USD/US:** American Dollars
- **MXN:** Mexican Currency
- **N/A:** Not Applicable
- **Max.:** Maximum
- **Hrs.:** Hours
- **Art.:** Article
- **C.P.:** Zip Code
- **Axa Ind.:** AXA under an Individual Policy
- **DSM:** Diagnostical and Statistical Manual of Mental Disorder
- **FDA:** Food and Drug Administration
- **IMC:** Body Mass Index
- **HIV:** Human Immunodeficiency Virus
- **AIDS:** Acquired Immune Deficiency Syndrome
- **UNE:** Customer Complaints Unit
- **Condusef:** The National Commission for the Protection and Defense of Users of Financial Services
- **Cofepris:** Federal Commission for the Protection against Sanitary Risks
- **NCCN:** National Comprehensive Cancer Network

IX. Registry

In compliance with provisions set forth in article 202 of the Insurance and Bonding Institutions Law (Ley de Instituciones de Seguros y Fianzas), the contractual documentation and technical note forming part of this insurance product are on file with the National Insurance and Bonding Commission (Comisión Nacional de Seguros y Fianzas) under registry **CNSF-S0048-0039-2020 dated January 1, 2020.**

Assistance Services included:

a. Dental Protection

By means of this service, Insureds shall be referred by the Company to in-network dental providers designated by the Company in the Mexican territory only.

This benefit provides the following dental services:

Free of charge
Comprehensive Evaluation One panoramic X-ray
Two dental cleanings per year

At preferential price: Paying 30% of the price
Additional teeth cleaning
Comprehensive periodontal evaluation
Periodontal scaling and root planning per quadrant
Periapical and radiographic series
Amalgams
Resins
Simple extraction
Endodontics

Dental Protection For children, including treatments	
Free of charge	**Paying 30% of the price**
Complete evaluation	Simple extraction
One panoramic X-ray per year	Periapical and radiographic series
One dental cleaning with fluorine per year	Resins, among others

Assistance Services subject to charge

b. Full Dental Protection (PDI)

By means of this service, the Insureds shall be referred by the Company to in-network service providers designated by the Company in Mexican territory for the provision of the follwing services at preferential price.

Third Molar Extraction

Maxillofacial
• Surgical removal of residual tooth roots
• Easy removal of residual tooth roots
• Ferulization
• Biopsy of hard tissue
• Intra-oral soft tissue biopsy
• Drainage of abscess-intraoral soft tissue
• Frenectomy
Periodontics
• Gingivectomy per arch
• Gingivoplasty
• Open Scaling and Root Planning (Per Quadrant)
• Closed Scaling and Root Planning (Per Quadrant)
• Crown lengthening per tooth
• Bovine bone grafting
• Musculoskeletal bone grafting
• Distal wedge
• Connective tissue graft
• Periodontal maintenance therapy

Prostheses
• Metal porcelain Crown
• Fiberglass pins and cores
• Poured pins and cores
• Porcelain inlay

Full Dental Protection for children, additionally including
• 2 sealants free of charge, paying only 30% of their original price for further sealants
• 1 resin for children free of charge

This assistance service may only be purchased within the first 30 (thirty) days as of the inception date of the Policy.

Cancellation

This assistance service may be cancelled only within the first 30 (thirty) calendar days as of the inception date of the Policy and at the request of the Insured.

Call toll free

800 911 9999

axa.mx

FEBRERO 2021

This translation into English is a professional courtesy only. In case of controversy, the original wording shall prevail.

Traducción\CGSalud\Gastos medicos\CG Flex Plus Nuevo Negocio Inglés (a partir del 1 de febrero 2020)

AXA Seguros, S.A. de C.V. Félix Cuevas 366, piso 6, col. Tlacoquemécatl, alcaldía Benito Juárez, 03200, Ciudad de México, México
Tels. 55 5169 1000 800 900 1292 axa.mx